23 March 2011	ITEM 5.3
Council	
REPORT OF THE DEPUTY CHAIR OF HEALTH AND WELL-BEING OVERVIEW AND SCRUTINY COMMITTEE	

Report on the Health and Well-being Overview and Scrutiny Committee's visit to Basildon Hospital

Following the agreement of the Health & Wellbeing Overview and Scrutiny Committee; a cross-member group of councillors visited Basildon and Thurrock University Hospital (BTUH). The visit sought assurance on the progress being made following the Care Quality Commission (CQC) Review of Compliance of BTUH on their three day inspection in December 2010.

The group visited on 17th February 2011 and were impressed with the newly appointed Director of Nursing, Diane Sarkar. Ms Sarkar was open and honest, proud of the on-going work but realistic in her expectations of the timeframe needed to ensure all aspects of the Compliance Review are met. She acknowledged where things needed improvement and the group were impressed at the rate of implementation of change. Despite the challenges, staff on the wards were welcoming and knowledgeable about their patients, systems and the Trust's aims for improving quality.

The wards appeared clean, well staffed and, when asked, staff were confident they could access more staff if an emergency arose. Patients on the wards reported they were happy with the care being provided.

In addition to the group visiting wards, a structured interview was held with Diane Sarkar to address how the specific issues raised by the CQC were being addressed. Diane verbally answered these questions and agreed to follow up with a written response.

Outcome 4 - People should get safe and appropriate care that meets their needs.

Q. Can you tell us what assessment tools you have in place to inform your baseline assessment and subsequent care-planning for nutritional status and pressure ulcers. What training has been delivered for staff on these?

A. Nutrition

Nutritional status is assessed on admission using a validated screening tool called MUST (Malnutrition Universal Screening Tool) as recommended by NICE 2006, Royal College of Nursing. Patients should

be assessed within 12 hours of admission (Standard in 'Assessing adult patients on admission to hospital Policy' 2011), and re-assessed at 7 days or sooner of condition changes.

MUST has been used within the Trust since 2003 and is taught to both Registered Nurses and Support Staff. It is incorporated within the initial assessment documentation and the responsibility of Registered Nurses to complete. Care should be planned using the information gathered in the initial assessment and MUST screening.

The wards use the risk assessment document which covers Waterlow and MUST assessments. The ward staff on induction are familiarised with the documents and assessment process. The assessments then indicate ongoing assessment and care planning.

On Trust mandatory training, staff are given tissue viability assessment training. There are study days for nutrition for trained and untrained staff. The Foundation Programme has been updated and incorporates assessment of patients.

Training is offered to Registered Nurses and Support Staff via Enteral Study Days on how to do MUST. We have recently purchased an e-learning package to help facilitate dissemination to a broader audience, including doctors and other allied healthcare professionals. Uptake of the e-learning will be monitored through the Training and Development Department.

Pressure Ulcers

The Trust uses the internationally recognised Waterlow Score Assessment tool to inform a patients baseline in assessing skin integrity and identifying patients at risk of their development. The Trust policy explicitly defines what actions are to be taken by the Health Care team to manage the patient care pathway appropriate to their identified needs. In addition, all pressure ulcers of grades 3 and 4 whether they originate from the Trust or the Community are subject to a Root Cause Analysis to determine causation and learning from outcome.

All registered nursing staff are provided with training on the assessment and management of skin integrity for patients.

Staff who require it are provided with instruction during their week induction and supervisory period upon commencement of their role.

For newly qualified nurses, they also receive further training as part of their induction and preceptorship period during attendance at the Trusts newly qualified Foundation Development Programme.

The Tissue Viability service provide a series of study days as part of a suite of programmes which covers basic nursing assessment through to

the management of complex wounds; this training is accessible to clinical nursing and midwifery staff and other staffing groups. The Specialist Nurse also provides individual support, supervision and training in practice for staff whilst undertaking of her clinical responsibilities.

The Trust local university provider, Anglia Ruskin University, deliver an academic degree level module for tissue viability for staff needing a more specialist level of knowledge and this is accessible through the core educational contract that the Trust holds with the University/East of England SHA.

Q. How is a person's discharge facilitated.

A. The patients are assessed on admission using the admission and discharge document. This helps to identify the patients' pathway. Currently in medicine patient pathways for discharge are being developed. The trained staff are responsible for planning the patient's journey, when a patient is identified as having complex needs then they may be referred to the Complex Case Management Team. Surgery are addressing nurse led facilitated discharges for gynaecology patients ad elective orthopaedics. Some wards have discharge facilitators however these are progress chasers. For the complex discharges, the complex care discharge team, work with social services and other relevant partners to discharge individuals to intermediate, rehabilitative; short or long term supported/residential or nursing home placement

Simple discharge is facilitated via the multi-disciplinary healthcare team who undertake an assessment of the individuals needs prior to discharge. This involves the collaboration of the medical teams, the nursing team, pharmacists, therapists and social workers, plus other professionals, dependant on the patient's explicit needs.

Q. What training is in place for staff in dementia awareness and what percentage of staff have had this training.

A. There is training provided by SEPT and in medicine 10 staff members attend this and in surgery 4 staff. Three staff are booked on the dementia modules at Essex University and two ward managers have already completed these. We are trialling an on line version which takes approx 3 hrs maximum to complete, the Senior Sister office computers on the DMOP wards have been configured so staff can use this for the programme. The foundation programme changes now also incorporate this training.

Training on caring for dementia patients forms part of the dementia project which has recently been commenced within the Trust. The intention is to roll training out across the organisation to all areas. In addition, the Alzheimer's society have provided the Trust with 2 support workers for a 3 month period to work with staff on the older peoples wards to improve the knowledge and experience of staff in meeting the needs of dementia

patients, in particular managing behaviour and improving the patient experience through distraction therapy.

A training strategy is being developed to roll out training relevant to the needs of the organisation and this will determine which other staff require training, to what level and how often. It is not possible to determine the percentage of staff trained at this point on the basis that a training needs analysis has not yet been carried out; therefore the baseline for determining the percentage is not yet available.

Outcome 5 - Food and drink should meet people's individual dietary needs.

Q. Do you have a standard form for completing food and fluid intake and how is this audited.

A. There is a standard 'food record chart' supplied by the Dietetic Department. This is under review. We include completeness of food record charts in a 'spot check' audits.

A major audit of nutritional care and documentation was carried out in January and an action plan to address improvements has been populated.

A 'live' documentation audit of all inpatients was carried out at the beginning of March, the results are currently being analysed.

An audit of documentation is carried out on a monthly basis, which is currently being reviewed

Outcome 8. people should be cared for in a clean environment and protected from the risk of infection.

Q. What percentage of staff have had infection control training?
Q. How is the staff training database managed on a ward level?

A. All staff who attend the Trust induction programme receive training in infection prevention and control as part of the programme.

All clinical areas have a local induction programme for Infection Prevention and Control and all new staff should complete this within 4 weeks of commencing.

Each area has an Infection Prevention Link Worker, who are trained in delivering hand hygiene training and carry this out locally to all staff on an annual basis. The register of competent/trained staff is held within the local area, copy sent to the governance lead who maintain a central register for their Directorate.

Outcome 10 Safety and suitablility of premises

Q. What action is being taken in relation to the revolving doors in the event of power failure and fire safety on the Cardio-Thoracic Centre.

A. Modifications will be completed which address the concerns regarding the revolving doors. An order has been placed and the work should be completed shortly. The actions to mitigate the risks associated with the fire doors is ongoing and has been endorsed by the Essex Fire Brigade.

Outcome 11. People should be safe from harm from unsafe or unsuitable equipment.

Q. Who is responsible for checking the results trolley; how often is this done and how is this audited.

A. Each Trolley has a checklist detailing all the equipment that must be available on the resuscitation trolley. The trolley must be stocked according to this list and no items should be added or removed without the agreement of the Resuscitation Service.

All members of staff must be familiar with the resuscitation equipment in their area. New members of staff and locum/agency staff must familiarise themselves with the resuscitation equipment and its location. Ward/Department Managers are responsible for ensuring that their areas have the correct equipment and that the resuscitation equipment is fully functioning, and adequate stocks of disposable items are maintained.

All resuscitation equipment must be checked on a daily basis. It is the ward/department managers' responsibility to check that the daily checks are taking place by reviewing the Resuscitation Equipment Signing book weekly. Resuscitation Equipment Signing books must be kept for 10 years in accordance with the Department of Health (2009) records management - retention periods. The Resuscitation Service will monitor the compliance of Resuscitation Equipment checking by performing "Spot Checks" and will produce quarterly audits in which the ward/area manager will be informed of the outcomes.

Q. Does the Acute Medical Unit (East) now have sufficient quantities of nebulisers?

A. Unfortunately at the time of the visit we had some that had been sent away for repair. These have now returned and we currently have sufficient for our needs. We are still looking to increase this number due to the fluctuations we experience especially through the peak in the winter months.

Q Can you update the Committee on the processes for reporting and learning from incidents.

A. Following the CQC in September the following was undertaken:

- An immediate action plan developed and reviewed 4 weekly.
- Trust SI policy reviewed to ensure alignment with EoE SHA policy, however further review is required following NHSLA review.
- Presentation on the 'Recognition and Escalation of SIs' delivered to CD Board, GMs, BOD, CEO forum, Clinical Governance Symposium and has been cascaded out through the organisation. Evidence is provided via the signed declaration form and minutes of meetings.
- A quiz was developed and used to assess the level of knowledge obtained following the presentation at the Clinical Governance Symposium, results have been analysed.
- The management of SI process has been reviewed with revised documentation. This was shared with the PCT and SHA. The trial was agreed for the use in 2 SIs and then to be re evaluated. 2 SI processes have just been completed and the documentation revised and improved.
- A revised report format was also been trialled a new one developed.
- A review of the training provision to the Investigating Officers has been undertaken and additional support to existing Investigating Officers has been provided. An RCA workshop has been provided for some staff and will be further cascaded to more staff. Criteria agreed for eligibility for an Investigating Officer is now included in the revised policy.
- To ensure changes happen in practice which are audited and evaluated are now monitored by: a) a follow up meeting to the SI process to ensure closure and completeness of all actions from the action plan b). An update on the action plans are included in the Directorate reports to Clinical Governance Management Group (CGMG), c) SIs now an agenda item on CGMG, d) Audits will now be monitored by the Clinical Effectiveness Unit (CEU). A 100 day follow up meeting is scheduled to ensure closure of the action plan.
- SI update, progress and immediate actions taken now an agenda item at Clinical Directors (CD) Board, Clinical Governance Committee (CGC), Board of Directors (BoD) and CGMG.
- A collated report of Complaints, Litigation, Incidents and PALs (CLIP) is now produced on a quarterly basis and is reported at the BoD which identifies themes and trends.
- A risk matrix has been developed to aid the grading of all new SIs.
- Discussions and sharing of information now more evident at EOE Directors of Nursing (DoN) meeting.

- A weekly spreadsheet is now populated and sent to the DON by mid day on a Tuesday and is then circulated to the Executive Team and discussed at the Executive meeting on a weekly basis.
- All time lines and reporting to the PCT have been achieved since October 2010.
- A meeting was facilitated with Directorate Risk Leads to improve their understanding and further streamline the process.
- A Board Assurance Framework for the management of SIs presented to and approved by the Board.
- Random audit of Clinical Incident forms now undertaken by the DoN and Medical Director on a weekly basis of 10 forms and actions taken to ensure completeness and appropriate immediate actions are taken
- A review of systems to support the process is under way
- Continual review of other Trusts and process with PCT and SHA via DoN
- Currently developing another policy for the investigation of Incidents Complaints and Claims to be NHSLA compliant.
- Recently updated the incident investigation proforma to include the investigation of complaints to streamline the process
- When an incident occurs it should be reported on the Trust's incident reporting form, the directorates investigate the incident according to the level, insignificant, minor, moderate, major, serious. The first three would be investigated locally the outcome of the investigation would be reported back to the risk/patient safety team, to assess if the investigation and outcome have been established, lessons learned and shared within the directorate. The incidents are also shared at the risk steering group with the Trust risk leads.
- Serious (and some major) incidents are investigated through the SI process, meetings are arranged and root cause analysis reports are produced. In the case of SIs there is a 45 working day investigation timeline. These incidents are reported externally to NHS SW Essex, Monitor and the EoE SHA.
- Lessons learnt from SI are reported at CGMG and then on to CGC. The attendees of the CGMG are asked to feedback the themes trends and lessons learnt for SI to their directorates following the meeting, action plans from these incidents are owned and presented by the directorates at subsequent meetings within their directorate reports.
- Directorates have their own governance meetings during which they share the lessons learnt from their investigations and the SIs. The directorates are responsible for feeding back outcomes to the individual who reported the incident.