Bundle Quality, Safety and Experience Committee 16 April 2019

Agenda attachments

00 - Agenda agreed by Chair and Executive Lead v3.docx

1	STANDING ITEMS
1.1	Welcome and Introductions *Susan Elsmore*
1.2	Apologies for Absence *Susan Elsmore*
1.3	Declarations of Interest *Susan Elsmore*
1.4	Minutes of the Committee meeting held on 19 February 2019 *Susan Elsmore* 1.4 QSE Mins 19.02.19 v3.docx
1.5	Action Log from 19 February 2019 *Susan Elsmore* 1.5 Action Log February.docx
1.6	Chair's Action taken since last meeting
1.7	QUALITY GOVERNANCE
1.8	Patient Story
1.9	Surgery Clinical Board Assurance Report 1.9 - Surgery Clinical Board QSE assurance report.docx
1.10	Mental Health Clinical Board Assurance Report: Reducing Length of Stay Project Plan *Steve Curry* 1.10 - Mental Health Services for Older People – In-Patient Care Improvement Project through ALOS reduction.docx
1.11	Mental Health Clinical Board: Report on Medical Cover for Mental Health Patients with Physical Needs on Llandough Site *Oral - Graham Shortland*
1.12	Community Health Council Report: One Simple Thing - Communication in the NHS and the UHBs Response *Angela Hughes* 1.12 - QSE Committee - April 2019 - One simple thing.docx
1.13	Annual Quality Statement (First Draft) [paper will be supported by a presentation] *Carol Evans* 1.13 - Annual Quality StatementFINAL_QSE_2019_04_16.docx
1.14	POLICIES
1.14.1	Labelling of Specimen's Submitted to Medical Laboraties Policy *Lisa Griffiths* 1.14.1 LABELLING OF SPECIMENS SUBMITTED TO MEDICAL LABORATORIES POLICY.doc
1.14.2	Labelling of Specimen's Submitted to Medical Laboraties Procedure 1.14.2 LABELLING OF SPECIMENS SUBMITTED TO MEDICAL LABORATORIES PROCEDURE.doc
1.14.3	Venepuncture for Non-Clinically Qualified Research Staff Policy 1.14.3 Venepuncture for Non Clinically Qualified Research Staff Policy.doc
1.14.4	EHIA Venepuncture for Non-Clinically Qualified Research Staff 1.14.4 EHIA Venepuncture for Non Clinically Qualified Research Staff Policy.doc
1.14.5	Venepuncture for Non-Clinically Qualified Reserach Staff Procedure *Lisa Griffiths* 1.14.5 Venepuncture for Non Clinically Qualified Research Staff Procedure V1.0 24_09_18.doc
1.15	Health and Care Standards Annual Audit Report *Ruth Walker*

1.15 - QSE- Health & Care Standards 2018.docx

1.15.1 - HCS audit 2018 appendix 1.docx

1.15.2 - HCS audit 2018 appendix 2.docx

2 HEALTH, PROMOTION, PROTECTION AND IMPROVEMENT

No items to report

3 THEME 2: SAFE CARE

3.1 Patient Safety Solutions (Standard 2)

Carol Evans

3.1 - QSE Committee - April 2019 - Patient Safety Solutions v4.docx

3.1.1 - Appendix 1 v2.docx

3.2 Patient Falls (Standard 2.3)

Fiona Jenkins

3.2 - Patient Falls Report.docx

3.3 Primary Outcome: People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury (Standard 2.5)

Fiona Jenkins

3.3 - Hydration and Nutrition Report 2019.docx

3.3.1 Hydration and Nutrition Powerpoint

3.3.1 - Nutrition and Hydration PP.pptx

3.3.2 Nutrition and Catering Terms of Reference

3.3.2 - Nutrition and Catering ToR.doc

3.3.3 Benefits of Colour Enhancing Patient Meals - Blue Crockery

3.3.3 - Benefits of Colour Enhancing pts meals - blue crockery.docx

3.3.4 Food and Drink Report - CHC Review

3.3.4 - Food and Drink Review - CHC Report.docx

3.3.5 UHW WAASP and Weighing Audit

3.3.5 - UHW WAASP & Weighing Audit.docx

3.4 Overview of Regulation 28 Reports 2018 / 19

Carol Evans

3.4 - Regulations 28 Report - Final.docx

3.5 Endoscopy Decontamination - Patient Notification Exercise

Ruth Walker

3.5 - Endoscopy decontamination PNE -April QSE v2.docx

4 THEME 3: EFFECTIVE CARE

4.1 Cancer Peer Review: Thyroid (Standard 3.1)

Graham Shortland

4.1 - Thyroid Peer Review report for QSE.docx

4.2 National Hip Fracture Database (NHFD)

Graham Shortland

4.2 - QSE NHFD report April 2019.docx

5 THEME 4: DIGNIFIED CARE

5.1 Healthcare Inspectorate Wales Activity Update

Carol Evans

5.1 - HIW Activity update - April 2019 -QSE v2.docx

5.1.1 - Appendix 1 - CMHT Thematic Review - All Wales recommendations - CV position - 20.12.18 - FINAL.docx

6 THEME 5: TIMELY CARE

No items to report

7 THEME 6: INDIVIDUAL CARE

No items to report

8 QUALITY, SAFETY AND EXPERIENCE COMMITTEE GOVERNANCE

8.1 Committee Self-Assessment of Effectiveness

Oral - Nicola Foreman

9 ITEMS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE

9.1	Minutes from Clinical Board Quality Safety and Experience sub-Committees - Exceptional Items to be raised by the Assistant Director, Patient Safety and Quality
	Carol Evans
9.1.1	Clinical Diagnostics and Therapeutics - after December 2018
	Steve Curry
	9.1.1 CDTCB - Minutes 9.1.19.docx
	9.1.1.1 CDTCB Minutes 13.2.19.docx
9.1.2	Mental Health - after November 2018
	9.1.2 MHCB - 17 January 2019 Minutes.doc
9.1.3	Primary, Community and Intermediate Care - after November 2018
	9.1.3 PCIC DRAFT mins Jan 2019 v2.docx
9.1.4	Specialist Services - after November 2018
	9.1.4 SSCB - Minutes QSE 23 11 18 Final.doc
	9.1.4.1 SSCB - Minutes QSE 13 12 18 Final.doc
	9.1.4.2 Final SpS QSE Minutes 24th Jan 2019.doc
	9.1.4.3 SSCB - Final Minutes QSE 15 2 19 vn2.doc
9.1.5	Medicine - after December 2018
	9.1.5 Medicine QSE Minutes 17.01.19.doc
9.1.6	Surgery - after November 2018
	9.1.6 Surgery CB QSE Minutes 2019 01 15.docx
9.1.7	Children and Women - after November 2018
	9.1.7 - C&W QSPE Minutes 22.01.19.docx
9.1.8	Dental - after January 2019
	9.1.8 - Q&S Minutes - 14-03-2019 - CONFIRMED.docx
10	ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE
	Susan Elsmore
11	REVIEW OF THE MEETING
	Susan Elsmore
12	DATE AND TIME OF NEXT MEETING:
	Tuesday, 18 June 2019, 9.00am *Corporate Meeting Room*

AGENDA

QUALITY, SAFETY & EXPERIENCE COMMITTEE

16 April 2019 at 9.00am
Corporate Meeting Room, HQ, University Hospital of Wales

1.	**Standing Items**	
1.1	Welcome & Introductions	Susan Elsmore
1.2	Apologies for Absence	Susan Elsmore
1.3	Declarations of Interest	Susan Elsmore
1.4	Minutes of the Committee Meeting held on 19th February 2019	Susan Elsmore
1.5	Action Log from 19th February 2019	Susan Elsmore
1.6	Chairs Action taken since last meeting	Susan Elsmore
1.7	**Quality Governance**	
1.8	Patient Story	Alun Tomkinson Mike Bond Clare Wade
1.9	Surgery Clinical Board Assurance Report	Alun Tomkinson Mike Bond Clare Wade
1.10	Mental Health Clinical Board Assurance Report: Reducing Length of Stay Project Plan	Steve Curry
1.11	Mental Health Clinical Board: Report on Medical Cover for Mental Health Patients with Physical Health Needs on Llandough Site	Graham Shortland / Ruth Walker (oral)
1.12	Community Health Council Report: *One Simple Thing – Communication in the NHS* and the UHBs Response	Angela Hughes
1.13	Annual Quality Statement (First Draft) [*paper will be supported by a presentation*]	Carol Evans
1.14 **1.14.1** **1.14.2** **1.14.3** **1.14.4** **1.14.5**	**POLICIES** Labelling of Specimen's Submitted to Medical Laboratories Policy Labelling of Specimen's Submitted to Medical Laboratories Procedure Venepuncture for Non-Clinically Qualified Research Staff Policy EHIA Venepuncture for Non-Clinically Qualified Research Staff Policy Venepuncture for Non-Clinically Qualified Research Staff Procedure	Lisa Griffiths
1.15	Health and Care Standards Annual Audit Report http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,76954831,253_76954832&_dad=portal&_schema=PORTAL	Ruth Walker
2.	**Health Promotion, Protection and Improvement**	
	No items to report	
3.	**Theme 2: Safe Care**	
3.1	Patient Safety Solutions (Standard 2)	Carol Evans
3.2	Patient Falls (Standard 2.3)	Fiona Jenkins
3.3	Primary Outcome:- People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury (Standard 2.5)	Fiona Jenkins
3.4	Overview of Regulation 28 reports 2018 - 2019	Carol Evans

3.5	Endoscopy decontamination – patient notification exercise	Ruth Walker
4.	**Theme 3: Effective Care**	
4.1	Cancer Peer Review: Thyroid (Standard 3.1)	Graham Shortland
4.2	National Hip Fracture Database (NHFD)	Graham Shortland
5.	**Theme 4: Dignified Care**	
5.1	Healthcare Inspectorate Wales Activity Update	Carol Evans
6.	**Theme 5: Timely Care**	
	No items to report	
7.	**Theme 6: Individual Care**	
	No items to report	
8.	**Quality Safety and Experience Committee Governance**	
8.1	Committee Self-assessment of Effectiveness	Nicola Foreman
9.	**Items Received and Noted for Information by the Committee**	
9.1	Minutes from Clinical Board Quality Safety and Experience Sub Committees – Exceptional Items to be raised by the Assistant Director, Patient Safety and Quality	Carol Evans
9.1.1	Clinical Diagnostics and Therapeutics – after December 2018	Steve Curry
9.1.2	Mental Health – after November 2018	
9.1.3	Primary, Community and Intermediate Care – after November 2018	
9.1.4	Specialist Services – after November 2018	
9.1.5	Medicine – after December 2018	
9.1.6	Surgery – after November 2018	
9.1.7	Children and Women – after November 2018	
9.1.8	Dental – after January 2019	
10.	**Items to bring to the attention of the Board/Committee**	Susan Elsmore
11.	**Review of the Meeting**	Susan Elsmore
12.	**Date and time of next Meeting: 18 June 2019 at 9.00am, Corporate Meeting Room**	Susan Elsmore

UNCONFIRMED MINUTES OF QUALITY, SAFETY AND EXPERIENCE
HELD ON 19 FEBRUARY 2019
CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:		
Susan Elsmore	SE	Chair
Maria Battle	MB	UHB Chair
Akmal Hanuk	AK	Independent Member – Community
Gary Baxter	GB	Independent Member - University
Dawn Ward	DW	Independent Member – Trade Unions
Michael Imperato	MI	Independent Member – Legal
In Attendance:		
Abigail Harris	AH	Executive Director of Planning
Angela Hughes	AH	Assistant Director of Patient Experience
Carol Evans	CE	Assistant Director of Quality & Safety
Caroline Bird	CB	Deputy Chief Operating Officer
Chris Lewis	CL	Deputy Director of Finance
Fiona Kinghorn	FK	Director in Public Health
Dr Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Dr Graham Shortland	GS	Medical Director
Nicole Foreman	NF	Director of Corporate Governance
Ruth Walker	RW	Executive Nurse Director
Secretariat:		Glynis Mulford
Visitors:		
Helen Donovan		Senior Nurse – Vale Locality
Kay Jeynes		Director of Nursing – PCIC Clinical Board
Rebecca Aylward		Director of Nursing – Medicine Clinical Board
Observers:		
Lowri Evans		Welsh Clinical Leadership Fellows
Thomas Cronarty		Welsh Clinical Leadership Fellows
Apologies:		
Robert Chadwick	RC	Director of Finance
Steve Curry	SC	Chief Operating Officer

QSE: 19/02/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting and introduced the two clinical fellows who observed the meeting.	**ACTION**
QSE: 19/02/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	

QSE: 19/02/003	**DECLARATIONS OF INTEREST** Independent Member, Michael Imperato declared his interest in the Blood Inquiry Review.	
QSE: 19/02/004	**MINUTES OF THE BOARD MEETING HELD ON 18 DECEMBER 2018** **Resolved – that:** (a) Subject to minor changes the minutes were confirmed as a true and accurate record.	
QSE: 19/02/005	**ACTION LOG FOLLOWING THE LAST MEETING** **QSE 18/190**: **Patient Story** – This action requested to have sight of the project plan relating to reducing length of stay but this was still outstanding. The Committee was assured of a process in place for emergency and cardiac care. The Committee agreed that an update on the situation in reference to what was the medical cover for mental health patients with physical health needs on the Llandough site should come to a future meeting. **QSE 18/191: Mental Health Clinical Board QS&E Assurance Report** – This item would come back in April. **QSE 18/196: Emerging Theme from UK Maternity Service Reviews** – The Director of Transformation would ask if the Long-Term Agreement (LTA) would be addressed in terms of having a clause around quality safety questions. It was agreed the Committee chair would write to SH as lead for commissioning to provide assurance that all LTAs would have a proforma with a specific quality clause around the commissioning function and this would go to Management Executive meeting for further conversation. RW asked Carol Evans to link with Melanie Wilkey to ensure this was covered off. This would be finalised in the LTAs. Regarding the lifts, the maternity work should be completed by May. In terms of the other two lifts there was an agreed programme based on assessment by lift engineers and insurance inspection. An update would be presented in June with schedules up to 2021. The Committee **RECEIVED** and **NOTED** the Action Log from the December meeting	**GS / RW** **RW** **CE** **AH**
QSE: 19/02/006	**CHAIR'S ACTION TAKEN SINCE LAST MEETING** No action had been taken since the last meeting.	

QSE: 19/02/007	**PATIENT STORY** Helen Donovan, Senior Nurse, Vale Locality and Kay Jeynes, Director of Nursing, PCIC Clinical Board presented 'Sally's story' who was significantly physically disabled due to the rapid onset of MS. Her complex needs were explained and the complicated relationship between all involved. Sally was often non-compliant with her care and treatment. Sally was placed and settled into a care home but had repeatedly asked to go home. The DoLs team were involved and her capacity periodically reviewed. There had been opposing views about this and there was a long process to reach the point of her returning home which was staggered and well supported for the transition. Sally's placement back home was driven by herself and with a review from the MDT agreed she was able to decide where her care was best met and understood the consequences of non-compliance with her care and treatment. Sally had learnt lessons from not complying with care and treatment and realised she was not helping herself. Since her return home there had been a reduction in weight, her confidence increased and she was looking to the future in doing voluntary work and making new friends. The team were still reviewing the care package and stated continuing health care was difficult. The following comments were made: • The Mental Health Capacity and Legislation Committee (MHCLC) noted that concern and care was always taken with the use of DoLs and it was pleasing to see this being undertaken in this case. The team was commended in terms of the story in looking at the Mental Health Act (MHA). • It was acknowledged this has been a difficult journey regarding conversations and the time it takes to implement a care package. The success was not just for Sally but the culture of the organisation. • Regarding Sally's views on becoming a volunteer in the Health Board, the UHB Chair asked if Helen Donovan would work with Sally to achieve her goal. • The approach was commendable and ties in with the HBs strategic approach. • This was an empowerment and patient rights story that enabled the opinion based on what the patient wanted. • The members applauded the team for their work which reflected the patients work and courage. This was an inspiring story encompassing staff resolve, persistence and motivation. It was suggested this item go forward for a Staff Recognition Award. The Chair commended the team for a very encouraging story and asked for thanks to be conveyed to colleagues. Resolved that: a) The Patient Story be **NOTED**	**HD**

QSE: 19/02/008	**PCIC CLINICAL BOARD ASSURANCE REPORT** Mrs Kay Jeynes, Director of Nursing, PCIC Clinical Board, presented the report and the following comments made: • In response to the Decontamination Group not having a representation from PCIC and the issues around decontamination, the Committee was assured that this was a standard agenda item but absence was due to a number of staff leaving the organisation. Further assurance was given that HIW inspections were undertaken with contractors and there had been no issues with decontamination. The Dental Quality and Safety Group met quarterly and there was a Dental Quality Framework with Welsh Government and no issues had been raised. • Regarding the environment issue with the flooding at Riverside, Independent Member, Dawn Ward, asked if there was anything the Committee could do to assist. In response it was stated that it was on the agenda to improve the premises. Furthermore, risk regulations came to force in 2014 with a Regulation and Inspection Social Care (RISCA) regulation new framework that oversees domiciliary providers and care providers. This formed regulations which everyone had to sign up to by the end of year whether in nursing or residential homes. • Other challenges presented were conversations with providers but not the Health Board and how it would fit in with the new clinical model. In addition, City Hospice and Marie Curie was regulated by different bodies. This was being challenged to be regulated by one. The Head of Governance in Welsh Government wrote to Ruth Walker and implied that they were unable to regulate but had awarded more provision to the City Hospice. Work had been undertaken to unpick some of the issues and a solution was being sought by 2020. In the meantime, all assurance was provided from the tendering process. • The End of Life lead would be organising a peer review within the next few months. The detail had been considered and the committee was assured there was nothing else that could be done. • A comprehensive estates plan had been produced listed by locality. The future of Riverside needed to be determined and there was a regular estates review with PCIC. There was a need to work through what was the long-term plan and would need to consolidate with either an existing facility or to develop a Hub in Riverside. A condition survey had been undertaken for all the buildings. • Also, highlighted was community staff at peak times taking between 1 -1½ hours to get to a patient which is distressing for all involved and needed to be resolved as this was a risk to the organisation.	

	Resolved – that: (a) The Committee **APPROVED** the actions taken by the PCIC Clinical Board	
QSE: 19/02/009	**REVISED BOARD ASSURANCE FRAMEWORK – QUALITY, SAFETY AND EXPERIENCE FOCUS** Mrs Nicola Foreman, Director of Corporate Governance presented the Board Assurance Framework. The Committee was informed there would be more check and challenge with controls in place and in time it would provide the Committee assurance to feed up to the Board. Currently, there was only one risk on the register for the Committee regarding Safety and Regulatory Compliance and should see this risk come down within six months. It was commented: • An Internal Audit report gave a rating of Limited Assurance on regulatory compliance. The Interim Head of Governance was making progress on this work. A presentation would be shown to the Audit Committee explaining where we were in terms of tracking with improvements to internal and external recommendations. The CHC reports were slow in response which was down to administrative processes internally but in future would see things more thoroughly tracked. • In terms of regulatory compliance, all regulations would be reviewed and this area was being worked on with executives. This would be raised with relevant Committees and was an ongoing work in progress. • Cross Independent Membership in Committees would provide assurance and it was agreed to review the tracker at Quality, Safety and Experience Committee. There was wider discussion on the other risks and changes being undertaken which would be addressed by their relevant Committees. **Resolved – that:** **(a)** The Committee **REVIEWED** the risk in relation to safety regulations compliance and **NOTED** further work would be undertaken in relation to the risk register	
QSE: 19/02/010	**GOSPORT INDEPENDENT PANEL REPORT** The Executive Nurse Director presented the above report and acknowledged they were not content that all systems and processes required was in place. Therefore, were unable to provide all the assurance it would like but for the Committee to understand where we were with actions to gain the assurance required. Patients affected in Gosport related to drug prescribing and the culture with the inability to challenge process. The Health Board have two community hospitals and as progress was made, updates would be brought to Committee to ensure all issues had been	

	addressed. The following comments were made: • A Medical Examiner would be employed in the Bereavement Department. This role should be in place by April of this year. Welsh Government had not classified it as a statutory role. • It had been understood that the function of the medical examiner officer would be under Shared Care Services and patients would have to pay a crematorium fee. There would be one medical examiner for 3000 deaths and the Health Board currently had around 2,400 deaths per year. There would be a need to look at both sites as this could cause unforeseen delays and would be looking at having part time medical examiners and officers in order to provide a timely service across the Organisation. The timetable was very tight and may not be achievable. A Management Executive paper would be presented in the next few weeks to outline the timetable. • In terms of Committee structure this would be reported to HSMB through to Board and the Medical Director was happy to bring an update on the Medical Examiner role in April. • There is a theme around stock control and monitoring of drugs in clinical areas and less of a theme in controlled drugs (CDs). Some drugs were not classified as CDs. It was recognised learning around stock control was difficult and more work was needed in this area. There had been a number of professional conduct disciplinary cases where drugs had been stolen but it was emphasised there was a good system in place. • There had been a shift in certain medicines not being classified as controlled medicines. Oramorph was no longer a controlled drug. • The NMC standards for Medicines Management had been withdrawn and replaced by the Royal College of Pharmaceutical Standards. The Nurse and midwifery Board received formal notification and actions were in place. • The Medical Director as chair of the Medicines Management Group reviewed the medicines code and progress was being made in terms of Standing Operating Procedures to ensure they were up to date and appropriate. **Resolved – that:** (a) To note the report be **NOTED** and **AGREED** that a further assurance report is presented to the June 2019 Committee *Gary Baxter, Independent Member left the meeting at 11.00am*	**GS**
QSE: 19/02/011	**COMMITTEE GOVERNANCE** Mrs Nicola Foreman, Director of Corporate Governance stated she would be working through all the committee documents for Board. The following comments were made: 1. **Workplan –** This was broadly the same as last year and would be presented as a pack at the end of March Board. There was further discussion around a few amendments for the workplan.	

	Resolved – that: a) The Committee **REVIEWED** the Work Plan 2019/20 b) **APPROVED** the Work Plan 2019/20 c) **RECOMMENDED** approval to the Board of Directors 2. **Terms of Reference:** The document would be **c**irculated to Committee members for reviewing and amendments would be undertaken offline with the Chair and Executive Lead. **Resolved – that:** a) The Committee **APPROVED** the changes to the Terms of Reference for the Quality, Safety and Experience Committee and b) **RECOMMENDED** the changes to the Board for approval. **3. Annual Report:** The contents of the paper were explained and that it provided assurance to the Board what should be covered by the Committee. It was emphasised this was also about accountability to the Health Board. It was suggested that items escalated to Board should also be added to the annual report to assure a formal record. The report showed the variety of issues that came to the Committee and was good governance of the subject matter discussed. It was recommended, subject to changes, that the Annual Report go forward to Board for approval. It was proposed for Clinical Boards to undertake an Annual Report. **Resolved – that:** a) The Committee **REVIEWED** the draft Annual Report 2018/19 of the Quality, Safety and Experience Committee and **RECOMMENDED** the Annual Report to the Board for approval. **4. Effectiveness Review:** – Nicola Foreman would facilitate a survey to review the effectiveness of the Committee. The results would be collated, and an action plan put in place which would standardise governance across all the Committees. **Resolved – that:** **a)** The Committee **APPROVED** that the attached effectiveness review is undertaken and results and action plan reported back to the next meeting of the Committee.	**NF**
QSE: 19/02/012	**ASSESSMENT UNIT UNIVERSITY HOSPITAL OF WALES – REPSONSE TO THE COMMUNITY HEALTH COUNCILS CONCERNS** Rebecca Aylward, Director of Nursing from the Medicine Clinical	

	Board informed the Committee that concerns were raised by staff and patients around the Assessment Unit (AU) and following the unannounced visit from the Community Health Council (CHC). The Medicine Clinical Board had put in short, medium and long-term actions. Focus had centred on the long-term plan with improvement actions and timescales. Some recommendations had been successfully achieved regarding nutrition and hydration and purchasing seating for patients. It was commented: • The footprint work and discussions with the Surgical Clinical Board were important and put in context of Major Trauma Centre and would like feedback and results of them. • Maria Battle highlighted that staff had raised concerns on patient safety visits but the Committee and the Board were not sighted on metrics and cannot see whether improvements had been made. There was a need to see a trajectory of improvement and vision of where this was going to and would ask the Chief Operating Officer to undertake this. • Regarding staff training it was noted there was not a lot of down time as this was a very busy department. It was a challenge to undertake training and needed to be creative and innovative. The e-module around dementia was readily available and was bringing training to the department in order not to take staff from area. • Queries were raised regarding inequalities of service during weekend periods. The CHC review had identified differences of care at weekend but such differences were not recognised by the Medicine Clinical Board nor reflected by a review undertaken by the department. It was confirmed that this would continue to be reviewed. • There was a need to have some assurance that this issue was not only covered by winter funding but needed to sustain the requirements in the plan that go beyond winter. • To look at the physio and OT function to see if an assessment could be undertaken so that patients could be discharged from the area. There was a need to focus on having people working 7 days. • Queries were raised on how the improvement could be sustained as the Improvement Manager role was for six months only. • The improvements made were working closely with the team, putting clear processes in place and a different way of working embedded within the team. • Data on the patient waiting in the AU the longest time and not the median length of time as the variation was extreme. • The Hydration and Nutrition Committee agreed to review the issues raised within the report. • The department was commended for the high level of work. **Resolved – that:** **a)** The Committee **SUPPORTED** the actions that were being	**SC**

	taken by MCB in relation to the recommendations made to the CHC	
QSE: 19/02/013	**CONCERNS AND CLINICAL NEGLIGENCE CLAIMS** Mrs Angela Hughes, Assistant Director of Patient Experience presented an overview of the above report. The following comments were made: • The Organisation was comparable to other Health Boards with the proportionality of medical and dental staff who were more exposed regarding the nature of complaints and this raised how they could be supported. • The Medical Director assured the Committee that there was a high level of support with a Joint Concerns meeting which was chaired by the Executive Nurse Director. • Trends and themes would be collated at the meeting and provide high level of support to the clinician who may be concerned or may not be engaged. This would feed into a high level clinical governance team. • Both junior doctor and consultant inductions were undertaken which included sessions on clinical governance and being open and transparent. This should be reviewed and sighted on actions to see whether there were improvements and suggested it go forward to the Strategy and Delivery Committee for monitoring. • Regarding the Stroke and Rehabilitation Centre there had been significant changes in leadership, and it would be helpful to have a plan on how this was being taken forward. This had been going on a long time in terms of governance and consideration should be provided on how the Board and Committee would be sighted on actions. It was agreed that a position paper on the plan on how to take this forward would be brought back to the Committee. • There were similar concerns around ophthalmology with the question of clinical leadership and root cause analysis around the route of insourcing. Concerns were received but improvements had not turned over quickly enough. A report from Ophthalmology would be considered for a future meeting. • The Committee was assured that the complaint regarding the car parking issue was being addressed in terms of the difficulties the elderly and disabled were encountering as they were unable to contact the Car Parking office. A further update was requested for the next meeting. • The Committee was assured in terms of capturing complaints that there was a standard process of capturing the concern of those being affected, how they were categorised, what actions had taken place and improvements undertaken. • There was learning from claims and redress cases. It was recognised that there would be cases litigated for a number of years after the event. • Once there was a breach of duty there was learning to be undertaken and this was to be promoted immediately as it was important not to wait until there was litigation in place.	**FJ** **SC** **AH**

	• Welsh Risk Pool (WRP) was changing Breach of Duty, which would be across the whole lifetime of the case. There was a need for staff to be made aware and understand the risk. A whole systems approach was being undertaken. • WRP had commented recently that we were ahead of how we approach some of these claims. An assessment looking at the level of robustness and work needed around root cause analysis would be undertaken. • It was highlighted regarding clinical negligence claims that there was not only a personal impact but also impact of settlement on the NHS which could take millions out of the healthcare system. • Future reporting would try and match the claims with the financial impact. **Resolved – that:** (a) The action was **CONSIDERED** and **AGREED** current actions (b) A more detailed report on stroke rehab unit to be brought to a future meeting (c) To provide a report to the Committee to gain better understanding in ophthalmology regarding service improvement activity to a future meeting (d) Car parking be considered in relation to the phone calls and the ability to contact the parking office	
QSE: 19/02/014	**MORTALITY AND HARM** Dr Graham Shortland, Medical Director gave an update on Mortality and Harm report which was provided on a six-monthly basis. **244.1 - NATIONAL EMERGENCY LAPAROTOMY AUDIT** This was a success story for the Health Board. The work undertaken had been difficult but had seen the biggest reduction across the UK and the key decision maker was clinicians being closer to the front door where significant improvement had been achieved with recognised good practice. The following comments were made: • Members agreed this was a UK exemplar and the First Minister was interested to know how this could be shared across Wales. This was about sustainability and spread across Wales. • The team was commended by the Committee for a great piece of work and were informed that this project would go through the HSJ Awards. **Resolved – that:** The Committee **NOTED** the assurance provide by the 2018 NELA report and the actions that had been undertaken	

	244.2 - HEART FAILURE SERVICES It was commented: • The dedication from staff was noted, highlighting the need for more additional work time. • It would be good to see the work rolled out on heart failure PROMS 2. **Resolved – that:** The Committee **NOTED** the assurance provided by the NCEPOD report Failure to Function and the National Heart Failure Audit and the NCEPOD recommendation checklist.	
QSE: 19/02/015	**MANAGEMENT OF ENDOSCOPY SURVEILLANCE PATIENTS** The Deputy Chief Operating Officer stated that work was ongoing to support this patient group. The overall volume had now decreased and introduced a risk rating and risk stratification for these patients as this reduction was in the higher risk category. Although there was a reverse in trend, in March there would be further reduction by 400 and it was recognised that whilst patients were sitting on the waiting list, processes were in place to mitigate the risks. The following comments were made: • Assurance had been received with regular reporting. • In recognising all the improvement work and feedback through LMC it was raised if we were confident that GPs had an acceptable route in in terms of when these patients were expedited. In response it was stated, overall endoscopy was happy that expediting processes were in place. There was also an internal expediting process. • Members commended and thanked the team for the work undertaken recognising this was a huge Q&S patient issue where significant improvements had been seen. **Resolved – that:** The Committee **NOTED** the current position and work ongoing in relation to the management of patients overdue their endoscopy surveillance procedure	
QSE: 19/02/016	**S16 OMBUDSMAN REPORT** A meeting would be held with the Clinical Board this week to go through actions agreed as a briefing was provided at the previous meeting. **Resolved – that:** (a) The report was **NOTED** for information	
	Maria Battle, Akmal Hanuk left the meeting 11.58am.	

QSE: 19/02/017	**MINUTES FROM CLINICAL BOARD QUALITY SAFETY AND EXPERIENCE SUB COMMITTEES (2.46)** • **Clinical Diagnostics and Therapeutics:** December 2018 • **Mental Health:** September, October, November 2018 • **Primary, Community and Intermediate Care:** July, Sept, Nov 2018 • **Specialist Services:** 9 and 31 Aug, Sept, Oct, Nov 2018 **Medicine:** December 2018 • **Surgery:** November 2018 • **Children and Women:** June, August, November 2018 • **Dental:** January 2019	
	ITEMS TO BRING TO THE ATTENTION OF THE BOARD 1. Escalation to the Board regarding community clinics and the impact this was having on patients and staff. 2. For the Board to note that the Committee had asked for further information on SRC and the triangulation of information and actions being undertaken. 3. To understand areas of concern of ophthalmology with culture, leadership and service.	
QSE: 19/02/018	**REVIEW OF MEETING** 1. Would look at IBabs as some members were having problems. 2. Considerable assurance was received around internal audits and HIW commented on the high quality of the Committee. 3. To review workplan and slim line the list and frequency of some of the reports to lighten the load. 4. New reporting templates were in place and would be reissuing for formality across all the CBs.	**NF**
QSE: 19/02/019	**ANY OTHER BUSINESS** There was no other business to raise.	
QSE: 19/02/020	**DATE OF THE NEXT MEETING OF THE COMMITTEE**	
	Tuesday, 16 April 2019 at 9.00am, Corporate Meeting Room, Headquarters, UHW	

ACTION LOG

QUALITY, SAFETY AND EXPERIENCE COMMITTEE MEETING
19 FEBRUARY 2019

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
QSE 19/02/011	Committee Governance – Annual Report	Items escalated to Board to be added to Annual Report	19.02.19	N Foreman	**COMPLETED**
QSE 18/196	Emerging Theme from UK Maternity Service Reviews	To consider where mothers would go in the Vale for ante natal clinics	19.02.19	A Harris	**COMPLETED.** An update was provided at the February meeting.
QSE 18/148	Care of Deteriorating Patient/Hospital at Night	Further assurance report required with timescales	18/09/18	Dr G Shortland	**COMPLETED.** An update was provided to the Board meeting in March.
Actions In Progress					
QSE 19/02/007	Patient Story	To help Sally achieve her goal of working in the Health Board as a volunteer	19.02.19	H Donovan	
QSE 19/02/010	Gosport Independent Panel Report	An update will be brought on the Medical Examiner Role	19.02.19	G Shortland	Update – QSE April 2019
QSE 19/02/011	Committee Governance	For items escalated to Board to be added to the annual report to assure a formal record	19.02.19	N Foreman	Updates will be provided to Committee on items to be escalated to Board
QSE 19/02/012	Assessment Unit, UHW – Response to the CHCs Concerns	To have feedback on the footprint work and discussion with Surgical Clinical Board. To see a trajectory of improvement and vision of where this was going and for the Chief Operating Officer to undertake this	19.02.19	S Curry	Report for June 2019 meeting
QSE 19/02/013	Concerns and Clinical Negligence	Stroke Rehabilitation Centre - to present a position paper to a future meeting	19.02.19	F Jenkins	Report for June 2019 meeting.

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
	Claims	Ophthalmology – to gain better understanding regarding service improvement activity. A report would be considered for a future meeting. Car parking – to provide a further update at the next meeting		S Curry A Harris	Update for June 2019 meeting Update at April 2019 meeting
QSE 19/02/018	Review of Meeting	To review IBabs as some members were experiencing problems	19.02.19	N Foreman	
QSE 18/053	Quality Safety & Improvement Framework	Receive detailed outcome based report	17/04/18	C Evans	QSE June 2019
QSE 18/135	Ombudsman Annual letter	Present update	8/09/18	R Walker	Awaiting final letter to be released by the Ombudsman Waiting QSE & Board decision
QSE 18/155.1 **QSE 18/155.1**	CD & T Minutes	Obtain environmental update re BMT WG package of deals have been taken forward in regard to securing monies for urgent capital clinical schemes	08/09/18 18/12/18	A Harris A Harris	Verbal Update - QSE April 2019 Verbal Update - QSE April 2019
QSE 18/190	Patient Story	An update to be provided at the April meeting and a report on what is the medical cover for mental health patients with physical health needs on the Llandough site to be brought to a future meeting	19/02/19 18/12/18	G Shortland / R Walker	A verbal update will be provided at the April 2019 meeting and a report will be submitted to a future meeting.
QSE 18/191	Mental Health Clinical Board, QS&E Assurance Report	The Committee to have sight of the Project Plan in regard to reducing Length of Stay	18/12/18	S Curry	Update QSE April 2019
QSE 18/196	Emerging Theme from UK Maternity Service Reviews	A formal request would be made to Cwm Taf regarding women in CAVs community who choose to deliver in Cwm Taf	18/12/18	S Elsmore	The Committee chair to write to Sharon Hopkins as lead in commissioning to provide assurance that all LTAs would have a proforma with a specific quality clause around the commissioning function and would go to the ME meeting

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
					for further discussion.
		To liaise with Melanie Wilkey to ensure this was undertaken	19/02/19	C Evans	
		To provide an update on the lifts refurbishment programme at the June Committee meeting	19/02/19	A Harris	A report will be presented in June meeting with schedules up to 2021.
QSE 18/203	Point of Care Testing	To be reviewed in six months' time.	18/12/18	R Walker	Update at QSE June 2019 meeting
Actions referred to committees of the Board					

Report Title:	**Surgery Clinical Board Assurace Paper**								
Meeting:	**Quality, Safety and Patient Experience committee**						**Meeting Date:**	16th April	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:									
Report Author (Title):	**Clare Wade (Interim Director of Nursing for Surgery Clinical Board)**								

SITUATION

This report provides details of the arrangements, progress and outcomes within the Surgery Clinical Board in relation to the Quality, Safety and Patient Experience agenda over the last 12 months. It will highlight the achievements, progress and planned actions of the Surgery Clinical Board in its aim to continue to improve and develop this very important agenda within the Clinical Board.

BACKGROUND

Between April 2018- March 2019 the Surgery Clinical Board had 5 Directorates which provide a significant number of emergency and elective services to Cardiff and Vale residents which include Trauma and Orthopaedics, General Surgery, Urology, ENT, Maxillo-Facial Surgery and Ophthalmology. The Clinical Board employs over 1800wte staff and has a budget of £120 million.

In addition to direct service provision for the local community of Cardiff the Surgery Clinical Board provides a significant number of services beyond the local population at both the University Hospital of Wales and University Hospital Llandough such as Spinal Surgery and Hepatobiliary Surgery

The Surgery Clinical Board also supports the activities of all other Clinical Boards within the Health Board through the provision of services provided by the Perioperative care Directorate, which includes Anaesthesia, Pain Management, Operating Theatres, Pre-Assessment and Sterile Services.

Whilst the majority of services provided by the Surgery Clinical Board are core activities, due to the high volume of activity and the diversity of its services, risk in the Clinical Board is high. Therefore robust risk management arrangements are in place to reduce and manage these in order that our service users and staff are kept safe.

The Surgery Clinical Board has a well-established formal Quality, Safety and Patient Experience (QSPE) that meets bi-monthly which is co-chaired by the Surgery Clinical Lead Medical Advisor (Consultant Anaesthetist) and the Director of Nursing for Surgery Clinical Board. This structure is formally replicated in each of the Clinical Directorates. The QSPE group has three key sub-

groups that report to it; a Health and Safety group, Infection Prevention and Control group and a Thromboprophylaxis Thrombosis and Anticoagulation group

These all meet bi-monthly, have formal terms of reference, are formally minuted and have a range of different stakeholders who attend to ensure that there is wide engagement in the overarching quality and safety agenda.

The QSPE group then report to the Clinical Boards formal business meeting which is held monthly and is chaired by the Clinical Board Director.

The formal board requires monthly assurance as to the quality, safety and effectiveness of the care it provides. The monthly assurance report to this group provides assurance of the activities and progress being made with regards to the Surgery Clinical Boards:

- Quality and Safety agenda
- Infection Prevention and Control Annual work programme
- National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs)
- IMTP
- Health and Care Standards
- Patient experience
- Financial and information governance
- Organisational Development and Workforce Planning
- The NHS Wales Quality Delivery Plans

ASSESSMENT AND ASSURANCE

The Clinical Board has an agreed agenda and comprehensive work plan for the next 12 months. The plan includes monitoring service delivery against required standards, monitoring and managing risks through the e -datix reporting system and the risk register.

Assurance is received via the robust mechanisms which are in place such as the UHB's internal Audit processes and through the Clinical Boards QSPE group and formal business meetings all of which have very strong medical, nursing and management representation and are fully minuted.

In summary the Surgery Clinical Board Quality, Safety and Patient Experience strives through strong leadership to:

- Ensure that there is a continuous review the quality and safety risks and take action to mitigate these on an ongoing basis.
- Continue to maintain a culture of improving quality, safety and patient experience throughout the Clinical Board.

- Continue to develop a culture of excellent staff engagement in the quality and safety agenda

ASSESSMENT

Governance, Leadership and Accountability

Quality, Safety and Patient Experience is the highest priority for the Surgery Clinical Board which has a robust and well attended quality and safety groups with strong representation from Management, Medical, Nursing and Allied Health Professional staff from both within and external to the clinical board.

Annual self-assessments against the Health and Care Standards continues alongside with the Risk Register

The Clinical Board Risk Register is monitored at Directorate and Clinical Board level on a regular basis locally. The top 3 risks on the Clinical Board risk register in March 2019 are:

Risks	**Mitigation**
Fabric and plant of the main theatre suite at UHW is of concern due to its age and the potential for there to be failures of the plant leading to cancelled operations.	Remedial works have been carried out on the theatres that posed the most significant concern. Plans have been drawn up with the Capital Planning team to address this issue in the longer term.
Escalating pressures from medical outliers, with consequential impact on activity delivery, RTT targets and efficiency opportunities. The situation has stabilised over the summer, but the winter of 2018/2019 resulted in significant increases. The commissioning of unfunded capacity in SAU and SSSU also continues.	Routine attendance of clinical board representative at patient flow meetings. Escalation process in place within the board to try and accommodate all Surgical patients within our bed base.
Bank/Agency use increasing due to staff shortages which invariably leads to reduce levels of patient care as there is reduced continuity of that care.	Micromanagement and contingency plans put in place on a daily basis by lead/senior nurses. Block booking of bank and agency as a way of integrating the agency and bank staff into a given area in order to help with continuity of care. Very proactive recruitment plan in place.

Healthy (Theme 1)

We promote the health of our staff and the wellbeing of our patients by proactively encouraging staff to take up the seasonal flu vaccine. As of the 31st March 2019 we had vaccinated 60.9% of our staff by a combination of using our own proactive flu champions and resources made available by the UHB. This has been a 20 % improvement over 2 years. The Surgery Clinical Board recently won the Beat Wales most Improved team. To win 'Most Improved Campaign' is validation for the new processes which we as a team we have been working hard to implement over the winter.
.A gym has recently opened at University Hospital Llandough to help those having treatment for breast cancer feel fitter, stronger and improve their confidence

All patients who attend a pre-operative assessment are if required given advice on smoking cessation, safe alcohol limits and healthy weight management. The clinical Board are currently making gains in the use of Prehab and have a dedicated project manager looking to implement this

Health and safety group reviews themes of staff accidents and incidents and have strong links with the H&S team and Staff side

The Clinical Board has a dementia care plan and has some very proactive staff who embrace this agenda passionately. In the last 12 months we have seen the following pieces of work carried out;

- "Get up get dressed get moving" has been adopted in our Trauma and orthopaedic wards and we hope to achieve a culture change across the UHB whereby all suitable patients are supported to be as active and independent as they can be
- Following successful bids for money (41K) General Surgery, H&N and T&O have improved the ward environments for patients who are cognitively impaired following the Kings Fund audit. This has involved improvements such as improving the decor of day rooms dementia clocks, tablets for patients to use, radios and head phones
- General Surgery and T&O are undertaking monthly audits to ensure the "Read About Me Scheme" is embedded in our wards.
- Clinical Board attendance at the UHB Dementia Training Steering Group

Safe Care (Theme 2)

Pressure Damage
The Clinical Board Director of Nursing facilitates a UHW wide group who look at this agenda on a monthly basis with a view to improving care in Cardiff and Vale but also seek to influence this agenda Wales wide. Over the last 12 months the Group has delivered on the following many work streams. :

- The Pressure Damage T&F group has looked at some of the complexities around the Bed Management Contract and have worked closely with procurement and have been instrumental in gaining funding to be able to change every bed (apart from speciality areas such as critical care and maternity) in the Health Board to a MMO 500 low rise bed along with a Promatt mattress. These beds and mattresses have been rolled out across the UHB in a structured fashion ensuring that staff are trained on the use of new Promatt mattresses which has replaced the older Primo Surface before the product is put in. Promatt is now used as the first choice basic mattress for general inpatient beds in the UHB.
- The Tissue Viability team have developed an information sheet for patient and their families to highlight the risk of pressure damage which is used for both inpatients and the community
- E- referral document for Tissue Viability Team
- Annual Pressure Damage Prevalence Audit (Feb 2019)
- Following the All Wales Wound/Pressure ulcer audit that took place in 2015 (Clarke et al.) highlighted the fact that there were large gaps in knowledge in using risk assessments (Waterlow) and that more training was required along with training on categorisation and selection of appropriate support surfaces. The UHB Tissue Viability team we are looking at changing over to the PURPOSE–T risk assessment as an opportunity to revisit these gaps in knowledge by providing a robust education package with its introduction. A Sub-group of the All Wales Tissue Viability Nurse Forum members are currently working together on this over the next few weeks/months. We will also be devising the Pathways/care plans which accompany the risk assessment tool

Thromboprophylaxis

The Surgery Clinical Board have a multi-professional surgery Thromboprophylaxis and Anticoagulant Group. The Clinical Board are compliant with the recent changes to NICE guidance re Thromboprophylaxis

Key quality improvement projects

- New build modular orthopaedic theatre in UHL has been completed and surgery is now being undertaken in that theatre,
- UHL SSU washer disinfector upgrade
- First in the UK delivered in UHL – A new treatment called electrostatic pressurised intraperitoneal aerosol chemotherapy (epipac) for use in the palliative treatment of advanced peritoneal malignancy

Significant quality and safety challenges

- Protein residue is a concern on re-usable surgical instruments following the washer disinfector processes. The Health Board was one of the pilot sites for the Pro-reveal Detection System for monitoring low levels of residue proteins. The pro-reveal technology uses a camera, florescent light and detection spray, to identify residue

proteins on reprocessed surgical instruments. To date we have over 18 months of data and our trend analysis shows consistent results, not just below the target of 5 µg, but below 1 µg. New systems for detection are in development and these will be trialled in the HSDU Department when available.

New ways of working

- Advanced Practitioners proving ear dewaxing service in house and off site in West Quay.
- Scope decontamination room being re-furbished in Main Theatres UHW

Electronic Nursing Documentation

- Ward A1 link (emergency surgery) have been selected as the pilot ward for the UHB to test the first phase of the newly approved, All Wales electronic nursing documents.

Resuscitation Cube

- The resuscitation service has been responsible for implementing the Resuscitation Service clinical audit data, which has been highlighted as best practice by the Rapid Response to Acute Illness Learning Set (RRAILS) and the Welsh Resuscitation Forum. The aim was to maximise collection, analysis and distribution of essential data related to Resuscitation and Emergency Care throughout the UHB to improve direct patient care and safety through resource planning, including educational requirements, in line with organisational policies and strategies, also in compliance with national and international guidelines and recommendations. CVUHB is the only health board in Wales that has a complete data set.

Serious Incidents and No Surprise Incidents reported to Welsh Government

Between 1/4/18 and 31/3/19 the Surgery Clinical Board reported 52 Serious Incidents and 3 No Surprise events to Welsh Government.

Never events

There were 4 reported never events in this period all of which have (or in the process of having) robust RCA's carried out

- Overdose of methotrexate for non-cancer treatment
- Retained foreign object post-operation
- Wrong implant/prosthesis
- Wrong surgery site

All serious incidents are considered by the appropriate clinical teams and Quality and Safety Groups. Action plans are developed and progress and evidence of completion are reported to the Clinical Board Quality, Safety and Experience Group for assurance purposes.

The main themes for serious incidents over the last 12 months are as follows:

Administrative Processes (Excluding Documentation)	2
Anaesthesia Care	1
Diagnostic Processes/Procedures	1
Medication/Biologics/Fluids	2
Patient Accidents/Falls	12
Pressure Ulcers	28
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	6
Total	**52**

Patient safety related incidents

There were **1722** Reported Patient Safety related incidents occurring within the Surgical Clinical Board between 1/4/18 and 31/3/19

The Top 10 themes were:

Patient Accidents/Falls	524
Pressure Ulcers	333
Devices, Equipment, Supplies	156
Medication/Biologics/Fluids	145
Documentation	96
Communication	75
Administrative process	67
Therapeutic/Processes/Procedures-(except medications/fluids/blood/plasma products administration)	65
Diagnostic Processes/Procedures	61
Anaesthesia Care	49

Falls Prevention and Reduction

There were 12 injurious falls reported between 1/4/18 and 31/3/19 all of which have had an injurious falls RCA conducted. So far the reviews have not identified any particular themes for the falls however they have given assurance that UHB policies, protocols and guidelines are being used in Directorates.

HM Coroner's inquests and regulation 28 reports
The Clinical Board has been involved in 4 inquests between 1/4/18 and 31/3/19 (where Surgery was the managing Clinical Board). Of these, none received a regulation 28 report.
Relevant Coroner and Ombudsman reports and recommendations are considered by the Directorate and Clinical Board Quality and Safety Groups.

Concerns, compliments and claims

Formal concerns
This remains a challenging aspect of quality for the Clinical Board to manage efficiently and effectively. Between 1/4/18 and 31/3/19 the Clinical Board received a total of:

- 249 formal concerns, of which 60% were responded to within the 30 day target. We recognise improvements can be made and have recently introduced new ways of working including tracker meetings with the concerns team, which should see improvements in timely repose rates

Informal concerns (72% of concerns were managed informally)
We received 650 informal concerns between 1/4/18 and 31/3/19 and 98% were responded to in time.

The Clinical Board remains committed to being very proactive in contacting and meeting individuals who raise concerns at the informal stage in an attempt to achieve quick resolution for the patients and their carers, evidence of this work can be seen in the reduction of formal concerns and an increase in our response rates over the last we months

The top four key themes from the formal and informal concerns in surgery are:

- Clinical Diagnosis and Treatment
- Cancellation of OPA
- Length of Outpatient waiting lists
- Length of wait for admission date

Compliments
The Clinical Board has received 474 compliments (which has increased considerably) which have been logged formally. These are shared with staff appropriately.

Claims
The Clinical Board has had 24 clinical negligence claims opened between 1/4/18 and 31/3/19 which is a considerable reduction from precious years which are split between the following:

(8) General Surgery and Wound healing
(2) Urology Ophthalmology and Head and Neck
(1) Perioperative Care
(13) Trauma and Orthopaedics

Infection prevention and control
Overview of position from 1/4/18 and 31/3/19

Clostridium difficile
On target to reach year end reduction target.
8 cases year to date (YTD) (target no more than 12)

Meticillin Resistant Staphylococcus Aureus (MRSA) bacteremia
Unfortunately the CB is not on target to reach year end reduction target of no cases.
5 cases YTD

Meticillin Susceptible Staphylococcus aureus (MSSA) bacteraemia
The CB is on target to reach year end reduction target of 12 cases.
10 cases YTD

Escherichia coli (E. Coli) bacteraemia
Unfortunately the CB is not on target to reach year end reduction target of 24 cases.
40 cases YTD

P.aeruginosa
2 cases YTD

Klebsiella spp
The CB is on target to reach year end reduction target of 12 cases.
4 cases YTD

T&O workstream
Guideline for the Investigation and Management of Urinary Tract Infection in Patients Undergoing Elective Joint Replacement Orthopaedic Surgery have been produced over the last year. A reduction in patient exposure to unnecessary antibiotics reduces the risks of adverse reactions including allergy, recolonisation or infection with antibiotic resistant organisms as well as antibiotic associated diarrhoea and Clostridium difficile.

The following has been achieved:

- Reduction in the number of inappropriate urine samples being sent for microscopy, culture and sensitivity (MC&S) from orthopaedic pre-assessment clinic.
- To eliminate treatment of asymptomatic bacteruria in this patient cohort.

- To stop unnecessary delays and cancellations of asymptomatic patients with positive urinary dipsticks.

Effective Care (Theme 3)

Adult Audiology launched "Patient knows Best" on 9th Sept 2018. Patients Know Best (PKB) is an e-health solution which empowers patients to manage their care, enabling professionals to share information while improving efficiencies. It is the first patient-controlled health information exchange (PCHIE) which is built around the patient, not the organization. PKB allows patients to create their own health profile and share this with family and professionals involved in their health care
The audiology team were able to use PKB to distribute information and other items, such as questionnaires, prior to a patients' appointments. In the first instance, this was done to measure initial handicap to inform our treatment plans, and then to measure residual handicap prior to a final review, this second questionnaire often completely negates the need for a final review before discharge to open access clinics.

These changes improve the quality of information provided by the patient, as they are completed at home in a relaxed atmosphere with support from family. This means that subsequently appointments are less rushed, enabling a rapport to be established. Moreover, final appointments can often be avoided altogether, releasing valuable clinical time.

In addition, PKB has a communication platform enabling patients to easily contact their clinician without visiting the site or getting through on busy telephone lines. It also includes an information platform which allows both patients and other nominated family members and friends to easily access information such as videos to reiterate instructions on the care and use of their hearing device, links to voluntary sectors, and information on assistive listening devices. AS a result of this Cardiff and Vale UHB Audiology team were recently honoured with the Sustainability Award from the National Planned Care Programme for the introduction of an interactive electronic solution to the UHB's audiology health pathway.

Audit
The Clinical Board has a formal audit plan in place, which includes both local and national audits. The results from these audits are fed back to Directorate and Clinical Board quality, safety and experience groups.

A new audit has replaced the Welsh Risk Pool audit is the Health Inspectorate Wales surgical inspection framework which has been launched and will be carried out across Wales on an unannounced basis. This audit will also encompass the work the UHB has done on the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards (LocSSIPS).

Dignified Care (Theme 4)

Dignified care inspections and CHC inspections carried out in 2018-2019 have not identified any areas of significant concern specifically in relation to dignity. The newly developed Band 5 induction programme has the UHBs values and behaviours that underpin it and the delivery of dignified care is specifically addressed.

It is expected that all wards participate in the monthly Health and Care Monitoring System Audits on a monthly basis and these indicators are reviewed at the monthly Nursing Board meetings attended by the Director of Nursing, Lead Nurses, Senior Nurses and Practice Educators. They are also reviewed at the monthly confirm and challenge sessions with ward Sisters and Charge Nurses and action plans put in place as necessary.

The Clinical Board have embedded the Enhanced Care model to look after patients who have a cognitive impairment safely with the aim of preventing harm from falls.

Clinical environments

There have been significant capital works that have taken place in the last 12 months to improve the environment and facilities for our patients and staff.

- Changing room refurbishment in main theatre
- Some ENT services transferred to UHL
- Award of major trauma centre for Main theatres UHW
- Refurbishment and installing a fully functioning anaesthetic room Th7 SSSU

Wards

At UHW ward A2 has had a total refurbishment.

Timely Care (Theme 5)

Day of surgery admission

A dedicated Day of surgery admission (DOSA) unit in SSSU has opened which has enabled all patients pre-surgery to be admitted in the same place which is known to all. This has allowed the Surgeons and Anaesthetists to know exactly where the patients area. With the new model of care we have seen a reduction in late starts and as we will have mapped the patient journey we will be able to facilitate the smooth flow of patients through inpatient beds and increase our performance against the national day case admission rates.

Nephrostomy robot pathway

Implementation of a surgical pathway for patients from across South Wales with suspected Cancer on their kidneys to be operated on using the state-of-the-art technology of the *Da Vinci* robot. This means that the patient experiences less pain, their recovery times are much quicker

and their length of stay in hospital after the procedure is just 2 days on average, as opposed to the 6 days required for the traditional open procedure. The significant complication rate of the robotic procedure is also currently 0%, a huge improvement from the 10% rate of open surgery.

Individual Care (Theme 6)

In implementing the National User Experience Framework service users are telling us we are in the main doing a good job but there is still work to do. We have a comprehensive action plan which carried out of the UHBs values into action initiative. We use all elements of the National User Experience Framework but we mainly use those in quadrant 1 and 4.

Real time – we carry out short surveys as part on the 'two minutes of your time' initiative and suggestion boxes on the wards. We have also have had patient kiosks in several of our clinical areas where the views of patients, their carers and staff are captured. The planned installation of Patient/Visitor Ward Information Boards at the entrance to all ward areas across the UHB and UHL has helped us significantly with this agenda.

Retrospective – Patient stories are shared at relevant groups within the Clinical Board

Proactive/reactive – Patient compliments are feedback to relevant staff. Also where concerns are raised by patients and their carers we do share the concerns with the relevant staff member/s in order that they can reflect on the patients' perception of the care they delivered and to make any changes that may be necessary.

Patient story telling is undertaken as part of the UHB Clinical Leadership Programme and it is this methodology the students use. Once the interviews are carried out the student submits their report to the ward sister/charge nurse and action plans if required are developed from this information.
Balancing – Concerns, compliments, Clinical Incidents, Service user and family feedback are used to help the clinical board decide on its planning ideas such as redesigning its services.

Staff and Resources (Theme 7)

Finance

1. The financial position at the end of Month 11 (Feb 2019) is £1.158 deficit.

2. The Clinical Board savings target is £4.714 m

3. Progress against this target is:

£4.163 green identified 88%

£0.439 amber identified 9%

£0.112m shortfall against target

- The recurrent full year effect CRP position is a £0.010m surplus.
- Year-end forecast £0.967m deficit

Staffing

Surgery Clinical Board Workforce Summary Report Jan 2019 Data

Key Performance Indicator	Monthly Actual (Jan 2019)	Comparison with Previous Month (Dec 2018)	Comparison with Previous Year (Jan 2018)	2018-19 target
Vacancy Rate (WTE)	8.63%	9.04%	7.75%	5.00%
Turnover Rate (WTE)	6.70%	6.09%	5.80%	7.0%
Sickness Absence Rate	4.97%	4.81%	4.93%	4.28%
PADR Rate	49.53%	47.29 %	53.20%	85.00%
Statutory and Mandatory Training Rate	64.37%	64.77%	59.81%	85.00%
Medical Appraisal	79.39%	78.95%	79.28%	85.00%

Nurse Staffing Act

From April 2018 the nurse staffing act became a statutory requirement. The Clinical Board have done a significant amount of work on staffing establishments and triangulating this with professional judgment and other tools such as acuity data. All inpatient wards now have supervisory sisters built into their establishments although due to staffing gaps these are not always able to be protected.

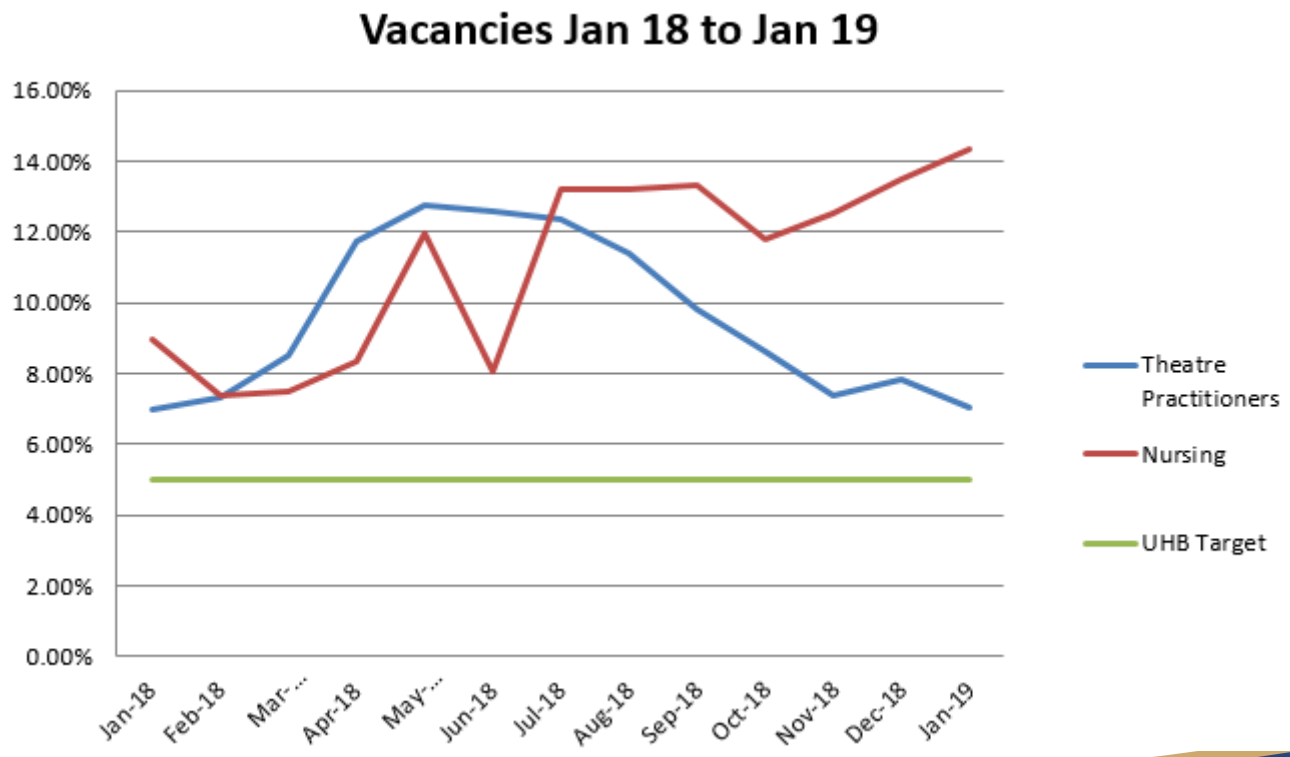
Recruitment

Registered Nurse and AHP recruitment has been a significant challenge and a lot of work has been put into try and address this. The Clinical Board hold regular recruitment meetings underpinned by a robust action plan which has driven several different initiatives such as:

- Dedicated supported 4 week supernumerary time for all new registered staff joining a ward.
- Keeping in touch days where UHB staff contact staff who have been appointed but may not be commencing employment for a few months e.g. Student Nurses/ODPs who are a few months off qualifying, and invite them in to talk to them about new initiatives and give them opportunity to meet with staff in the team they are joining.
- Student Streamlining awareness events

Whilst historically the staffing position for theatres was of concern at nearly 12% (Graph 1) this has reduced exponentially over the last 6 months to just over 6% with more staff still to join the team. The situation for the wards shows a different picture showing an increase from 7% in February 2018 to over 14% in January 2019. Whilst it has been relatively easy to appoint staff from the numerous recruitment initiatives such as recruitment evenings and UHB events, the biggest challenge is now retaining these nurses.

Graph 1



Retention

Whilst we have a very comprehensive work plans and action plans to try and address nurse retention such as holding celebration events, surgery star awards, employee engagement events and trying to instil a feeling of being part of a bigger team such as via dedicated Facebook pages, it is still proving to be inadequate. Anecdotal evidence from exit questionnaires would suggest that surgical nursing staff are unhappy on the wards due to the emergency pressures on the organisation. In particular surgical nurses feel disenfranchised particularly in relation to the number of medical patients they are nursing on surgical wards especially throughout the winter periods. They are specialised surgical nurses who want to care for surgical patients. As a result our exit questionnaires tell us that many are leaving to work in other clinical areas or hospitals including the private sector.

Staff engagement

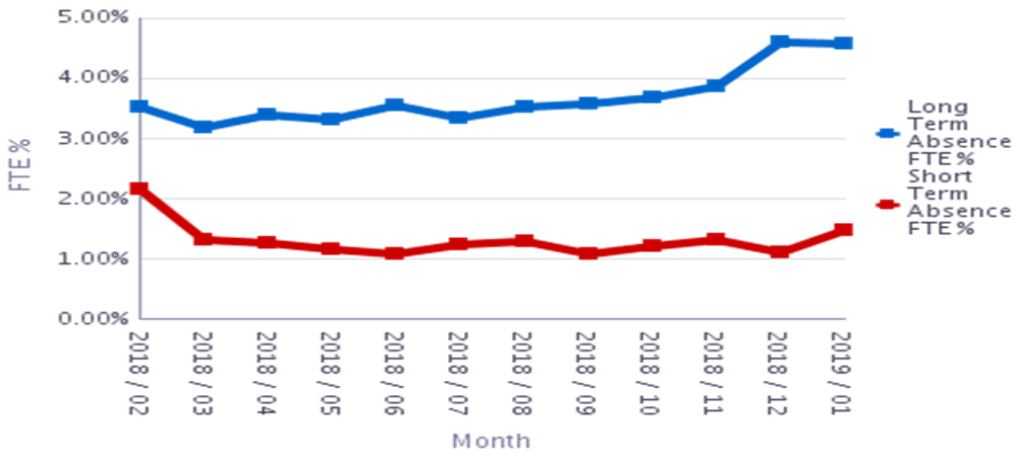
A significant amount of work has been carried out in the Clinical Board over the last 18 months to make this agenda a priority. The following are some of the highlights of the good work being done or being planned;

- Clinical Board and Directorate newsletters
- OD work ongoing in Theatres and HSDU to improve engagement
- Promoting the Health Board values and behaviours, including values based recruitment;
- Celebration Event
- Team Development
- Each Directorate having a workforce plan that they can develop and own staff
- Succession Planning
- Talent Management
- Leadership & Development Programme ongoing in Theatres and HSDU
- Keeping in touch days for New Starters
- Training Tuesday on A5,
- Clinical Skills days for Nurses
- Professional Nursing Forums
- Registered and un-registered engagement groups
- Student Streamlining engagement sessions

Sickness absence

Whilst sickness absence is not at the UHB target levels all Directorates appear to be managing their sickness well.

Graph2: Comparison of long term/short term absence



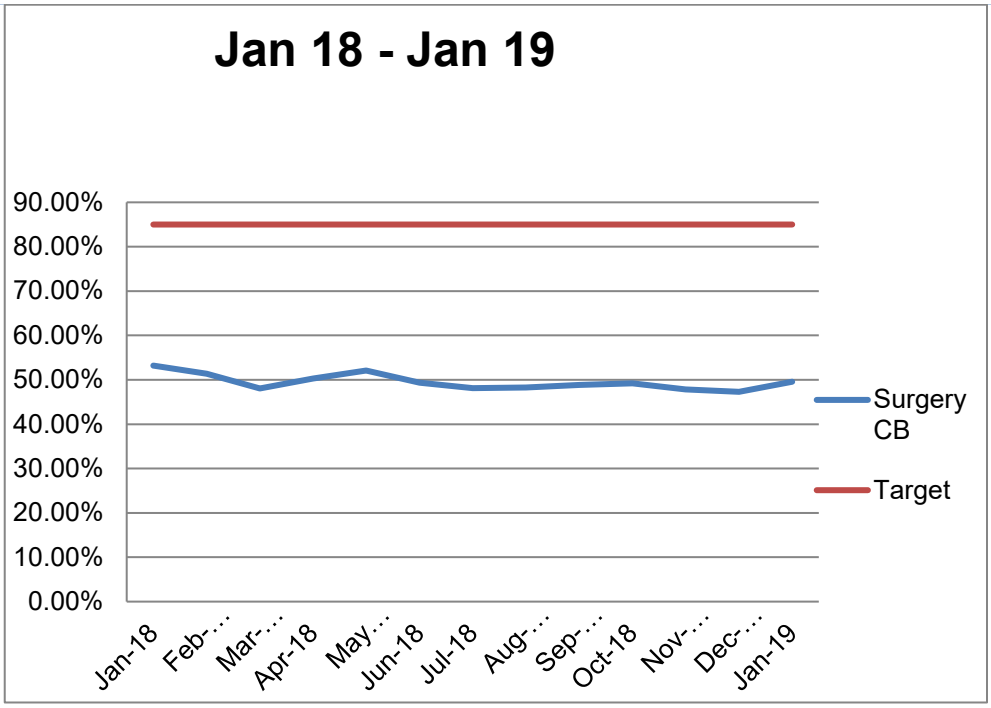
Actions that have been put in place to help support managers with this agenda are;

- Support for managers with both short and long term absence via:
  Bespoke training by the Workforce & OD Team
  Sickness Absence Surgeries with Line Managers, to discuss individual cases
- Compliance Against the Policy:
  Audit programme, focussing on hot spot areas to check;
- Health & Wellbeing Promotion via sickness surgeries and training
- Redeployment and return to work opportunities for staff

PADR compliance

PADR compliance has decreased to 49.3% in December against a UHB target of 85%. There are several areas that have completed PADRs to 100% and hot spot areas that the Clinical Board have focused on.

Graph 3: Surgery Clinical Board - non-medical PADR Compliance



Actions to enable sustained improvement:

- Managers are able to access training in how to retrieve their latest reports via the ESR team.
- CB continue to meet with Senior Nurses and Clinical Leaders from Theatres in UHW to give a clear message regarding improvement. The same will happen with Senior Nurses and Clinical Leaders in UHL.
- CB SMT hold managers to account regarding performance with PADRs during confirm & challenge meetings, 1: 1 meetings, etc.
- Encouragement to use ESR database, not department database as the ESR data is what is reported upon
- Unfortunately enabling work hasn't delivered the level of improvement that the Clinical Board anticipated.

Statutory & Mandatory Training
Current Compliance by Directorate as of January 2019

General Surgery	61.45%
Head & Neck Maxillofacial & Ophthalmology	62.76%
Surgery Management	65.22%
Theatres, Anaesthetics, SSU, Endoscopy & Sterilisation Services	65.50%
Trauma and Orthopaedics	65.79%
Urology	59.91%
Grand Total	**64.37%**

Actions to enable improvement:

- Managers to validate ESR data to ensure that we are starting from an accurate baseline.
- Face to face learning sessions communicated throughout the Clinical Board via FB, email, etc.
- CB SMT hold managers to account regarding Statutory & mandatory training compliance during performance reviews, confirm & challenge meetings, 1: 1 meetings, etc.

Awards and recognition

Many staff in the Clinical Board have received awards and recognition for the work they do to improve the lives for patients and their carers. Also many teams and individuals have had their work published or they have been invited to speak at conferences or present posters.

Awards won in 2018/19

- Winner of the RCN Nurse year award for the Mental Health and Learning Disabilities Category (Andy Jones)
- Winner of the RCN General Registered Nurse Award Category (Suzanne Thomas)
- Runner up in the RCN Nurse of the Year Awards – Supporting Improvement through Research Award. (Angela Jones)
- Planned Care Sustainability award for Patient Knows Best initiative (PKB)

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The governance processes embedded in the core business of the Surgical Clinical Board and its Directorates
- Evidence of regular performance management reporting
- Independent review of the business of the Surgery Clinical Board by internal and external bodies such as Internal audit, CHC, HIW, Welsh Risk Pool, Welsh Government
- Temperature gauge activities such as Cancer peer review, local audits (IPC, environmental) , Clinical Board walkabouts, benchmarking, unannounced inspections, acuity audits, healthcare standards, patient experience questionnaires and kiosks
- Nursing dashboard overview
- The Clinical Board recognises the key areas of improvement and actions required to further improve quality, safety and patient experience

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **NOTE** the progress made by the Clinical Board to date
- **APPROVE** the content of this report and the assurance given by the Surgery Clinical Board.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x
Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*								

Report Title:	**Mental Health Services for Older People – In-Patient Care Improvement Project through ALOS reduction**								
Meeting:	**Q.S.E**					**Meeting Date:**			
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	**Chief Operating Officer**								
Report Author (Title):	**Director of Operations – Mental Health**								

SITUATION

The Mental Health Service for Older People's Directorate has a total of 115 beds, of which a little over half (66) are acute assessment beds. Of those, 50 are dementia assessment beds and 16 are functional mental illness (non dementia) assessment beds. The remaining beds in the directorate are EPA or Extended Assessment Beds. The Directorate no longer offers a 'bed for life' with these EPA beds. In addition to this, the dementia service has all the ingredients of a community service that is capable of keeping people out of hospital, with a crisis team, nursing home liaison service and a typically resourced integrated community service.

Mental Health services has seen 40% of its beds close over the last 11 years with two MHSOP wards closing in the last 5 years, most recently in September 2017, ward East 14 at UHL, a 16-bed functional (non dementia) male ward was closed and the other remaining 16-bed functional ward (Daffodil) became mixed gender. The service broadly is still adapting to this closure, and on average sees a split of 22% / 78% functional / dementia patients within in the inpatient service, which often results in placing functional patients on a dementia ward.

In spite of these bed closures, the MHSOP service, along with other services across the UHB, remain an obvious national outlier, for high Average Length of Stay (ALOS) and bed numbers in the UK, specifically for its elderly population in hospital beds. This is a cause of concern for the Mental Health Clinical Board (MHCB) as we know that an unnecessarily long length of stay in hospital, particularly for dementia patients, leads to a loss of independence and self care skills and can worsen confusion and disorientation. Also a lack of appropriate care home settings, family resistance and carer stress often means patients staying longer on our wards. This results in inpatient waiting lists and increasing difficulty in finding a placement if the patient develops physical health needs or experiences increased frailty whilst in the inpatient setting.

Further to this, it is apparent that our current nursing establishments are over-stretched across this large inpatient service and experience difficulty in providing sustainable staffing and establishment numbers leading to a heavy reliance on temporary staff, including agency. We know that the overuse of bank and agency staff can lead to sub-optimal patient care and increased lengths of stay.

In light of this, and as part of a wider UHB plan to reduce ALOS in its inpatient elderly population, the UHB recently approved the appointment of a pilot Band 7 clinical post in MHSOP to look at improving inpatient pathways and ALOS in MHSOP.

This paper explores the plans the Directorate and Clinical Board have in reducing ALOS, bed numbers and the disproportionate resources associated with elderly inpatient care in the Clinical Board

BACKGROUND

Assessment Beds (all on UHL site) in MHSOP Include:

- East 10 – 16 beds - Dementia Assessment – Male
- East 12 – 16 beds - Dementia Assessment - Female
- East 18 – 18 Beds – Mixed Gender Dementia Assessment
- Daffodil – 16 beds – Mixed Gender – Functional Assessment (non dementia)

Data and feedback from the UK Royal College of Psychiatrists benchmarking network in the 2016/17 and 2017/18 financial years has shown Cardiff and Vale Mental Health Services for Older People directorate to have 43-62% higher average length of stay compared to the upper quartile of 68 for other NHS mental health providers, including the 7 Welsh health boards. **See table 1 for ALOS comparison.**

Table 1

	2016/17	2017/18		2016/17	2017/18
	Whole Organisation			**Peer Group - my region (7 HB's)**	
Average Length of stay:					
MHSOP (C&V UHB)	151	130		151	130
Mean	81	78		75	78
Lower quartile	65	65		51	58
Median	82	76		62	73
Upper quartile	93	91		84	89

Over the last year we have seen reduction in ALOS over 3 of the 4 acute assessment wards.

Ward	Qtr 1 2017/18	Qtr 2 2017/18	Qtr 3 2017/18	Qtr 4 2017/18	Qtr 1 2018/19	Qtr 2 2018/19	Qtr 3 2018/19	Qtr 4 2018/19
East 10	285	132	106	157	125	112	121	147
East 12	144	347	163	127	192	141	106	103
Daffodil	116	139	190	185	165	78	85	143
East 18	291	166	220	137	147	82	90	140

Inpatient beds per population have reduced over the period; however these remain 59% higher than the upper quartile for the same peer group. The directorate currently has 66 acute assessment beds (50 dementia and 16 functional mental health). For information there are also

16 Young Onset Dementia beds at St Barrucs unit in Barry Hospital and 33 extended assessment beds spread over two wards at UHL. **See table 2 below for assessment beds benchmarked comparison:**

Table 2.

	2016/17	2017/18		2016/17	2017/18
	Whole Organisation			**Peer Group - my region (7 HB's)**	
Inpatient beds per 100,000 population:					
MHSOP (C&V UHB)	108	83		108	83
Mean	47	44		57	60
Lower quartile	33	33		44	45
Median	43	39		51	57
Upper quartile	57	52		64	73

Within the directorate there is a considerable pressure on the inpatient nursing resource, with overspends against nursing of £599k in 2016/17 and £895k in 2017/18 mostly due to temporary nursing costs attributable to increased acuity resulting in high levels of patient close observations and specialling, as well as staff absence due to sickness, of which stress and anxiety is the highest contributory factor.

In terms of reliance on beds, the Cardiff and Vale MHSOP services have a typically resourced core community service with additional crisis/home treatment resource and a nursing home liaison team. On face value, it has the elements of a service required to have a low ALOS and bed reliance.

The Clinical Board and MHSOP directorate would therefore like to reduce the pressures on ward teams, with an aim to improve the patient flow through the service, resulting in a reduction in average length of stay and number of delayed discharges on acute assessment wards, allowing a natural bed reduction programme which should then reduce the dependence on temporary nursing costs and therefore the MHSOP nursing overspend.

ASSESSMENT

From an initial assessment over the first 2/3 months there are many factors and multiple streams of work that are important in reducing ALOS. The directorate has now initiated work-streams to improve efficiency and effectiveness in these critical areas – including:

- discharge planning from admission
- effective reporting and monitoring of ALOS and inpatient pathway performance
- staff training and awareness of long lengths of stay
- closer working with social work, Complex Care Commissioning Team and community teams
- MDT working and ward rounds
- Clarity of MDT roles and responsibilities

- Optimisation of support services such as crisis and day services
- Care Home Liaison Function

It is proposed that the directorate initially work towards reducing by 9/10 within the 2019-20 calendar year, with a further 4/5 beds released in quarter 4. This would require an average length of stay of 89-91 days, which would be in line with upper quartile ALOS in benchmarking peer organizations. The intention is to either reduce a small number of beds on each of the assessment wards or close an entire ward. The latter will require Community Health Council involvement at an early stage for engagement/consultation purposes. For both options, the important work by the project lead will need to continue. Table 3 below suggests the ALOS reductions required to achieve the reduced bed numbers

	2016/17	2017/18	2016/17	2017/18	Bed reduction options:				
	61 Organisations		Peer Group - my region (7 HB's)		9 beds total (6 acute asst)	10 beds total (7 acute asst)	11 beds total (8 acute asst)	13 beds total (9 acute asst)	14 beds total (10 acute asst)
Average Length of stay:					Required ALOS, if reduced as above				
MHSOP (C&V UHB)	151	130	151	130	95	94	**93**	**91**	**89**
Mean	81	78	75	78					
Lower quartile	65	65	51	58					
Median	82	76	62	73					
Upper quartile	93	91	84	89					
Inpatient beds per 100,000 population:					Beds per 100,000 population, if reduced as above				
MHSOP (C&V UHB)	108	83	108	83	76	75	**73**	**72**	**71**
Mean	47	44	57	60					
Lower quartile	33	33	44	45					
Median	43	39	51	57					
Upper quartile	57	52	64	73					

ASSURANCE is provided by:

ALOS and bed reductions will primarily improve outcomes for patient care with the secondary effect of bed reductions allowing a more sustainable workforce with reductions in agency and temporary staff requirements. Patient demand still has to be met and these efforts will be allied with support from the MHSOP community team including REACT crisis service, Care Homes Inreach Liaison, SOLACE and CMHT's. The reduction is also dependant on outside factors such as care home availability, which has decreased by 55 beds in the past year.

RECOMMENDATION

The Committee is asked to:

- Support a phased bed reduction programme of up to 14/15 beds in 2019/20

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable at present

REPORT TITLE:	**One simple thing:** Communication in the NHS in Wales January 2019								
MEETING:	Quality Safety and Experience Committee						**MEETING DATE:**	**16th April 2019**	
STATUS:	**For Discussion**		**For Assurance**		**X**	**For Approval**		**For Information**	
LEAD EXECUTIVE:	Executive Nurse Director								
REPORT AUTHOR (TITLE):	**Assistant Director of Patient Expereince**								

PURPOSE OF REPORT:

SITUATION:

This report has been written to provide the Committee with a response to the All Wales CHC report on communication
Report can be accessed here

REPORT:

BACKGROUND:

The all Wales work was led by the Board of Community Health Councils (CHCs) on behalf of the 7 CHCs in Wales as part of their drive to bring about better communication between the NHS and those using the health service.

CHC's heard from over 1,300 people from across Wales. The report shows that at its best, communication in the NHS made difficult times bearable, helped to build trust in NHS care and made people feel safe.

Some of the best experiences shared with CHC's showed how good communication led to people in vulnerable situations feeling involved, empowered and in control of their own health and care. The report also tells how poor or no communication left people feeling frustrated and scared. Patients did not always feel that they had any say or control over their health and care and were not always able to voice their concerns easily.

There were many examples where people tried and failed to find the information they needed to access NHS services or look after themselves. This included no available information as well as inappropriate, out of date, unclear or conflicting information.

Patients also said the language often used in the NHS made no sense to them, and they were frustrated that simple things that make things easier in everyday life such as text messaging and email were not routinely used across the NHS.

ASSESSMENT:

It should be noted there is no ability to drill into key themes from individual organizations.

To contextualize this report across Wales and the population of over some 3 million people. We have 18 million estimated contacts in Primary care, 1 million EU attendances, 750, 000 hospital admissions and 3 million outpatients' attendances.

The report was themed and the report will address each themed area and the current Health Board position

- Attitude, understanding and listening.
- Empathy when delivering bad views
- Keeping people informed and involved
- Appointments
- Using technology
- Coordination of care and communication across services
- Using Welsh
- Meeting individual needs
- Raising concerns

Attitude, understanding and listening.
Key Issues from the report
The report noted that it was important for the people involved in their care and treatment to listen to them.
It was felt that staff of the NHS working together with people who use NHS services to drive change and make improvements was important.

Empathy when delivering bad views
Issues from the report
Good communication skills were needed when delivering bad news.

Keeping people informed and involved
Issues from the report
NHS could and should do more to keep people informed about their health, care and treatment.
It could be difficult to understand what was going on when many different professionals were involved.
The language used in the NHS was not always easy to understand
People would like more written information to take away with them so that they don't forget what was said.

Appointments
Issues from the report
Communication with NHS services to book and change appointments was often difficult. When appointments were cancelled new ones were not always made automatically. People had to

follow up or chase for a new appointment to be made

Using technology
It was felt that the NHS could use modern technology better to make communication in the NHS quicker and easier. Extending the use of on-line booking of appointments, improving phone systems and using text messages as a reminder were common suggestions.

Coordination of care and communication across services
Some people had experienced times when the NHS failed to communicate properly between its different parts or with other services.

Using Welsh
People discussed the importance of being able to access services through the medium of Welsh. People shared experiences both good and not so good

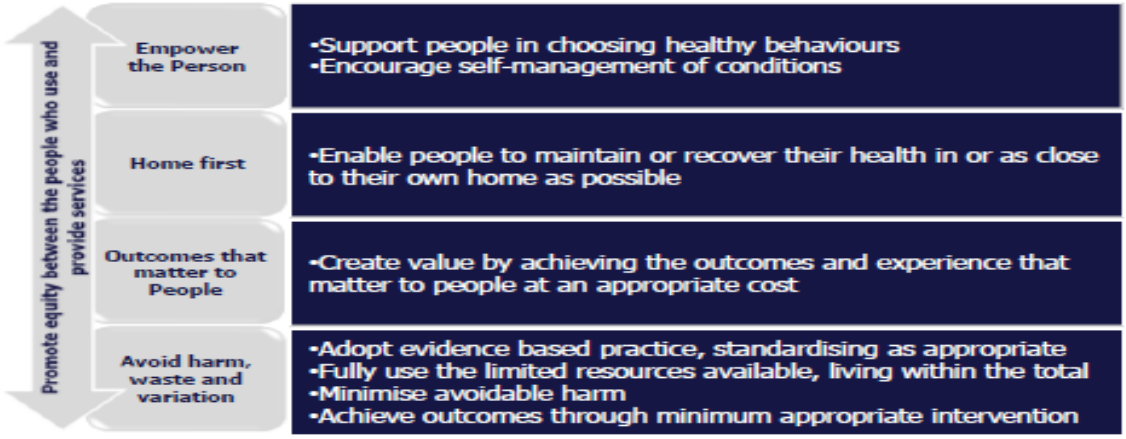
Meeting individual needs
Many people told us how important it is that the NHS considers and responds effectively to meet individual communication needs when delivering its services.

Raising concerns
People told us that it was not always easy to raise a concern about NHS services or to have concerns heard and responded to quickly without making a formal complaint.

UHB Response to the issues raised in the report

Caring for people, keeping people the Health Board strategy has at the heart the patients and communities that we serve. The next three years will take us over the halfway mark of our long term strategy Shaping Our Future Wellbeing and we remain fundamentally committed to its delivery. The design principles of the strategy, home first, empowering individuals, delivering outcomes that matter to people and avoiding waste, harm and variation are principles which cross organisational boundaries and support the achievement of the Area Plan.

Our Design Principles



Our design principles are all about empowering patients

In the Health Board we encourage our clinical staff to share copies of letters written following their out patients appointments.

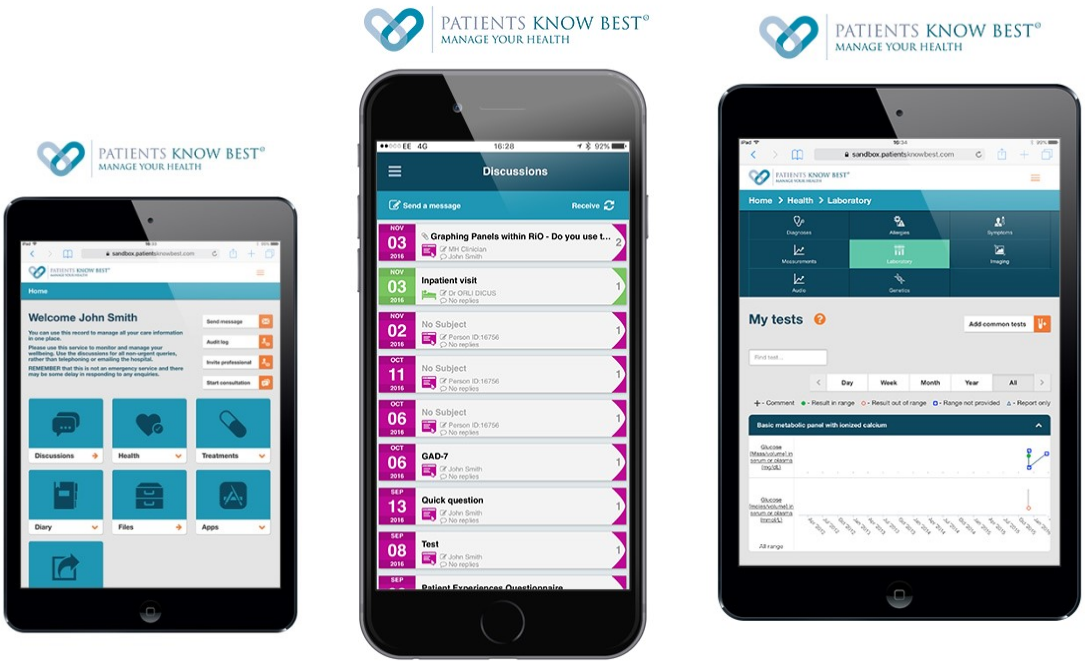
We are exploring the use of technology to keep our patients better informed regarding their own health care

Communication is a theme often raised in our patient experience feedback and in Cardiff and Vale Mr Alun Tomkinson (Consultant ENT / Clinical Board Director for Surgery) has been piloting PKB (Patient Knows Best)

Patients Know Best is for people who want more control over decisions about their healthcare. Patients Know Best stores medical notes from any healthcare provider connected to its service. The patient has secure access to their notes on the go, which is safe and useful if abroad or seeing a clinician for the first time.

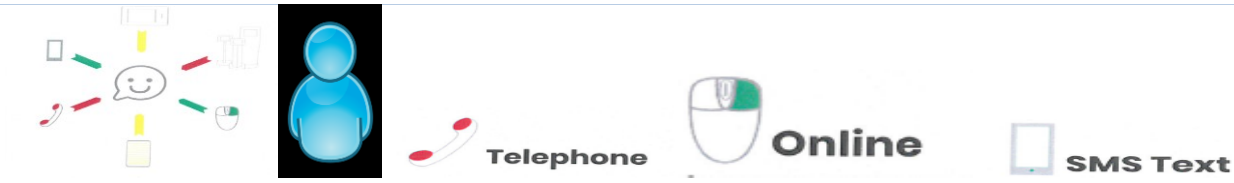
Messages can be sent to the healthcare team, patients can have online consultations, track symptoms and edit care plans with their clinicians online.

The service can also store information from a range of devices and apps that track and monitor health.



Whilst this programme works best with a clearly identified pathway of care –exploring the technological answers to improved communication with patients is a fundamental element of implementation of the UHB strategy and could enable the clinical stratification of patients on waiting lists to enable close monitoring and risk management. Information can also be provided and stored that facilitates an informed decision about consent for treatment and other available options

From discussion with our patients it was clear that we need multi-channel communication.



We have a text reminder system for appoitments in many parts of the Health Board.

We are using technology to help with sensory loss and translation services. We are piloting DAISY Online Interpreting. This is aimed at providing quicker, more cost efficient access to communication support for deaf/hearing loss people to engage with public sector services; it is an innovative remote access British Sign Language (BSL)/English

Using Skype for business, DAISY 'Face to Place' facilitates quick and cost efficient access to vital communication support via qualified/registered BSL/English interpreters for deaf people and lip speakers and or/note takers for people with hearing loss. DAISY can be accessed via iPads, tablets, Smartphones, laptops or personal computers and importantly via the Health Board's own internal current IT system. DAISY will enable deaf/hearing loss patients to access services independently and facilitate Health Board's staff direct engagement, discussion and work with them.

How to raise a concern-across the Health Board and in our primary care settings we have many posters explaining how to raise a concern. We encourage people to phone us, e mail, call into our information centres and talk with a member of our PALS (Patient Advisory Liaison team). We have updated the Internet pages and added a link to a Concerns Form that patients can complete making it easier for patients and families to raise concerns. This helps to ensure a comprehensive response is provided.

The Concerns Team agree the Terms of Reference with the Complainant and provide the Investigating Officer with the specific questions to be investigated as agreed with the person raising the concern. This helps to ensure a comprehensive response is provided. In our ongoing evaluation of the concerns service this initial contact and listening to people has been appreciated. We encourage personal contact with each Complainant to ensure that we acknowledge their correspondence in a more empathetic and personal manner than just formally writing to them.

We often include evidence of you said / we did in our reports to Board.

RECOMMENDATION:

The Committee is asked to **CONSIDER** the information provided within the report.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	

2. Deliver outcomes that matter to people	**X**	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	**X**
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention		Long term		Integration		Collaboration		Involvement	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable

Kind and caring / Caredig a gofalgar — Respectful / Dangos parch — Trust and integrity / Ymddiriedaeth ac uniondeb — Personal responsibility / Cyfrifoldeb personol

REPORT TITLE:	**Annual Quality Statemement**							
MEETING:	Quality Safety and Experience Committee					**MEETING DATE:**	**16.04.2019**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**	
LEAD EXECUTIVE:	Executive Nurse Director							
REPORT AUTHOR (TITLE):	**Head of Patient Safety and Quality Assurance**							

PURPOSE OF REPORT:

SITUATION
The purpose of this report is to present a draft Annual Quality Statement (AQS) 2018-2019 for approval.

REPORT:

BACKGROUND
NHS bodies are required to publish Annual Report and Accounts, an important element of this will be the publication of the Annual Quality Statement. Welsh Government issued guidance on production of the AQS in March 2019.

The AQS is intended to provide an opportunity for the health board to inform the public about the quality and safety of the services that it provides, including how it is making better use of resources to deliver safe, effective and patient centered services and how it provides care that is dignified and compassionate.

The AQS for 2018/2019 is required to be published no later than 31st May 2019.

ASSESSMENT
Each chapter of the AQS is aligned to a theme within the Health and Care Standards and comprises several elements:

- A patient and staff story,
- An update of the quality, safety and improvement framework where applicable.
- A focus on the successes and challenges across the health board.

The patient and staff stories have been developed in conjunction with clinical teams and patients across the UHB to reflect the approach being taken to ensure that care is being provided in the most appropriate settings. The stories provide context to the themes explored in each chapter and link to Shaping our Future Wellbeing Strategy.
The update of the Quality, Safety and Improvement Framework describes the progress made against the key domains within the health and care standards and the work that remains underway.
The third element explores the successes and challenges in 2018/19 across the health board.

Due to the timeframes for publication final year figures around performance and delivery will be inserted following the approval of the draft and before publication. The Annual Quality Statement is subject to approval from Internal Audit prior to publication.

Development of the AQS has been in collaboration with colleagues across the health board and in partnership with the Community Health Council, as well as through engagement with the Stakeholder Reference Group.

RECOMMENDATION:
The committee is asked to*:*
Approve the Draft Annual Quality Statement

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention		Long term	x	Integration		Collaboration	x	Involvement	x	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	No If "yes" please provide copy of the assessment. This will be linked to the report when published.

Reference Number: *TBA unless document for review* **Version Number:** 1 *unless document for review*	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

LABELLING OF SPECIMENS SUBMITTED TO MEDICAL LABORATORIES POLICY

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will advocate and promote the accurate labelling of specimens and accompanying laboratory request forms for safe and effective patient care. This policy describes the requirements for accurate positive identification of the patient from whom the specimen was taken, the clinical details surrounding the patient and the person and location where the result should be sent.

Policy Commitment

Cardiff and Vale University Health Board is committed to achieving excellence in providing safe, effective, efficient and compassionate care. In order to achieve this it is necessary to ensure that effective procedures are in place to ensure that all samples taken for laboratory investigations can be accurately and unambiguously assigned to the correct patient, and that all necessary information for analysis, interpretation and reporting is provided.

Supporting Procedures and Written Control Documents

This Policy and the supporting procedures describe the following with regard to sample labelling and patient identification.

- UHB 101 Patient Identification Policy
- UHB 100 Consent to Examination or Treatment Policy
- UHB 138 Incident, Hazard and Near Miss Reporting Policy and Procedure.
- UHB 149 Standard Infection Control Precautions Procedure

Scope

This policy relates specifically to the labelling of **specimens** submitted to Cardiff and Vale University Health Board medical laboratories for investigation and/or storage for subsequent investigation, and encompasses all body fluids and tissues, except blood components, blood products, cells or tissues for the purposes of transfusion or transplantation, or for storage for possible subsequent transfusion or transplantation.

Requirements for such transfusion related samples are described in the UHB 348 Blood Component Transfusion Procedure. Samples taken for point of care testing should follow the UHB 062 Point of Care Testing Policy.

Equality and Health Impact Assessment	*An Equality and Health Impact Assessment (EHIA) has ~~/ has not~~ been completed and this found there to be a no impact.*

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	For example: Health System Management Board
Accountable Executive or Clinical Board Director	……. Director [insert title of post holder]

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	14/10/2009	17/08/2010	
1	07/06/2011		No change
2	14/06/2012		Some sections clarified; requirement for full name of referring clinician, location and clinical details made mandatory (except where patient safety would be put at risk)
3	05/03/2013		Updated to clarify specimen forms need to state the Consultant initial and surname, not full name.
4			Updated to clarify the management of known high risk specimens.

Equality & Health Impact Assessment for

Labelling of Specimens Submitted to Medical Laboratories

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	No proposed change to Laboratory Medicine Service delivery. Document reviewed to provide clarity on sample labelling acceptance criteria and actions in the event of non-conformance with the policy.
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Clinical Diagnostics and Therapeutics, Clive Morgan, Assistant Director of Therapies
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The aim of this policy is to ensure that robust arrangements are in place to ensure that samples taken for laboratory analysis or storage can be accurately and unambiguously identified, and that all necessary information is supplied for appropriate and timely analysis, interpretation and reporting. In addition, any issues arising from the non-conformance with this policy will be reported via UHB 138 Incident, Hazard and Near Miss Reporting Policy and Procedure to establish the root-cause of the issue to avoid recurrence.
4.	Evidence and background	Cardiff and Vale University Health Board (UHB) is one of the largest NHS

	information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	organisations in the UK, providing healthcare services for 475,000 people living in Cardiff and the Vale of Glamorgan. There are currently approximately 558 staff employed within the Laboratory Medicine Directorate that are involved in the collection, processing, testing, storage, reporting or management of patient specimens from both internal or external sources. On an average day we carry out 13,715 blood tests. http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/10%20-%20UHB%20Shaping%20Our%20Future%20Wellbeing%20Strategy%20Final.pdf There are many papers that present the importance of accurate patient identification to the prevention of medical errors and demonstrate improvement after introducing and enforcing sample labelling procedures. https://scholar.google.co.uk/scholar?hl=en&as_sdt=0,5&as_vis=1&qsp=3&q=positive+patient+identification https://scholar.google.co.uk/scholar?hl=en&as_sdt=0%2C5&as_vis=1&q=reducing+sample+labelling+errors&btnG= The Laboratory Medicine Directorate service has dedicated intranet and internet pages that explain the service, the testing repertoire and turn-around times. http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,972415,253_972416&_dad=portal&_schema=PORTAL The Laboratory Medicine Directorate undertakes engagement with service users via user surveys, responding to compliments and concerns, incident management and service user engagement days.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Service users, patients, staff.

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going	Negative, there may be an assumption that a name belongs to a specific gender traditionally but the gender recorded may be opposed to this and the conflict may be seen as an error in the absence of qualifying supporting information.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
through any medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
			Mislabelled Specimens, Page 11.
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.10 People according to their income related group:	Policy applied to all samples	Disseminate policy and	Mitigation captured in

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	encourage use of user hand books.	introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure	Policy applied to all samples but for paediatric samples, precious samples	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction –

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
and/or service	professional discrepancy can be applied within the appropriate laboratory.		http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered:	Policy applied to all samples but for paediatric samples,	Disseminate policy and encourage use of user hand	Mitigation captured in introduction –

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	precious samples professional discrepancy can be applied within the appropriate laboratory.	books.	http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
7.4 People in terms of their use of the physical environment:	Policy applied to all samples but for paediatric samples, precious samples	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction –

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	professional discrepancy can be applied within the appropriate laboratory.		http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
7.5 People in terms of social and community influences on their health: Consider the impact on	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffand

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	be applied within the appropriate laboratory.		vale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A globally responsible Wales			

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory. Patient identification may be misinterpreted in the case of a transgender patient presenting with opposite gender name and gender recorded on same episode.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Complete on issuing policy.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	N/A			
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure an • d/or service proposal: ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts	continues unchanged as there are no significant negative impacts			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) ○ stops. Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review				

Reference Number: *TBA unless document for review* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *17*

LABELLING OF SPECIMENS SUBMITTED TO MEDICAL LABORATORIES PROCEDURE

Introduction and Aim

Accurate labelling of specimens and accompanying laboratory request forms is very important for safe and effective patient care.

This policy describes the requirements for accurate positive identification of the patient from whom the specimen was taken, the clinical details surrounding the patient and the person and location where the result should be sent. These are the minimum requirements for accepting a specimen and logging it onto the laboratory database in line with the Right First Time Requesting Initiative launched in April 2013. Some laboratory tests have very specific requirements about how the specimen should be obtained, the preservative used (or not used) and the clinical information required to perform the correct test and interpret the results properly.

In some circumstances, e.g. where sequential specimens are taken, it is important to identify not only the patient but also the individual specimen (by date and time taken). Each laboratory produces a user guide, which should be consulted before sending specimens for specialist tests.
http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/

Cardiff and Vale University Health Board is committed to achieving excellence in providing safe, effective, efficient and compassionate care. In order to achieve this it is necessary to ensure that effective procedures are in place to ensure that all samples taken for laboratory investigations can be accurately and unambiguously assigned to the correct patient, and that all necessary information for analysis, interpretation and reporting is provided.

Cardiff and Vale University Health Board is also committed to the health, safety and welfare of all its staff, by providing a safe workplace and systems of work. In order to achieve this it is necessary to ensure that staff have the necessary information when obtaining, transporting and processing hazardous biological materials

Objectives

The aim of this policy is to ensure that robust arrangements are in place to ensure that samples taken for laboratory analysis or storage can be -

- accurately and unambiguously identified
- all necessary information is supplied for appropriate and timely analysis, interpretation and reporting
- issues arising from the non-conformance with this policy will be reported via UHB 138 Incident, Hazard and Near Miss Reporting Policy and Procedure to establish the root-cause of the issue to avoid recurrence.

Scope

This policy relates specifically to the labelling of **specimens** submitted to Cardiff and Vale University Health Board medical laboratories for investigation and/or storage for subsequent investigation, and encompasses all body fluids and tissues, except blood components, blood products, cells or tissues for the purposes of transfusion or transplantation, or for storage for possible subsequent transfusion or transplantation.

Requirements for such transfusion related samples are described in the UHB 348 Blood Component Transfusion Procedure. Samples taken for point of care testing should follow the UHB 062 Point of Care Testing Policy.

Equality and Health Impact Assessment	*An Equality and Health Impact Assessment (EHIA) has ~~/ has not~~ been completed and this found there to be a no impact.*
Documents to read alongside this Procedure	This Policy and the supporting procedures describe the following with regard to sample labelling requirements. . **Other supporting documents are:** • UHB 017 Labelling of Specimens Submitted to Medical Laboratories • UHB Dignity at Work Process. • UHB 002 Data Protection Policy • UHB004 Infection Control Procedure for Meticillin Resistant Staphylococcus Aureus • (MRSA) in Acute Hospitals • UHB 053 Major Incident Plan • UHB 062 Point of Care Testing (POCT) Policy • UHB 068 Blood and Component Transfusion Policy • UHB 100 Consent to Examination or Treatment Policy • UHB 101 Patient Identification Policy • UHB 138 Incident, Hazard and Near Miss Reporting Policy and Procedure. • UHB 149 Standard Infection Control Precautions Procedure • UHB 265 Infection Control Procedure for Viral Hepatitis • UHB 348 Blood Component Transfusion Procedure • UHB 349 Creutzfeldt-Jakob Disease (CJD) and Variant CJD (Vcjd) Minimising the Risk of Transmission Infection Prevention & Control Procedure • *Transmission Based Precautions Procedure 2015* • *Viral Hepatitis (updated 2015)* • *Varicella Zoster (Chicken Pox)* • *Infection Control Procedure for Needlestick and Similar Sharps Injuries* • *UHB 089 Control of Substances Hazardous to Health (COSHH) Procedure*
Approved by	Quality, Safety and Experience Committee

Accountable Executive or Clinical Board Director	*Title of post holder*
Author(s)	*Directorate Quality Manager*

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
	Date of Committee or Group Approval	*TBA*	*New procedure to replace previous UHB 017 Labelling of Specimens Submitted to Medical Laboratories Policy, including additional guidance on management of high risks samples.*

Contents

1.0 Introduction

Accurate labelling of specimens and accompanying laboratory request forms is very important for safe and effective patient care.

This policy describes the requirements for accurate positive identification of the patient from whom the specimen was taken, the clinical details surrounding the patient and the person and location where the result should be sent. These are the minimum requirements for accepting a specimen and logging it onto the laboratory database in line with the Right First Time Requesting Initiative launched in April 2013. Some laboratory tests have very specific requirements about how the specimen should be obtained, the preservative used (or not used) and the clinical information required to perform the correct test and interpret the results properly.

In some circumstances, e.g. where sequential specimens are taken, it is important to identify not only the patient but also the individual specimen (by date and time taken). Each laboratory produces a user guide, which should be consulted before sending specimens for specialist tests.
http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/

Cardiff and Vale University Health Board is committed to achieving excellence in providing safe, effective, efficient and compassionate care. In order to achieve this it is necessary to ensure that effective procedures are in place to ensure that all samples taken for laboratory investigations can be accurately and unambiguously assigned to the correct patient, and that all necessary information for analysis, interpretation and reporting is provided.

Cardiff and Vale University Health Board is also committed to the health, safety and welfare of all its staff, by providing a safe workplace and systems of work. In order to achieve this it is necessary to ensure that staff have the necessary information when obtaining, transporting and processing hazardous biological materials

2.0 Aims and Objectives

The aim of this policy is to ensure that robust arrangements are in place to ensure that samples taken for laboratory analysis or storage can be -

- accurately and unambiguously identified
- all necessary information is supplied for appropriate and timely analysis, interpretation and reporting
- staff that are involved in or detect issues arising from the non-conformance with this policy, that result in (near) patient harm, will be expected to report to the organisation in line with UHB 138 Incident, Hazard and Near Miss Reporting Policy and Procedure to establish the root-cause of the issue to avoid recurrence. Incident reporting may be

undertaken by the receiving laboratory but the investigation will remain the responsibility of the referring clinical area

3.0 Definitions

For the purposes of this document, **a specimen** means the quantity of tissue, fluid, or other sample submitted for testing, together with its container and the request form.

3.1 Inappropriate labelling describes any situation where the information provided on the specimen container or request form is incorrect or not adequate for the purposes of the laboratory investigation requested. This includes the following categories:

- **Unlabelled specimens** have an absence of labelling on either the container or the request form, or have no request form.

- **Mislabelled specimens** have a mismatch between the patient information on the specimen container and the accompanying form, or between the information supplied and information from another source (e.g. a previous specimen from the same patient, or data on PMS)

- **Inadequately labelled specimens** have insufficient information on the tube or request form for either the proper identification of the patient or the specimen, or for the correct performance, interpretation and communication of the analysis.

4.0 Scope of the Policy

This policy relates specifically to the labelling of **specimens** submitted to Cardiff and Vale University Health Board medical laboratories for investigation and/or storage for subsequent investigation, and encompasses all body fluids and tissues, except blood components, blood products, cells or tissues for the purposes of transfusion or transplantation, or for storage for possible subsequent transfusion or transplantation.

Requirements for such transfusion related samples are described in the UHB 348 Blood Component Transfusion Procedure. Samples taken for point of care testing should follow the UHB 062 Point of Care Testing Policy.

5.0 Stakeholder Responsibilities

The responsibility for requesting a laboratory investigation lies with an authorised practitioner (normally a medical clinician). It is the responsibility of

the requester to ensure that specimen containers are correctly labelled and request forms completed to an acceptable standard (see below). If another person, e.g. a phlebotomist, obtains specimens from a patient on behalf of a requesting practitioner they must ensure that the labelling meets these standards (see below). All staff who take Pathology specimens are responsible for ensuring they are collected in a manner that meets the requirements of the tests requested. It is also the responsibility of the person requesting an investigation or storage of a sample to ensure that they have obtained the necessary informed consent for all procedures requested (refer to UHB 100 Consent to Examination or Treatment Policy).

Managers and senior staff in clinical areas are responsible for ensuring that staff who collect samples are aware of this policy and are competent in sample collection, requesting and labelling. Managers and senior staff in clinical areas must also ensure that appropriate action is taken where incidents arising from breaches of this policy occur, including responding to or reporting incidents on Datix, conducting root cause analysis and assessing any feedback provided to them.

Phlebotomists and Laboratory staff are required to adhere and enforce this policy; they should therefore be treated in accordance with the UHB Dignity at Work Process. Laboratory staff who receive samples which cannot be processed due to breaches in this policy must ensure that departmental procedures for acceptance of samples are followed, incidents that result in (near) patient harm may be reported to Datix if appropriate.

The Lead Executive for Patient Quality and Safety is the Executive Director of Nursing, who in conjunction with the Executive Medical Director and the Executive Director of Therapies and Health Science have ultimate responsibility for ensuring effective clinical governance arrangements and the quality of patient care. This responsibility is discharged within the Clinical Boards and Directorates via the Clinical Board Directors, Laboratory/Clinical Directors, and appropriate senior managers.

It is the responsibility of Clinical Board Quality, Safety and Experience Groups to implement this policy, ensuring that appropriate up-to-date guidance is available and implemented at directorate level, and that compliance is audited at departmental level. Outcomes from audit and monitoring must be fed back to Directorates through the Clinical Board clinical governance structure.

6.0 Procedure for Labelling Specimens

6.1 Specimen Collection

6.1.1 Phlebotomists will not bleed a patient without a completed and signed request form. The form must include full patient identification, Consultant's initial and surname, location and clinical details. Incomplete request forms will be returned for completion before blood is collected.

6.1.2 Staff must ensure they have positively identified the patient, following the relevant UHB 101 Patient Identification Policy, before taking a sample.

6.1.3 Specimen labelling should be performed in the presence of the patient. Pre-labelling empty sample containers and leaving filled containers unlabelled for any period of time is extremely poor clinical practice which poses a high risk of mislabelling and must not be tolerated under any circumstance. In the event of the requesting clinician, or other member of staff, becoming aware of any errors in sample identification discovered after the specimen has been sent for processing, this must be reported immediately to the laboratory to prevent incorrect information remaining on the laboratory databases with the potential for an adverse clinical incident.

6.1.4 When using an addressograph label, staff should take special care that they are the correct ones for the patient.

6.1.5 The person who takes the sample should sign the request form and record the date and time the sample was taken.

6.1.6 The UHB is currently implementing electronic test requesting. The system allows clinicians to order requests electronically and print test labels to attach to specimens to facilitate the booking in process and improve legibility. The same principles must be employed, with regard to patient safety, when utilising an electronic request form.

6.2 Labelling the Request Form

6.2.1 Specimens will not be processed by the laboratory without an appropriate request form.

6.2.2 Laboratories require a minimum data set before a specimen can be registered to ensure safe and accurate retrieval of data. It is the requesting clinician's responsibility to enter these details **legibly** on the appropriate form.

6.2.3 In certain special situations, e.g. where patient anonymity must be protected, there are agreed protocols for specific investigations which do not require patient names.

6.2.4 In an emergency situation where the identity of the patient cannot be established or Patient Management Systems (PMS) are not working, the requesting clinician must notify the laboratory in order that temporary arrangements can be made, in compliance with the agreed protocol.

6.2.5 Minimum Data Set (excluding Blood Transfusion samples)

An addressograph label should be used whenever possible**.**
The following information is essential for patient identification:

1. Patient's NHS number and/or hospital number, AND
2. Patient's name (surname and first name – not initial), AND EITHER
3. Patient's address (minimum first line), including postcode, if known, OR[1]
4. Patient's date of birth

[1]If the patient is from a communal address, the date of birth is required

6.2.6 The following is essential for prompt and accurate reporting and to comply with Right First Time:

5. Clinician's Initial and Surname with overall responsibility for the patient (usually a Consultant or GP)
6. Ward / Department and Hospital, or other address to which the report should be sent
7. Relevant clinical information

6.2.7 The following information is required for scientific and clinical interpretation:

8. Date and time specimen **taken** (NOT when requested)
9. Patient's gender.

6.2.8 The following Information is required to contact the requestor (e.g. for critical results or in the event of problems with the sample):

10. Legible name and extension/bleep number of requesting clinician

6.3 Addressograph Labels

Addressographs must only be used for specimens taken from the person whose details are on them. They **must not** be modified or altered for use for other people's specimens, e.g. partners or siblings. The only exception to this is for certain requests regarding fetuses, when the mother's addressograph may be used with the fetal origin of the specimen clearly stated.

6.4 Labelling the Specimen Container

Each specimen container (**NOT** the lid or cap) must be labelled **by the person taking the specimen** with:

1. Patient's name (surname and first name – not initial)
2. Patient's date of birth
3. Patient's hospital number or NHS number (if available)

In addition it is desirable for the time and date the sample was collected to be annotated.

An addressograph is the preferred method of labelling in all areas of the laboratory service **except the blood transfusion laboratory** where hand-written details are required.

6.5 Recording the Collection of Specimens

When a blood sample is taken the date and time of collection and the name of the person who took the sample should be entered into the appropriate places on the request form. This information is important for ensuring the suitability of samples for analysis and appropriate interpretation of data. It is also useful in the event of enquiries about sample collection.

6.6 Biohazard Specimens

For specimens from patients who are known or suspected to be infected with a Hazard Group (HG) 3 agent (primarily blood-borne viruses) the container (and ideally the request form also) **must** be clearly identified with a yellow hazard 'danger of infection' warning sticker. This policy acknowledges the requirements to maintain patient confidentiality in addition to inform and protect staff, Appendix 1 provides a detailed literature review of the current guidance. Appendix 2 provides a detailed list of biological agents where there is a legal requirement for additional or enhanced precautions above Containment Level (CL) 2 and biological agent which pose a danger to an unborn child. If the referring clinician refers a sample which is suspected or known to contain a non-derogated HG 3 organisms or a biological agent which poses a danger to an unborn child (appendix 2) then this must be clearly labelled with a 'danger of infection' sticker so that the laboratories can handle the samples safely. Although COSHH sets out the minimum requirements for each level of containment, certain HG3 agents can be worked with under reduced containment in particular circumstances.

N.B. hazard group 4 agents can only be handled by specialist laboratories.

All infectious or potentially infectious samples should also be double bagged. For samples other than blood, all UHB Procedures (especially UHB 149 Standard Infection Control Precautions Procedure) and National Guidelines relevant to the infectious agent (e.g. MRSA, TSE) should be followed. If in doubt, guidance should be sought from the laboratories or Infection Prevention and Control Team before taking samples. Failure to identify hazardous specimens is a breach of the duty of care under Health and Safety legislation. Patient confidentiality should be preserved by ensuring that the identity of patients is kept confidential in its packaging while being transported to the laboratory.

Forms and sample containers must be kept separated and **not** placed into the same plastic bag/compartment.

6.7 Procedure for Handling Inappropriately Labelled Specimens

(For definitions see 6 above)

6.7.1 Feedback to Requestors

A member of laboratory staff will attempt to contact the requesting clinician when practicable, and/or a report will be sent requesting a repeat sample.

6.7.2 Unlabelled Specimens

All unlabelled specimens will need to be retaken. Only rarely will exceptions be made when retaking is not a **reasonable** option, there are compelling clinical reasons, and there is clear evidence of patient identity. Such a specimen will need to have the patient's identity confirmed by the person responsible for collecting the specimen and that person will have to sign a laboratory record confirming this, thereby accepting responsibility for the identity of the specimen. A comment will be added to the Laboratory Information Management System (LIMS) to acknowledge the labelling error and any potential authorisation from clinician to proceed to analysis.

6.7.3 Mislabelled Specimens

All specimens with different patient's details on the request form and the container, will have to be retaken. Only rarely will exceptions be made when retaking is not a **reasonable** option, there are compelling clinical reasons, and there is clear evidence of patient identity. Such a specimen will need to have the patient's identity confirmed by the person responsible for collecting the specimen and that person will have to sign a laboratory record confirming this, thereby accepting responsibility for the identity of the specimen. A comment will be added to the Laboratory Information Management System (LIMS) to acknowledge the labelling error and any potential authorisation from clinician to proceed to analysis.

6.7.4 Inadequately Labelled Specimens

Where specimen labelling falls short of the full requirements of patient identification, initial and surname of Medical Practitioner, location and clinical details, samples will not be analysed, except, at the discretion of the laboratory, when:

- repeat sampling is not feasible, and
- not analysing could seriously compromise patient care (e.g. unrepeatable samples, such as CSF), and
- patient identity can reasonably certainly be deduced.

A member of laboratory staff will attempt to inform the requesting clinician either by telephone or report (if that person can be identified from the form) and:

- If there is an overriding clinical reason for processing the specimen, offer the opportunity to come to the laboratory and complete the labelling. The person completing or correcting the labelling must be the person who took the specimen, must be able to satisfy themselves of the identity of the specimen and must sign a laboratory record confirming this, thus accepting responsibility for the identity of the specimen.
- Inform the clinician that if this is not done within one day (or shorter period if the analyte is less stable), the specimen may be discarded. Cellular pathology specimens may be retained unprocessed for a limited period.
- Keep the specimen in a designated place for the agreed period of time.
- If specimens have to be discarded (or retained unprocessed for longer than one day) a record will be made in the laboratory computer system and an appropriate notification made to the requesting ward/department/practice.

A similar procedure will apply to all specimens that have been received in the laboratory for which, during processing, a member of the laboratory staff has good reason to doubt the identity of the specimen. A comment will be added to the Laboratory Information Management System (LIMS) to acknowledge the labelling error and any potential authorisation from clinician to proceed to analysis.

6.7.5 Recording of Labelling Incidents

The laboratory will keep a record of all inappropriately labelled specimens. This record will include:

- precise details of the inappropriate labelling
- the name and address of the patient
- the name of the requesting clinician
- the ward, unit, or practice
- Consultant in charge of the case where possible

Where the laboratory agrees to analyse an inadequately labelled specimen, the name and department/section of the person taking responsibility for the specimen will also be recorded.

Labelling incidents that result in (near) patient harm will be treated as clinical incidents and dealt with according to the UHB 138 Incident, Hazard and Near Miss Reporting Policy and Procedure.

When repeated labelling incidents can be identified as originating from a single Unit or Practice, an appropriate Consultant, General Practitioner or Practice Manager will be informed.

7.0 Resources

No resources are being made available specifically in response to the revision of this policy. The procedures described are already best practice in the UHB. This revision represents a more rigorous application of those practices, and decreased tolerance of substandard practice in the interest of patient safety. Some re-sampling of patients is anticipated.

8.0 Staff Training and Education

All new medical practitioners and other health care professionals should be made aware of local guidance and the importance of correct patient and sample identification. It is the responsibility of Clinical Boards to ensure that staff have access to appropriate training, and observe all UHB Policies and Procedures. Training of new medical practitioners and other health care professionals in laboratory usage should continue at induction. No facilities for any additional formal training required as a result of this policy will be available.

9.0 Review

This policy will be reviewed at least every 3 years and more frequently if any developments or changes in practice inform the Health Board otherwise.

10.0 Monitoring and Audit

The quality of information supplied with specimens will be audited regularly as part of the Laboratory Medicine internal audit programme and results reported to the Clinical Board Quality Safety and Experience Group.

11.0 Distribution

This policy will be available for viewing via the UHB intranet.

12.0 Equality

An equality impact assessment has been undertaken to assess the relevance of this policy to equality and potential impact on different groups, specifically in relation to the General Duty of the Race Relations (Amendment) Act 2000 and the Disability Discrimination Act 2005 and including other equality legislation. The assessment identified that the policy presents a positive impact as all patients and colleagues will be treated equally under this policy.

Appendix 1 High risk labelling policy: Literature review

The Health and Safety Executive's (HSE) "*Approved List of Biological Agents*" states as a fundamental principle of good laboratory safety systems that:

> *"where there is a high risk of staff exposure to a hazard group 3 biological agent, laboratory staff may need additional information."*

The HSE builds on this advice in their *"Safe working and the prevention of infection in clinical laboratories and similar facilities"* guidance by suggesting that:

> *"The most common method of providing information on specimens known or suspected of posing a risk of infection is to use a 'danger of infection' label. Use of a standard label for all such specimens coming into the laboratory reduces scope for confusion. Reception staff need to send specimens bearing a danger of infection label directly to the appropriate laboratory department, unopened"*

This is a legal requirement. This is further supported by another legal requirement imposed by the Control of Substances Hazardous to Health Regulations (2002) (COSHH) to record exposure to Hazard Group (HG) 3 or HG 4 organisms:

> "Under COSHH employers must keep details about employees exposed to hazard group 3 or 4 biological agents, where there is a deliberate intention to work with or use the group 3 or 4 agent or, in the case of an incidental exposure, a risk assessment shows there is a significant risk. Employees should be considered as having been exposed unless exposure has been prevented, and not merely controlled. The details recorded should include:
>
> - the type of work the employee does;
> - the biological agents to which they have been exposed (where this is known);
> - records of accidents and incidents involving exposure to the biological agents concerned.
>
> These details should be kept for at least 10 years after the last known exposure, except in the case of certain exposures which may give rise to infections with longer-term implications, where they should be kept for 40 years."

Management of Health and Safety at Work Regulations 1999 (MHSW) also establishes the requirement to manage infection risks to new and expectant mothers in the workplace. Specific pathogens require the employer to make suitable adjustments to protect new and expectant mothers in pathology laboratories:

- Chlamydia psittaci
- Cytomegalovirus

Appendix 1 High risk labelling policy: Literature review

- Hepatitis A
- Hepatitis B
- Human immunodeficiency viruses
- Listeria
- Parvovirus
- Rubella
- Toxoplasma
- Varicella-zoster (chickenpox)

Advisory Committee on Dangerous Pathogens (ACDP) Guidance "INFECTION RISKS to new and expectant mothers in the workplace" also lists a range of microbes cause infections in the human population and may also infect pregnant women. These may or may not have an adverse effect on the baby

- Borrelia burgdorferi (Lyme disease);
- Coxiella burnetii (Q fever);
- Campylobacter spp. and Salmonella spp (gastroenteritis);
- Lymphocytic choriomeningitis virus (LCM),
- Mycobacterium tuberculosis (TB),
- Treponema pallidum (syphilis)

Accidents or incidents which result in or could result in the release or escape of a biological agent likely to cause severe human disease, i.e. a HG3 or HG4 agent (defined as a dangerous occurrence) also have to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) (RIDDOR).

Therefore samples which are known, or suspected to contain HG 3 or HG 4 organisms must be labelled as such to allow employers to comply with the legal requirement established by a number of statutory implements.

It is anticipated that the revised General Medical Council (GMC) guidance "Confidentiality: good practice in handling patient information" read in conjunction with "Confidentiality: disclosing information about serious communicable diseases" will provide the following advice:

> *"If a patient who has been diagnosed with a serious communicable disease refuses to allow you to tell others providing their care about their infection status, and you believe that failing to disclose the information will put healthcare workers or other patients at risk of infection, you should explain to the patient the potential consequences of their decision and consider with the patient whether any compromise can be reached.*
>
> *Like everyone else, healthcare workers are entitled to protection from risks of serious harm. But disclosure of information about a patient's infection status without consent is unlikely to be justified if it would make no difference to the risk of transmission – for example, if the risk is likely to be managed through the use of universal precautions that*

> *are already in place. If the patient continues to refuse to allow you to tell other members of the healthcare team about their infection status, you must abide by their wishes unless you consider that disclosing the information is necessary to protect healthcare workers or other patients from a risk of death or serious harm."*
>
> *"If it is not practicable to seek consent, and in exceptional cases where a patient has refused consent, disclosing personal information may be justified in the public interest if failure to do so may expose others to a risk of death or serious harm. The benefits to an individual or to society of the disclosure must outweigh both the patient's and the public interest in keeping the information confidential.*
>
> *If you consider that failure to disclose the information would leave individuals or society exposed to a risk so serious that it outweighs patients' and the public interest in maintaining confidentiality, you should disclose relevant information promptly to an appropriate person or authority. You should inform the patient before disclosing the information, if it is practicable and safe to do so, even if you intend to disclose without their consent."*

The overarching legal principle contained within this guidance is that you must disclose information if it is necessary to protect healthcare workers or other patients from a risk of death or serious harm. Safety considerations always takes primacy over information governance. This requirement is explicitly laid out in COSSH and HSE guidance *"Safe working and the prevention of infection in clinical laboratories and similar facilities".*

In the context of the GMC guidance universal precautions, otherwise known as standard infection control precautions, are the basic infection prevention and control measures necessary to reduce the risk of transmitting infectious agents. The HSE clarify the standing of the term 'universal precautions' in their document *"Safe working and the prevention of infection in clinical laboratories and similar facilities"*:

> *"The use of the term 'universal precautions' is not helpful with regard to the*
> *measures needed for handling biological agents, as it is not clearly defined.*
> *Adopting universal precautions may result in a standard of practice which is not high enough. The precautions needed must be based on an assessment of the risks involved, which may be influenced by several factors, such as the biological agents known or suspected to be present and the type of work being carried out."*

Universal precautions in the context of pathology facilities would be dependent on the containment level of the laboratory. Therefore any sample

known or suspected to contain HG 3 or HG 4 organisms cannot be handled with the universal precautions deployed at CL2.

The HSE's "Approved List of Biological Agents" states that:

> *"working with HG 2 biological agents requires a minimum of Containment Level CL 2; HG3 agents being handled at a minimum of CL3"*
>
> *"CL3 or CL4 must be used, where appropriate, if the employer knows or suspects that such a containment level is necessary even if there is no intention to deliberately propagate and concentrate biological agents"*

Therefore there is a legal requirement for additional or enhanced precautions above CL 2 if the laboratory is referred a sample which is suspected or known to contain a non-derogated HG 3 organisms (appendix 2).

Although COSHH sets out the minimum requirements for each level of containment, certain HG3 agents can be worked with under reduced containment in particular circumstances. In order to be able to do this the employer must follow the relevant ACDP guidance agreed or approved by the Health and Safety Commission (HSC). The HG3 agents eligible for reduced containment are listed in the latest edition of the HSC's "*Approved list of biological agents".* In the Approved List, the agents for which this is relevant are indicated in the hazard group column with an asterisk (*) and are listed in Appendix 2. These are known as derogated organisms.

Derogation from CL3 does not imply that the work can be carried out at CL2, it simply allows certain physical containment requirements, normally expected at CL3, to be dispensed with. All other aspects of the work, in particular supervision and training, should reflect the high standards expected at CL3. Any decision to reduce containment measures should be made on the basis of a local risk assessment which takes into account the specific nature of the work.

Appendix 2

Biological Agent	Human Pathogen Hazard Group	Notes
BACTERIA		
Bacillus anthracis	3	Classified under Specified Animal Pathogens Order (SAPO)
Brucella abortus	3	Classified under SAPO Danger to unborn child
Brucella canis	3	Classified under SAPO
Brucella melitensis	3	Classified under SAPO
Brucella suis	3	Classified under SAPO
Burkholderia mallei (formerly Pseudomonas mallei)	3	Classified under SAPO
Burkholderia pseudomallei (formerly Pseudomonas pseudomallei)	3	
Chlamydophila psittaci (avian strains)	3	Danger to unborn child
Chlamydophila trachomatis	2	Danger to unborn child
Coxiella burnetti	3	
Escherichia coli, verocytotoxigenic strains (eg O157:H7 or O103)	3*	Toxigenic
Francisella tularensis (Type A)	3	
Listeria monocytogenes	2	Danger to unborn child
Mycobacterium africanum	3	
Mycobacterium bovis	3	
Mycobacterium leprae	3	
Mycobacterium malmoense	3	
Mycobacterium microti	3*	
Mycobacterium szulgai	3	
Mycobacterium tuberculosis	3	Danger to unborn child
Mycobacterium ulcerans	3*	
Rickettsia akari	3*	
Rickettsia canada	3*	
Rickettsia conorii	3	
Rickettsia montana	3*	
Rickettsia prowazekii	3	
Rickettsia rickettsii	3	
Rickettsia sennetsu (Ehrlichia sennetsu)	3	
Rickettsia spp	3	
Rickettsia tsutsugamushi	3	
Rickettsia typhi (Rickettsia mooseri)	3	
Salmonella paratyphi A	3*	
Salmonella paratyphi B/java	3*	
Salmonella paratyphi C/Choleraesuis	3*	

Appendix 2.

Biological Agent	Human Pathogen Hazard Group	Notes
BACTERIA (continued)		
Salmonella typhi	3*	
Shigella dysenteriae (Type 1)	3*	Toxigenic
Treponema pallidum (syphilis)	2	Danger to unborn child
Yersinia pestis	3	
FUNGI		
Blastomyces dermatitidis (Ajellomyces dermatitidis)	3	
Cladophialophora bantiana (formerly Xylohypha bantiana, Cladosporium bantianum)	3	
Coccidioides immitis	3	Allergen
Coccidioides posadasii	3	Allergen
Histoplasma capsulatum var capsulatum (Ajellomyces capsulatus)	3	
Histoplasma capsulatum var duboisii	3	
Histoplasma capsulatum var farcinimosum	3	
Paracoccidioides brasiliensis	3	
Penicillium marneffei	3	Allergen
Rhinocladiella mackenziei (formerly Ramichloridium)	3	
HELMINTHS		
Echinococcus granulosus	3*	
Echinococcus multilocularis	3*	
Echinococcus vogeli	3*	
Taenia solium	3*	
PROTOZOA		
Leishmania brasiliensis	3*	
Leishmania donovani	3*	
Naegleria fowleri	3	
Plasmodium falciparum (malaria)	3*	
Toxoplasma gondii	2	Danger to unborn child
Trypanosoma brucei rhodesiense	3*	
PRIONS - unconventional agents associated with transmissible spongiform encephalopathies (TSEs)		
Sporadic Creutzfeldt-Jakob disease agent	3*	Restrictions on post mortem examinations
Sporadic fatal insomnia agent	3*	Restrictions on post mortem examinations
Variably protease-resistant prionopathy agent	3*	Restrictions on post mortem examinations
Familial Creutzfeldt-Jakob disease agent	3*	Restrictions on post mortem examinations

Appendix 2.

Biological Agent	Human Pathogen Hazard Group	Notes
PRIONS - unconventional agents associated with transmissible spongiform encephalopathies (TSEs) (continued)		
Fatal familial insomnia agent	3*	Restrictions on post mortem examinations
Gerstmann-Sträussler-Scheinker syndrome agent	3*	Restrictions on post mortem examinations
Variant Creutzfeldt-Jakob disease agent	3*	Restrictions on post mortem examinations
Iatrogenic Creutzfeldt-Jakob disease agent	3*	Restrictions on post mortem examinations
Kuru agent	3*	Restrictions on post mortem examinations
VIRUSES		
Absettarov virus	3	Strain of Central European tick-borne encephalitis virus (Far Esatern subgroup)
Alkhurma haemorrhagic fever virus	3	Subspecies of Kyasanur Forest disaes virsu
Andes virus	3	
Australian bat lyssavirus	3	Classified under SAPO
B virus (Macacine herpesvirus 1)	4	
Banna virus	3	
Belgrade (Dobrava) virus	3	
Bhanja virus	3	
Borna disease virus	3	
Bundibugyo ebolavirus 4	4	
Bunyavirus germiston	3	Synonym: Germiston virus Subspecies of Bunyamwera virus
Central European tick-borne encephalitis virus	3	
Chapare virus	4	
Chikungunya virus	3*	
Crimean/Congo haemorrhagic fever virus	4	
Dengue viruses types 1–4	3	
Duvenhage virus	3	Classified under SAPO
Eastern equine encephalomyelitis encephalitis virus	3	Classified under SAPO
European bat lyssaviruses 1 and 2	3	Classified under SAPO
Everglades virus	3*	
Far Eastern tick-borne encephalitis virus (Russian spring–summer encephalitis virus)	4	
Flexal virus	3	

Appendix 2.

Biological Agent	Human Pathogen Hazard Group	Notes
VIRUSES		
Getah virus	3	
Guanarito virus	4	
Hantaan virus (Korean haemorrhagic fever)	3	
Hanzalova virus	3	
Hendra virus (formerly equine morbillivirus)	4	Classified under SAPO
Hepatitis B virus	3*	Danger to unborn child
Hepatitis C virus	3*	Danger to unborn child
Hepatitis D virus (delta)	3*	Synonym: Deltavirus Hepatitis delta virus Danger to unborn child
Hepatitis E virus	3*	Danger to unborn child
Herpesvirus simiae	4	
Human cytomegalovirus (Human herpsevirus 5)	2	Danger to unborn child
Human herpes simplex viruses 1 and 2	2	Danger to unborn child
Human immunodeficiency viruses	3*	Danger to unborn child
Human parvovirus 4, 5, B19	2	Danger to unborn child
Human pegivirus	3*	Formerly known as GB virus C; or Hepatitis G virus Danger to unborn child
Hypr virus	3	
Israel turkey meningitis meningoencephalomyelitis virus	3	
Japanese encephalitis virus	3	Classified under SAPO
Junin virus	4	
Kumlinge virus	3	
Kyasanur Forest disease virus	4	
La Crosse virus	3	Subspecies of California encephalitis virus
Lagos bat virus	3	Classified under SAPO
Lassa fever virus	4	
Louping ill virus	3*	
Lujo virus	4	
Lymphocytic choriomeningitis virus LCMV (all strains other than Armstrong)	3	
Machupo virus	4	
Marburg marburgvirus	4	
Mayaro virus	3	
Measles virus	2	Danger to unborn child
Middelburg virus	3	
Mobala virus	3	
Mokola virus	3	Classified under SAPO
Monkeypox virus	3	
Mucambo virus	3*	
Mumps virus	2	Danger to unborn child

Appendix 2.

Biological Agent	Human Pathogen Hazard Group	Notes
VIRUSES		
Murray Valley encephalitis virus	3	
Ndumu virus	3	
Negishi virus	3	
Ngari virus	3	Subspecies of Bunyamwera virus
Nipah virus	4	Classified under SAPO
Omsk haemorrhagic fever virus	4	
Oropouche virus	3	
Piry virus	3	
Powassan virus	3	
Primate T-cell lymphotropic viruses types 1 and 2	3*	Synonyms: Human T-cell lymphotropic viruses (HTLV) types 1 and 2
Rabies virus	3*	
Reston ebolavirus 4	4	Includes strain Siena
Rift Valley fever virus	3	Classified under SAPO
Rocio virus	3	
Rubella virus	2	Danger to unborn child
Sabia virus	4	
Sagiyama virus	3	Subspecies of Ross River virus
Sal Vieja virus	3	
San Perlita virus	3	
SARS-related coronavirus	3	
Seoul virus	3	
Severe fever with thrombocytopoenia syndrome virus (SFTS)	3	
Siberian tick-borne encephalitis virus	3	
Simian immunodeficiency virus	3*	
Sin Nombre virus (formerly MuertoCanyon)	3	
Snowshoe hare virus	3	Subspecies of California encephalitis virus
Spondweni virus	3	Subspecies of Zika virus
St Louis encephalitis virus	3	Classified under SAPO
Sudan ebolavirus 4	4	
Tai Forest ebolavirus 4	4	Previously known as Ebola Cote d'Ivoire virus
Tick-borne encephalitis virus	3	
Tonate virus	3*	
Variola virus (major and minor)	4	All strains including Whitepox virus
Venezuelan equine encephalitis virus	3	Classified under SAPO
Wesselsbron virus	3*	
West Nile fever virus	3	Classified under SAPO
Western equine encephalitis virus	3	Classified under SAPO
Yellow fever virus	3	
Zika virus	3	See Spondweni virus

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Management of Health and Safety at Work Regulations 1999 (MHSW), No. 3242.

National Patient Safety Agency, *Right Patient – Right Care*. NPSA 2004

National Patient Safety Agency (NPSA) Safer Practice Notice (SPN) 14; Right Patient, Right Blood 2006

Public Health Wales information regarding service provision (e.g. microbiology, virology, gynaecology cytology) to C&V via a Service Level Agreement can be sought from -
http://www.publichealthwales.wales.nhs.uk/

RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013), No. 1471.

Equality & Health Impact Assessment for

Labelling of Specimens Submitted to Medical Laboratories

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	No proposed change to Laboratory Medicine Service delivery. Document reviewed to provide clarity on sample labelling acceptance criteria and actions in the event of non-conformance with the policy.
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Clinical Diagnostics and Therapeutics, Clive Morgan, Assistant Director of Therapies
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The aim of this policy is to ensure that robust arrangements are in place to ensure that samples taken for laboratory analysis or storage can be accurately and unambiguously identified, and that all necessary information is supplied for appropriate and timely analysis, interpretation and reporting. In addition, any issues arising from the non-conformance with this policy will be reported via UHB 138 Incident, Hazard and Near Miss Reporting Policy and Procedure to establish the root-cause of the issue to avoid recurrence.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings	Cardiff and Vale University Health Board (UHB) is one of the largest NHS organisations in the UK, providing healthcare services for 475,000 people living in Cardiff and the Vale of Glamorgan. There are currently approximately 558 staff employed within the Laboratory Medicine Directorate that are involved in the collection, processing, testing, storage, reporting or management of patient specimens from both internal or external sources. On an average day we carry out 13,715 blood tests. http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/10%20-

	• research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	%20UHB%20Shaping%20Our%20Future%20Wellbeing%20Strategy%20Final.pdf There are many papers that present the importance of accurate patient identification to the prevention of medical errors and demonstrate improvement after introducing and enforcing sample labelling procedures. https://scholar.google.co.uk/scholar?hl=en&as_sdt=0,5&as_vis=1&qsp=3&q=positive+patient+identification https://scholar.google.co.uk/scholar?hl=en&as_sdt=0%2C5&as_vis=1&q=reducing+sample+labelling+errors&btnG= The Laboratory Medicine Directorate service has dedicated intranet and internet pages that explain the service, the testing repertoire and turn-around times. http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,972415,253_972416&_dad=portal&_schema=PORTAL The Laboratory Medicine Directorate undertakes engagement with service users via user surveys, responding to compliments and concerns, incident management and service user engagement days.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Service users, patients, staff.

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or	Negative, there may be an assumption that a name belongs to a specific gender traditionally but the gender recorded may be opposed to this and the conflict may be seen as an		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	error in the absence of qualifying supporting information.		
6.4 People who are married or who have a civil partner.	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.9 People who communicate using the Welsh language in terms	Policy applied to all samples but for paediatric samples,	Disseminate policy and encourage use of user hand	Mitigation captured in introduction –

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	precious samples professional discrepancy can be applied within the appropriate laboratory.	books.	http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
6.12 Consider any other groups and risk factors relevant to this	Policy applied to all samples but for paediatric samples,	Disseminate policy and encourage use of user hand	Mitigation captured in introduction –

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
strategy, policy, plan, procedure and/or service	precious samples professional discrepancy can be applied within the appropriate laboratory.	books.	http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
7.3 People in terms of their income and employment status: Consider the impact on the availability and	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	appropriate laboratory.		and under heading Mislabelled Specimens, Page 11.
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A globally responsible Wales			

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory. Patient identification may be misinterpreted in the case of a transgender patient presenting with opposite gender name and gender recorded on same episode.

Action Plan for Mitigation / Improvement and Implementation

	Action	**Lead**	**Timescale**	**Action taken by Clinical Board / Corporate Directorate**
8.2 What are the key actions identified as a result of completing the EHIA?	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Complete on issuing policy.	Mitigation captured in introduction – http://labhandbook.cardiffandvale.wales.nhs.uk/testkb/ and under heading Mislabelled Specimens, Page 11.

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	N/A			
8.4 What are the next steps? Some suggestions:- • Decide whether th strategy, policy, plan, procedure an • d/or service propos o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)	continues unchanged as there are no significant negative impacts			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
○stops. Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review				

Reference Number: *TBA unless document for review* **Version Number:** 1	**Date of Next Review:** **Previous Trust/LHB Reference Number:** *N/A*

Venepuncture for Non Clinically Qualified Research Staff Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, this policy will identify the key standards required to ensure the safe practice of venepuncture by research staff without clinical qualifications working within Cardiff and Vale University Health Board.

Policy Commitment

The purpose of this policy is to state the expected standards of care to minimise the associated risk of harm to patients and staff when undertaking venepuncture. To reduce this risk it is imperative to ensure that non clinically qualified research staff have received appropriate training and education, together with a period of supervised practice and assessment to ensure they are competent to undertake this invasive procedure autonomously.

Supporting Procedures and Written Control Documents

This Policy and the supporting procedure describe the following with regard to Venepuncture for Non Clinically Qualified Research

- Staff Roles and Responsibilities
- Limitations
- Training

Other supporting documents are:

UHB Documents

1. Consent to Examination or Treatment Policy
2. Labelling of Specimens Submitted to Medical Laboratories Policy
3. Infection Control Procedure for Hand Decontamination
4. Patient Identification Policy
5. Blood Transfusion Policy
6. Mental Capacity Act and Tool Kit
7. Infection control procedure for Needle stick injury

National guidelines

1. Aseptic Non-Touch Technique (ANTT)
2. Royal Marsden Guidelines
3. Informed Consent in Research as part of Good Clinical Practice training

Scope This policy is restricted to all unregistered practitioners working in research roles within the UHB, who are required to undertake venepuncture to support the delivery of research or drug trials. For the purposes of this policy, this includes permanent, temporary, bank and agency staff as well as holders of honorary contracts and letters of access. For the remainder of this document these staff will be referred to as 'Research Staff' This document serves to outline the conditions under which Research Staff working within research may be considered suitable to undertake venepuncture training and the limitations that apply.	
Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and found there to be a no impact

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Research Governance Group
Accountable Executive or Clinical Board Director	Executive Medical Director

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	New Document
2			

Equality & Health Impact Assessment for

Venepuncture for Non Clinically Qualified Research Staff Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Medical Directors Office Zoe Boult 46124
3.	Objectives of strategy/ policy/ plan/ procedure/ service	Extend access to non clinically qualified staff to undertake venepuncture within research studies in the UHB
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages	• Similar policies from other organisations within the UK were reviewed and advice was sought from similar research active Trusts within England via the UK wide Lead Nurse for Research Forum • Stakeholders were not engaged in the EHIA and/or policy development but were consulted in order to share views. • The draft procedure was reviewed by the Research Governance Group prior to consultation. • The UHB's usual arrangement with regard to consultation was followed (ie. 28 days on the intranet)

	• comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	UHB Staff without a professional qualification working within research delivery will be affected by the Policy.

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	There does not appear to be any impact.	n/a	n/a
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy would be made accessible to staff in alternative formats on request or via usual good		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	management practice.		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	There appears not to be any impact on staff		
6.4 People who are married or who have a civil partner.	There appears not to be any impact on staff		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	There appears not to be any impact on staff		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There appears not to be any impact on staff		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There appears not to be any impact on staff		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	There appears not to be any impact on staff		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design	There appears not to be any impact on staff	Policy and procedure documents can be made available in Welsh medium if required	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A Wales of vibrant culture and thriving Welsh language			
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There appears not to be any impact on staff.		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	There appears not to be any impact on staff.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	There are no other groups including Carers or risk factors to take into account with regard to this Policy.		

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation	Not applicable		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
and/or those experiencing health inequalities Well-being Goal - A more equal Wales			
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight	Not applicable		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	Not applicable		
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food,	Not applicable		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging;	Not applicable		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	Not applicable		

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of administrative type policies.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	None identified	N/A	N/A	N/A
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required?	As there has been potentially no impact identified, it it is unnecessary to undertake a more detailed assessment and formal consultation is not require			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps?	This EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).			

Reference Number: **Version Number:** 1.0	**Date of Next Review: 16 OCT 2021** **Previous Trust/LHB Reference Number:** *N/A*

Procedure for Non Clinically Qualified Research Delivery Staff to perform Venepuncture

Introduction and Aim

This document supports the UHB Policy for Non Clinically Qualified Research Delivery Staff to perform Venepuncture. The aim of this procedure is to ensure the safe practice of venepuncture by research delivery staff without clinical qualifications working within Cardiff and Vale University Health Board (UHB).

Objectives

The objective of this procedure is to

- State the expected standards of care to minimise the associated risk of harm to patients and staff when undertaking venepuncture.
- To reduce this risk by ensuring that non clinically qualified research delivery staff have received appropriate training and education, together with a period of supervised practice and assessment
- To ensure that all non clinically qualified research delivery staff are competent to undertake this invasive procedure autonomously.
- Identify the roles and responsibilities of UHB staff and limitations on the scope of practice

Scope

This procedure is restricted to all non clinically qualified research delivery staff within the UHB, who are required to undertake venepuncture to support the delivery of research projects and clinical trials. For the purposes of this procedure, this includes permanent, temporary, bank and agency staff as well as holders of honorary research contracts and letters of access. For the remainder of this document these staff will be referred to as 'Research Delivery Staff'

This document serves to outline the conditions under which research delivery staff working within research may be considered suitable to undertake venepuncture training and the

limitations that apply.	
Equality Health Impact Assessment	An Equality Health Impact Assessment (EHIA) has been completed to support the Policy document implementation (Policy for Non Clinically Qualified Research Delivery Staff to perform Venepuncture). The Equality Impact Assessment completed for the policy found there to be no impact.
Documents to read alongside this Procedure	**UHB Documents** 1. Consent to Examination or Treatment Policy 2. Labelling of Specimens Submitted to Medical Laboratories Policy 3. Infection Control Procedure for Hand Decontamination 4. Patient Identification Policy 5. Mental Capacity Act and Tool Kit 6. Infection control procedure for Needle stick injury **National guidelines** 1. Aseptic Non-Touch Technique (ANTT) 2. Royal Marsden Guidelines *3.* Informed Consent in Research as part of Good Clinical Practice training
Approved by	Research Governance Group recommended for Quality, Safety and Experience Committee

Accountable Executive or Clinical Board Director	Executive Medical Director
Author(s)	Senior Manager (R&D) Senior Nurse for Research Education & Training

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1.0	16/10/2018		New Policy and Procedure

Venepuncture for Non Clinically Qualified Research Delivery Staff Procedure

CONTENTS **Page No.**

1.0 Introduction

The aim of this procedure is to ensure the safe practice of venepuncture by research delivery staff without clinical qualifications working within Cardiff and Vale University Health Board (UHB).

Cardiff and Vale Research & Development Office and LED department have stipulated the following training requirements for non clinically qualified research delivery staff performing venepuncture as part of their role:

- Research Delivery staff employed by the UHB and/or employed via temporary staffing are able to access LED training for venepuncture. Clinical practice will be supervised by appropriately experienced staff in their clinical team and competence assessed by a member of staff who has been trained as a clinical skills assessor.

- Research Delivery Staff working under an Honorary Research Contract or with a letter of access from another health board, who are performing venepuncture on CVUHB patients and based with a clinical team (therefore able to undertake supervised practice based assessments), may attend LED venepuncture training at an agreed cost if they cannot access it elsewhere. Clinical practice will be supervised by appropriately experienced staff in their clinical team and competence assessed by a member of staff who has been trained as a clinical skills assessor.

- Research Delivery Staff working under an Honorary Research Contract or with a letter of access from another health board, who can provide evidence of venepuncture or phlebotomy training and competence assessment within the last 3 years, will require a one off competency

assessment prior to performing this skill in the UHB with a member of staff who has been trained as a clinical skills assessor.

All research delivery staff who are performing venepuncture will be required to complete the following:

- Aseptic no touch technique (ANTT) e learning and practice based assessment
- UHB Core Mandatory Training (online)
- Basic Life Support (BLS)

A practice based update assessment every 3 years with a member of staff who has been trained as a clinical skills assessor.
E learning can be accessed via LED, details of which will be provided on application for a research passport by the R&D Office
Please see Appendix 1 for a detailed flow chart of training and assessment criteria.

2.0 Roles and Responsibilities

2.1 The R&D Senior Management Team will ensure that

- Any concerns escalated where staff are not meeting requirements of the UHB to attend training and assessment to perform venepuncture are dealt with appropriately.
- Line managers are supported in monitoring compliance with the venepuncture policy.
- Any incidents related to venepuncture and involving this staff group that are reported using the UHB Datix system are investigated, actioned and followed up.

2.2 Line managers and Team Leads of research delivery staff will ensure that

- Staff required to perform venepuncture as part of their role have had this identified at their PADR, and have completed mandatory training and BLS prior to registering for venepuncture training with LED.
- Non clinically qualified staff who are training to perform venepuncture have received basic clinical safety or first aid training prior to attending venepuncture training with LED.
- Staff are booked to attend venepuncture training provided by Cardiff and Vale UHB LED department, and are supervised and assessed by trained clinical skills assessors to achieve competence within 3 months of attending training.
- Staff trained and assessed as competent to perform this skill are given adequate support and opportunity to maintain this competency following assessment.
- Compliance with the venepuncture policy is maintained.
- Any incidents related to venepuncture are reported using the UHB Datix system, and are investigated, actioned and followed up

2.3 The R&D Office will ensure that

- Research Teams and Principal Investigators are aware of, and are compliant with this procedure and training requirements
- Staff applying for a letter of access or honorary research contract are referred to the R&D training lead to arrange the appropriate training and assessment to perform this skill

2.4 Research Delivery Staff will ensure that

- They are aware of, and are compliant with this procedure and training requirements
- Any concerns about the clinical safety or wellbeing of the patient they are taking blood from are immediately escalated to an appropriately clinical trained and qualified member of staff

- Any concerns about performing the clinical skill or maintaining their competence is escalated to a line manager
- They do not perform any duty outside of the scope of their practice or competence

3.0 Limitations

- Requirement for an individual to gain competence in venepuncture must be made as part of an individual or team PADR by an appropriate Line Manager.
- Research Delivery Staff may only carry out a venepuncture procedure on a patient/client on the delegated instruction of a doctor/nurse practitioner or team leader/deputy where this delegated responsibility is listed and signed off on the Study Delegation Log by the Principal Investigator.
- Research Delivery Staff may only undertake venepuncture for research samples as outlined in the study protocol. If research participants require standard clinical blood samples to be taken during the same visit, this may be done by research delivery staff to avoid the need for patients to have two procedures. Responsibility for the completion and review of these standard blood samples, including the completion of request forms must be undertaken by the clinical team.
- Research Delivery Staff may not take blood samples for any clinical indication where specialist training is required. This restriction includes but is not restricted to blood sampling for transfusion cross matching, blood sampling for blood cultures.
- Research Delivery Staff must not under any circumstances access peripheral venous cannulae, peripheral or central access devices to obtain blood samples. Such devices must only be accessed by clinically trained registered practitioners.

- Research Delivery Staff may only undertake venepuncture within staffed clinically designated areas of the UHB where immediate clinically qualified help is readily available.

4.0 Training

The existence of this Procedure and its implications for research delivery staff will be covered during UHB R&D training events and during induction for all research delivery staff.

5.0 Implementation

All staff undertaking Research Delivery within the UHB together with those who have a specific responsibility within this procedure are responsible for its implementation.

6.0 Equality

The UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups. We have not undertaken an Equality and Health Impact Assessment on this procedure but undertook an EHIA as part of the Venepuncture for Non Clinically Qualified Research Delivery Staff Policy that underpins this procedure and received feedback on the policy and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment on the policy found that there was no impact to the equality groups mentioned.

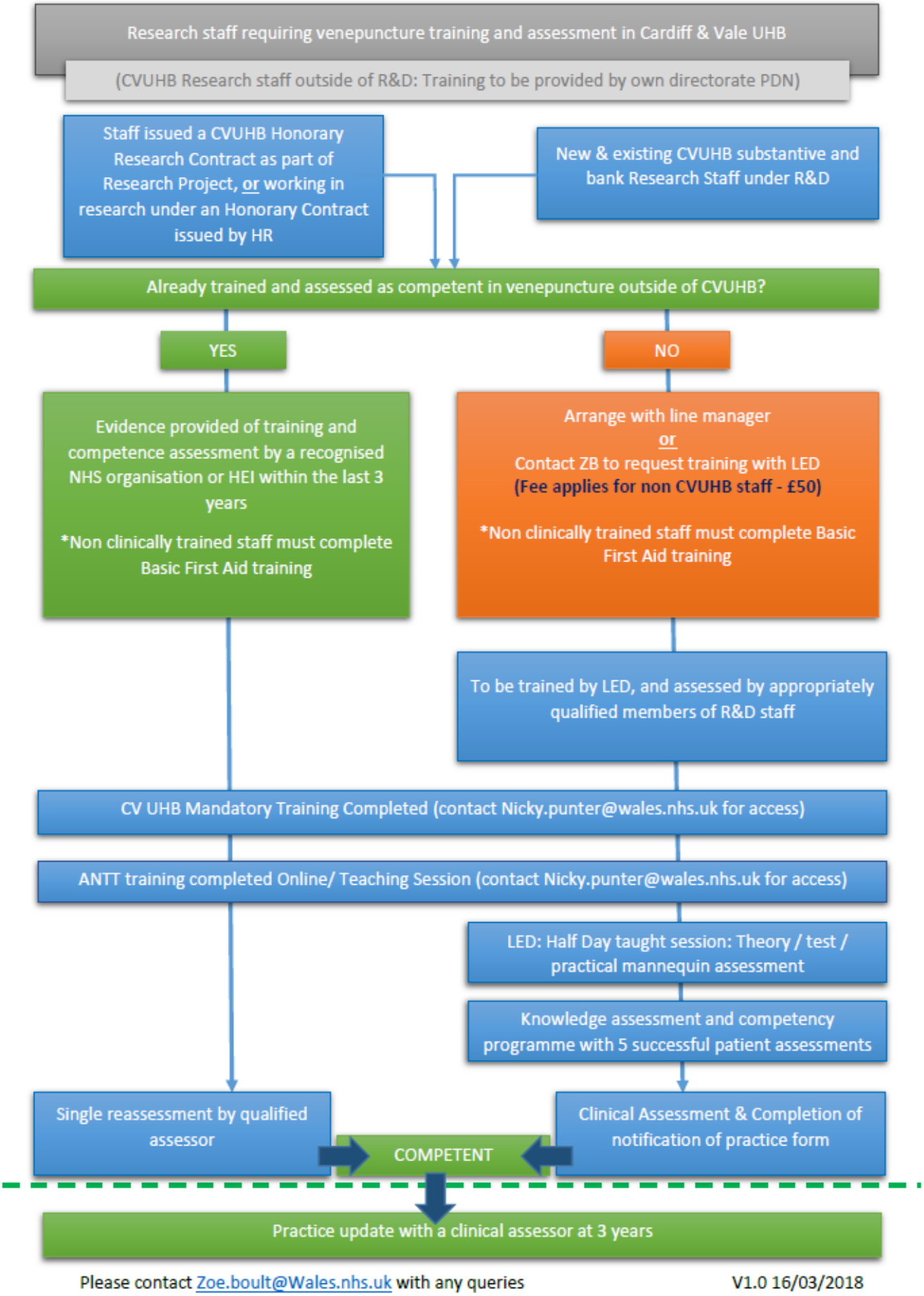
7.0 Distribution

The document will be available via the UHB Inter and Intranet and on the R&D Internet pages.

8.0 Review

The Policy underpinning this procedure will be reviewed every 3 years, or more regularly if new legislation so requires.

Appendix 1: Venepuncture Training Flow Chart



REPORT TITLE:	**Health & Care Standards Audit (December 2018)**								
MEETING:	Quality Safety and Experience Committee						**MEETING DATE:**	**16.04.19**	
STATUS:	**For Discussion**		**For Assurance**	**/**	**For Approval**		**For Information**	**/**	
LEAD EXECUTIVE:	Executive Nurse Director								
REPORT AUTHOR (TITLE):	**Senior Nurse – Standards & Professional Regulation**								

PURPOSE OF REPORT:

SITUATION:

Cardiff & Vale UHB undertake the Health & Care Standards Audit on an annual basis. This report details the main findings of the 2018 audit. The full report and actions to be taken in response to the audit findings are detailed in Appendix 1.

REPORT:

BACKGROUND:

NHS Wales published the new **Health and Care Standards** in April 2015, following the Ministerial review of the 26 standards for Health Services in Wales (Doing Well Doing Better) and the 12 Fundamentals of Care Standards. The new 22 Health and Care Standards place the person at the center and emphasise the importance of strong leadership, governance and accountability.

The 2018 Health & Care Standards Audit is comprised of operational questions and patient feedback.

The UHB continues to increase the number of clinical areas taking part in the audit, 110 teams took part in the most recent audit. Likewise, the highest number of patient/parent responses were returned. In total 1078 patients/parents responded to questionnaires. As well as competing the quantitative rating scales, patient/parents provided over 1300 additional comments about the care they have received.

ASSESSMENT:

"*The staff here are wonderful, they cared not just for medical needs but for personal needs too. All of them are so very thoughtful and go above and beyond. They do more than they are required to do and are really are a credit to this health board*."

<u>Operational Standards</u>

A comparison of this year's audit results against previous year's show that the UHB continues to make improvements across most of the overall themes. This reflects the fact that improved compliance is achieved for most operational questions every year. (Full details of all operational questions are detailed in appendix 1)

(Table 1)

Operational Audit Overall Theme Summary	2016 RAG%	2017 RAG %	2018 RAG %
Staying Healthy	73%	76.9%	78.8% ⇧
Safe Care	92%	93.1%	93.6% ⇧
Effective Care	86%	86.5%	88.2% ⇧
Dignified Care	85%	86.5%	85.9% ⇩
Timely Care	-	85.7%	94.3% ⇧
Individual Care	90%	90%	88.5% ⇩
Staff and Resources	93%	94%	95.9% ⇧

A comparison of operational standards across the past three years demonstrates that clinical areas achieve greater and more frequent improvements than reductions in scores (see appendix 2: table 1, 2 & 3). Most notably, year on year improvements have been achieved for standards that related to:

1- Nutrition and Hydration: staff knowledge of dietary requirements, frequency of beverage rounds, frequency of water jug changes and availability of snacks
2- Care planning & evaluation of care for people who lack capacity
3- Evaluating the care of people with substance misuse problems
4- Provision of smoking cessation information
5- Medication charts completed fully and correctly

Reductions in compliance, totaling more than 5% over three years, are confined to the following standards:

1. Fire restraint doors are free from obstruction or closed
2. Assessment of cultural & spiritual needs
3. Reviewing patient hygiene and continence needs within agreed timescales
4. Patient documentation captures their preferred name

Patient Feedback:

Service User Question	Overall Rag % 2016	Overall Rag % 2017	Overall Rag % 2018
On a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall experience?	**89%** (673 responses)	**91%** (901 responses)	**92%** (1078 responses)

Of the 1300 comments written by patients and parents, the majority are compliments about staff attitude and quality of care. Community Children Directorate completed the audit for the first time and attained a parent satisfaction rate of 95% across all teams.

Low scores were rendered for the following questions:

1- 77.8% in relation to: *Do you get enough sleep & rest?*
2- 79% in relation to: *Were you given help and advice on how to prevent damage to your skin?*
3- 73% in relation to: *Parents were encouraged to attend ward rounds (neonatal and paediatric areas)*

Analysis of patient feedback indicates that the lower scores are not a UHB wide concern. Most clinical areas achieve an above average responses from patients/parents. Low scores recorded in certain clinical areas have the effect of reducing the average.

RECOMMENDATION:
The Quality, Safety and Expereince Committee is asked to:

NOTE - The continued improvements made across most standards, especially in relation to; nutrition & hydration, evaluation of care for people with substance misuse problems, availability of smoking cessation information, full completion of medication charts and care planning for people lacking capacity.

NOTE - The high parent satisfaction (95%), based on over 300 responses, achieved within Children's Community Directorate. This high rating had the effect of increasing the UHB's overall patient satisfaction to its highest recorded level (92%)

NOTE - The reduced compliance of standards, detailed in appendix 2, that have occurred for three consecutive audits.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	/	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	/	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	/
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	/
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention		Long term	/	Integration		Collaboration	/	Involvement	/	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / **Not Applicable** If "yes" please provide copy of the assessment. This will be linked to the report when published.

Kind and caring / Caredig a gofalgar · Respectful / Dangos parch · Trust and integrity / Ymddiriedaeth ac uniondeb · Personal responsibility / Cyfrifoldeb personol

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Health & Care Standards Monitoring Audit

Annual Report

December 2018

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Executive Summary

"*The staff here are wonderful, they cared not just for medical needs but for personal needs too. All of them are so very thoughtful and go above and beyond. They do more than they are required to do and are really are a credit to this health board*."

Cardiff and Vale University Health Board Shaping Our Future Wellbeing Strategy 2015 – 2025, embraces our philosophy of putting patients at the centre of everything we do to deliver safe and effective care, achieve excellent patient (carer/user) experience and excellent staff experience**.**

NHS Wales published the new **Health and Care Standards** in April 2015, following the Ministerial review of the 26 standards for Health Services in Wales (Doing Well Doing Better) and the 12 Fundamentals of Care Standards. The new 22 Health and Care Standards place the person at the centre and emphasise the importance of strong leadership, governance and accountability. The Fundamentals of Care (FOC) National information system was redesigned during 2015 to align with the new Health and Care Standards and is now called the **NHS Wales Health and Care Monitoring System.**

The Health and Care Standards Monitoring Audit (HCSM audit) (formally known as the Fundamentals of Care Audit) is usually mandated by the Chief Nursing Officer (CNO) for Wales for completion by Welsh Health Boards and Trusts on an annual basis. The Health Board then submitted an audit report in January of each year to the Office of the chief Nursing Officer for Wales and the findings were included in an All Wales report. With the introduction of the Health and Care Standards in 2015, and the annual self-assessment process, the completion of the audit has ceased to be mandated but as a Health Board, the user experience and operational element of the audit are undertaken by nurses and midwives as means of demonstrating positive patient feedback and good practice as well as identifying where improvements are required. The detailed results of the audit are presented in this report

Feedback from patients confirms the high standards of care provided across the Health Board with an overall satisfaction rate of 92% (91% in 2017 & 89% in 2016). They are also complimentary towards the attitude and behaviour of staff and nearly all patients (98.4%) who participated in this year's audit felt that they had been 'always' or 'usually' treated with dignity and respect during their stay or attendance to hospital.

One of the lowest scores this year related to sleep and rest with an overall patient satisfaction rate of 77.82%. A low score was also rendered for the following:

- 79% in relation to question: *Were you given help and advice on how to prevent damage to your skin?*
- 63% in relation to question: *Were you able to speak Welsh to staff if you needed to?*
- 73% in relation to: *parents were encouraged to attend ward rounds (paediatric & neonatal areas)*

The operational audit findings have confirmed a number of key areas for improvement

Standard 2.2 Preventing Pressure Ulcer and Tissue Damage

- Compliance around care planning to look after skin

Standard 2.3 Falls Prevention

- Compliance around having an up to date care plan in respect of falls risk

Standard 2.4 Infection Prevention and Control

- Compliance around the provision of hand hygiene opportunities for patients pre meals (score has improved for two consecutive years)

Standard 2.5 Nutrition and Hydration

- Compliance around providing at least 7 beverages in 24 hours (score has improved for two consecutive years)
- Compliance around changing of water jugs 3 times a day (score has improved for two consecutive years)

Standard 2.6 Medicines Management

- Completion of a Medication Safety Audit and action plan

Standard 3.1 Safe and Clinically Effective care

- Compliance with evidencing advocacy involvement for patients who lack capacity

Standard 3.2 Communicating Effectively

- Compliance around Carers needs assessment

Standard 3.5 Record Keeping

- Compliance with provision of up to date care plan for patients
- Compliance with documenting patient's preferred language
- Food and fluid charts to be signed by a registered nurse

Standard 4.1 Dignified Care

- Documenting the cultural and spiritual needs of patients
- Completing pain assessments
- Documenting and care planning for patients with identified sleep issues
- Foot and Nail care
- Mouth care (improvement from last year)

Standard 4.2 Patient Information

- Compliance around consent to sharing information

Standard 6.1 Planning Care to Promote Independence

- Screening questions for patient with dementia, delirium or cognitive impairment
- Compliance with documenting that the family and carer have been involved in the discharge planning
- Use of Positive Behavioural Plans prescribing individual restrictive practices
- Assessment and care planning for people with a learning disability

Standard 6.2 People's rights

- Compliance with documenting that children and young people have been involved in the decision making process for there are.
- Mother's requiring breastfeeding support have documented evidence of assessment and discussion

Key Improvements

There have also been improvements made as compared to the outcome of the audit undertaken in 2017, with the headlines being the following:

Standard 1.1 Health Promotion, Protection and Improvement

- Smokers are receiving information about smoking cessation
- Patients with an identified problem relating to alcohol intake have been assessed and care plans are reviewed within agreed timescales

Standard 2.1 Managing risk and Promoting Health and Safety
- Improved compliance with completion of risk assessment for bed rails

Standard 2.2 Preventing Pressure and Tissue Damage
- Patients are assessed in respect of their skin condition

Standard 2.3 Falls Prevention
- Patients have been assessed in respect of falls risk

Standard 2.5 Nutrition and Hydration
- Snacks are available for those who miss a meal or who are hungry

Standard 2.6 Medicines Management
- Medication charts are correctly and fully completed
- Medication charts completed clearly and patient information is complete
- The patient's identity is checked prior to giving medication
- All drug cupboards/trolleys are locked and secure

Standard 3.1 Safe and Clinically Effectively Care
- Deprivation of Liberty Safeguard application has been made where patient liberty has been deprived
- Deprivation of Liberty Care plans are in place and reviewed

Standard 3.2 Communicating Effectively
- Patients have an up to date care plan in respect of communication needs

Standard 4.1 Dignified Care
- Washing and bathing facilities are suitable for all patients
- Increased provision of a quiet room for patients to spend time away from the bed side
- Patients are given the opportunity to go to the toilet before eating
- Improved compliance with care planning for mouth care

Standard 6.1 Planning Care to Promote Independence
- Improved compliance in documented evidence around screening of patients with cognitive impairment

Standard 7.1 Workforce
- Clinical staff are wearing identification badges

Continual Improvements

There have also been continual improvements made across 2016, 2017, 2018.The main areas of improvement include:

Standard 2.5 Nutrition and Hydration
- Compliance around providing at least 7 beverages in 24 hours
- Compliance around changing of water jugs 3 times a day

3.1 Safe and Clinically Effectively Care

- Compliance relating to assessment of mental capacity and review of deprivation of liberty care plans
- Compliance relating to medication management

Community Child Health Audit

Community Child Health localities and flying start teams undertook their first Health & Care Standards Audit. Engagement from parents across the service was excellent and the directorate obtained over 370 responses. Overall, parents rated their satisfaction with the service at 95%. Furthermore, a review 50 health visiting records also indicated that compliance against all standards exceeded 95%.

I would like to extend my gratitude to all the patients, carers and staff involved with the 2018 HCSM audit process and for providing assurance of where we are providing excellent standards with fundamentals of care and for identifying where we need to focus our continuous quality improvement during 2018.

Ruth Walker
Executive Nurse Director

1. Situation

The All Wales Health and Care Monitoring System (HCMS) (formerly the Fundamentals of Care System) complies with the requirements set out in Safe Care, Compassionate Care (A National Governance Framework to enable high quality care in NHS Wales 2013) and with the NHS Wales National Clinical Audit and Outcome Review Plan (2013/14). The findings from the Francis Enquiry (2013) and the Trusted to Care report (2014) emphasise the importance of organisations focusing on quality through measuring patient outcomes, as well as improving efficiencies and resource management.

2. Background

Introduction

The Health and Care Standards (HCS) were published on 1 April 2015. The HCS are the core standards for the NHS in Wales and bring together and update the expectations previously set out in "*Doing Well Doing Better Standards for Health Services in Wales",* and the *"Fundamentals of Care"* in conformity with the Health and Social Care (Community Health and Standards) Act 2003.

The 22 HCS have been designed to fit with the seven quality themes identified in the NHS Outcomes and Delivery Framework which were developed through engagement with the public, patients, clinicians and stakeholders. Each theme includes a number of standards which have been mapped against the NHS Outcomes and Delivery Framework measures, and measures relating to the fundamental aspects of care and specific areas that comply with legislation and guidance.

The standards provide the framework for how services are organised, managed and delivered on a day-to-day basis. They establish a basis for improving the quality and safety of healthcare services by providing a framework which can be used in identifying strengths and highlighting areas for quality improvement.

The HCSM audit provides the opportunity to measure for improvement against the 22 Health and Care standards. The audit:

Enables patients/carers to:

- Share their views and experiences on what we do well and where we need to improve, which will be used to help improve the services we provide
- Have a voice in the quality of the care they receive

Empowers staff to:

- Make a difference and ensure ownership of their practice
- Have a voice in the care that they provide and ensure the focus is on essential elements of care and caring.
- Identify areas of good practice and highlight issues for concern
- Develop action plans to monitor change

Enables organisations to:

- Have a mechanism to monitor/measure the quality of care
- Develop organisational policies and procedures
- Identify key themes for improvement
- Adopt a culture of openness and transparency with the quality standards

The results of the Audit provide an opportunity for staff and the Health Board to reflect on

- What are we doing well?
- What do we need to improve?
- How can we improve the experience of our patients and staff?

Undertaking the Health and Care Monitoring Audit 2018

The time scales to complete this year's audit was 1st October - 30th November 2018.
For the Health Board, the Executive Nurse Director mandated that Sister/Charge Nurse/ Midwife across all wards and department completed the operational audit and the patient surveys. The audit recommended that a sample size of 15 patients per ward/ department for the patient survey, which is the same as previous audits undertaken.
In addition to this, Community Child Health completed the audit for the first time. They collaborated on an All Wales basis to develop operational audit questions and parent surveys. Health visitor records across all teams were audited against operational standards and parent surveys were provided at Flying Start centres and during home visits.

Interpreting the Results

The results of the HCSM Audit is only one method by which we monitor the quality delivered and therefore is part of a wider picture. Information from this audit needs to be interlinked with results from other data sources (e.g. mortality reviews, infection control rates, concerns trends, findings from Executive Walk rounds/inspections and clinical audit findings) to be assured that the UHB is doing the right things well and providing care which is dignified, safe and effective to meet the needs of individuals.

2. Assessment

Calculation Method Used
Changes were introduced in 2015 to enable the aggregation of the various question types by Health Care Standards Theme and Standards providing more meaningful and representative responses to the individual questions and audit as a whole. This method still

applies for the 2018 audit. Further information on the methodology used can be provided, if required.

Below is a table which shows the criteria for the Red, Amber, and Green scoring.

RAG Key	
RED	50% or less
AMBER	51 to 84%
GREEN	85% and over

Overall Summary

The HCM audit involves asking patients about their experiences of care, and reviewing delivery of care and the assessment of the operational application of the 22 HCSs. This included:

- Examination of patient records to measure compliance against the standards
- Observation of clinical practice
- Environmental assessment

It is important to note that additional questions have been added and amendments been made to the wording of some questions within the themes on the basis of feedback from staff undertaking the 2017 audit as well as from National Specialist Nursing and Midwifery groups. Also, some questions are not included in the operational audit and patient surveys for all areas. Although no direct comparison of overall results can be drawn between this year and previous operational audits undertaken at the UHB, comparison is possible for most questions. Specifically, a total of 184 questions have remained the same since 2016.

Patient Experience Summary

Understanding the experiences of patients, and their relatives/ carers is a key priority for the Health Board, and the HCSM audit Patient survey is only one method by which we can monitor the standard of care provided and better understand the patient experience.

Between 1st October and 30th November 2018, a total of 1078 patient experience surveys were completed across 110 clinical areas. This is compared with the 901 surveys completed in 2017 across 105 areas and 673 completed in 2016 in 95 areas. 744 were completed by the patient/service user, 171 by a friend/ family/carer and 158 completed with the support of a Healthcare Professional.

As reported in the 2017 audit, the results of this year's patient survey demonstrate that the majority of patients were satisfied with the standards of care that they received from the Health Board and are complimentary regarding the professional and respectful behaviour of most of the staff. The survey also demonstrates that we do not get it right all of the time and this feedback is essential to improve practice.

The Patient Survey results (*Appendix 1*) show that the Health Board achieved a level of compliance for the Service User survey questions of > 85% in 41 out of the 47 questions. Of note, not all questions are core to all service user surveys and additional questions

have been included or questions removed on request of specific All Wales Specialist Nursing groups.

When asked to rate their overall satisfaction with the care provided service users gave the organisation a rating of 92% enabling the Health Board to achieve a RAG rating of green. This score is the highest achieved over a number of years.

Table

Service User Question	Overall Rag % 2016	Overall Rag % 2017	Overall Rag % 2018
On a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall experience?	89%	91%	92%

Children's Community Directorate participate in the audit for the first time and received 304 responses to Parent Experience Surveys.

Highlights for the Service User Experience

- The outcome of this years' patient survey does not vary greatly from the findings of last year's survey.
- Patients are telling us that they are being treated with dignity and respect.
- Patients are telling us that staff are kind, helpful and polite.
- Nearly all patients who responded feel safe.
- Patients are not having enough sleep and rest.
- There is room to improve the involvement of patients in ward rounds and with their care decisions around discharge.
- There is room to improve the availability of advice given to patients about how to prevent damage to their skin.
- The majority of service users have said that they were listened to.
- Complimentary comments about staff attitude comprise the most frequent response type.

In addition to the above, highlights from the Community Child Health survey are:

- Across 377 surveys, parent satisfactions with the service averaged 95%
- Parents rate staff kindness and ability to explain things clearly at 94%

The themes emerging from the user comments has made it possible to align them to a relevant Health and Care Standard, although this has not been done formally on an All Wales basis. The survey outcome acts as a reminder of what we are doing well most of the time and what we need to improve to make the experience of all service users better.

Summary Operational Audit

The operational audit was undertaken by 110 wards, departments and community teams across the Health Board from the following areas:

- General medical wards
- Surgical wards
- Specialist wards offering tertiary services
- Theatres
- Outpatients Departments

- Day Surgery Units
- Unscheduled Care
- Mental Health
- Maternity
- Neonatal Care
- Paediatrics
- Children's Community

The audit results demonstrate that the UHB achieved a level of compliance for the operational questions of > 85% in 6 of the 7 Health and Care Standards themes. Table 1 provides a breakdown of the operational scores and identifies that improvement has been made across the standards.

Table 1

Operational Audit Overall Theme Summary	2016 RAG%	2017 RAG %	2018 RAG %
Staying Healthy	73%	76.9%	78.8%
Safe Care	92%	93.1%	93.6%
Effective Care	86%	86.5%	88.2%
Dignified Care	85%	86.5%	85.9%
Timely Care	-	85.7%	94.3%
Individual Care	90%	90%	88.5%
Staff and Resources	93%	94%	95.9%

This year's results reflect the outcome of previous audits undertaken: the themes are similar in that improved communication and documentation is required in order to drive up standards.
Table 2 provides a breakdown of the operational scores per standard and identifies the improvement that is required for elements of each of the standards.

Table 2 Operational HCSM Audit Summary

Theme	Health and Care Standard	2016 RAG	2017 RAG%	2018 RAG%
Staying Healthy	1.1 Health Promotion, Protection and Improvement	72.9%	76.9%	78.8%
Safe Care	2.1 Managing Risk and Promoting Health and Safety	94%	94.8%	92.6%
	2.2 Preventing Pressure and Tissue Damage	89.7%	91%	89.7%
	2.3 Falls Prevention	91.4%	91.7%	91.4%
	2.4 Infection Prevention and Control (IPC) and Decontamination	90.8%	91.9%	92.9%
	2.5 Nutrition and Hydration	90.3%	91.9%	93.4%
	2.6 Medicines Management	95.3%	94.1%	95.3%

	2.7 Safeguarding Children and Safeguarding Adults at Risk	97.4%	92.6%	97.8%
	2.8 Blood Management	100%	88.6%	90%
	2.9 Medical Devices, Equipment and Diagnostic Systems	95.8%	97.7%	98%
Effective Care	3.1 Safe and Clinically Effective Care	75.5%	81.6%	88.5%
	3.2 Communicating Effectively	83.7%	84.4%	88.7%
	3.3 Quality Improvement, Research and Innovation	-	100%	84.2%
	3.4 Information Governance	-	100%	100%
	3.5 Record Keeping	89.3%	87.9%	87.9%
Dignified Care	4.1 Dignified Care	84.8%	86.5%	86.1%
	4.2 Patient Information	85%	86.3%	84.3%
Timely Care	5.1 Timely Access	-	85.7%	94.3%
Individual Care	6.1 Planning Care to Promote Independence	89.1%	89.3%	87.2%
	6.2 Peoples Rights	96.5%	92.8%	96.3%
	6.3 Listening and Learning from Feedback	92.6%	93.1%	95.9%
Staff and Resources	7.1 Workforce	92.7%	94%	95.9%

The action plan for improvement will focus particular attention on standards that are RAG rated below 85%.

Audit Detail

The next section provides a detailed report across the operational audit and patient experience survey undertaken across wards and departments.

Standard 1.1 Health Promotion, Protection and Improvement
People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities.

Table 4

	Standard 1.1 Health Promotion, Protection and Improvement	RAG % 2016	RAG % 2017	RAG % 2018
	Are all staff aware of Baby Friendly?	100%	100%	100%
	Has the patients smoking habits been assessed?	84%	87%	87%
	Where patient is a smoker, is there documented evidence that they have been provided with information in relation to smoking cessation	61%	62%	71%
	Has the patient's weight been measured?	91.26%	92%	94.2%
	Is there documented evidence that where the patients weight is unhealthy that they have been provided with information relation to a healthy diet	85%	83%	83%
	Has the patient's alcohol intake been assessed?	69%	74%	74%
	Where the patient has an identified problem with alcohol intake, is there an up to date care plan of care which is being implemented and evaluated and has been reviewed within an agreed timescale?	51%	55%	62%
	Has the patient's illicit substance use been assessed?	52%	63%	58%
	Where the patient has an identified problem with illicit substance use, is there an up to date care plan of care which is being implemented and evaluated and has been reviewed within an agreed timescale?	41%	53%	58%
	Are health promotion resources available to patients whilst waiting for assessment or treatment?	-	-	100%

	Are patient information leaflets regarding treatment and management of the injury given to patients on discharge?	-	-	100%
	Are health promotion information boards displayed in the clinical area to empower CYP and their parent/carer to take responsibility for their health and well being	-	100%	100%
	Are staff able to signpost CYP and their parent/carer to services for information, advice and support?	-	100%	98%
	Is there written evidence that the infant's feeding was discussed?	-	-	96%
	Is there written evidence that the infant feeding checklist was commenced?	-	-	80%
	Is there written evidence that the feeding data was recorded?	-	-	96%
	Is there evidence that the 10 steps approach to nutrition and infant feeding was discussed?	-	-	88%
	Is there written evidence that the blood spot screening results have been discussed?	-	-	100%
	Is there written evidence that Neonatal hearing screening results have been discussed?	-	-	100%
	Is there evidence that the appropriate proformas used for assessment have been undertaken? (e.g. SOGS/developmental proformas)	-	-	100%
	Is there evidence that immunisations have been discussed?	-	-	100%
	OVERALL RAG%	73%	76.9%	80.0%

Operational Narrative

There has been a little improvement in compliance with Standard 1.1 Health Promotion, Protection and Improvement.

The life style choices questions within this standard were new for the 2016 audit and although the audit scores indicate that improvement is required, there is evidence from the narrative provided that wards and departments are making appropriate referrals to enable support for patients to adopt a healthier lifestyle. Other notable improvements & comments include:

- Within two years, there has been a 10% improvement in awareness as to how to access smoking cessation support for patients.
- Within two years, there has been a 11% improvement in care planning and evaluation of care for patients with an identified alcohol problem.
- Clinical areas are providing patients with a range of health promotion information leaflets. These relate to healthy diets, smoking cessation, alcohol consumption & sleep.
- Paediatric wards have posters/information signposting parents to a range of health promotion advice, including smoking cessation, diet & sleep.
- Women are followed up where required by the substance misuse midwife. Referrals to healthy pregnancy clinic are made for all women with a BMI above 35.
- All staff in maternity services receive annual baby friendly training.

Specifically for Maternity Services, Baby Friendly is a UNICEF initiative that continues to be used to promote breastfeeding as the foundation for a baby's future health and wellbeing. All staff were aware of Baby friendly and receive annual updates. Breast feeding support in all pregnancies is promoted and supported and workshops pre and post-delivery are available for all pregnant women working within the UHB. Additional questions relating to the support of mothers with their choice of feeding are included in Standard 6.2 People's rights.

The implementation of standardised electronic documentation in 2019 may further improve the outcomes for this standards. Comments made by several clinical areas indicates that some assessment and admission documents omit questions relating to smoking, diet or alcohol consumption.

Service User Perspective:
There are no service user questions applicable for this standard.

Standard 2.1 Managing Risk and Promoting Health and Safety

People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.

Table 5

Standard 2.1 Managing Risk and Promoting Health and Safety	RAG % 2016	RAG % 2017	RAG % 2018
Do all patients wear an identification band which states their first and last name, date of birth and NHS number?	94.86%	94.5%	94.29%
Do women have access to general information about the birth centre/midwife led unit/obstetric unit prior to admission or on arrival?	100%	100%	100%
Is there evidence that women are receiving the Bump, Baby and beyond Book or how to access it online?	80%	80%	-
Is the patient's identity checked visually and verbally prior to undertaking a procedure?	97.27%	97.7%	98.7%
For this episode of care, is there documented evidence that the patient has an up to date manual handling risk assessment?	96.15%	97.9%	95.14%
For this episode of care, where the patient has an identified manual handling risk, is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	90.4%	92.8%	87.1%
If a patient has been assessed as requiring bed rails, is there an up to date risk assessment in place?	88.23%	93.4%	91.4%
Is the Child/Young Person in an age appropriate bed with cot sides/bed rails in situ?	94.29%	100%	100%
Within the clinical area, are all fire restraint doors free from obstruction or closed if not automatic self closing?	94.79%	91.4%	87.5%
Are the security doors and cameras operating effectively?	100%	100%	100%
Are entrances to the Birth Centre/Midwife Led Unit/Obstetric Unit visible both day and night?	100%	100%	100%
Is there evidence that the department is compliant with the WHO checklist? (*theatres audit only*)	100%	100%	100%
Are bed/trolley rails used on patients requiring a trolley for completion of a procedure?	-	-	100%
Are wheelchairs available to all patients who are unable to weight bear due to nature of minor injury?	-	-	100%
Is there written evidence that sudden Infant Death was discussed?	-	-	100%
Is there evidence that the home environmental risk assessment has been completed?	-	-	96%
OVERALL RAG %	94%	94.8%	92.6%

From the overall score for this standard remains consistently high across annual audits. As one of seven standards with a score of >85% for all questions, it is clear that the safety and welfare of our patients is taken seriously. The comments made suggest that there is an opportunity to improve compliance with updating documentation relating to manual handling.

There is a need to improve compliance with ensure fire doors are free from obstruction or closed. The score for this question has reduced for the third consecutive year. Wards report that lack of storage facilities cause difficulty in fully complying with this standard.

Good Practice

- Improved compliance with risk assessment for patient requiring bed rails.
- New ID arm bands & printers have been introduced across wards. Weekly ID band audits are taking place.
- Patient identity is checked visually and verbally for 99% of procedures undertaken. This represents the highest compliance rate achieved for this standard.
- Where ID bands are not suitable, some area have implemented photo IDs. MHSOP directorate achieves this across all wards.
- Where comments have been made they say that risk assessments are completed on admission and updated on a weekly basis in line with Health Board procedures.
- WHO checklist is completed in Theatres. 100% compliance noted for three consecutive years for GA & LA cases.
- Regular midwifery support throughout a women's pregnancy provides opportunities to discuss services available to all women using the maternity service.

Opportunities for Improvement

- Where ID bands are not in use, a formal means of identifying patients, for example, photo ID, should be in place in all areas.
- Despite continuing to score 85%>, a 7.5% reduction has been noted in compliance relating to fire doors being left open or obstructed. As well occasions when staff have left doors opened or wedged, poor compliance primarily occurs due to lack of storage facilities for equipment or because of outstanding maintenance requests to fit automatic self-closing fire doors.

Service User Perspective

Table 6

Service User Question	Date	Never	Sometimes	Usually	Always	Overall
Throughout your stay/attendance, how often did you feel that you were made to feel safe?	2016	0.16%	0.79%	9.15%	89.91%	99.03%
	2017	-	1.25%	8.06%	90.69%	98.75%
	2018	0.15%	0.73%	7.14%	91.98%	99.13%
During your stay, when you asked for assistance, did you get it when you needed?	2017	0.24%	3.42%	20.39%	75.95%	96.34%
	2018	0.45%	4.96%	19.10%	75.49	94.6%

The number of comments regarding feeling safe are minimal. Patients report that staff attitude and communication is the determinant to their sense of safety. One comment related to feeling unsafe due to maintenance related issues.

There's nowhere to hold onto whilst in the shower. The water floods everywhere and I feel very unsafe.

When I came into hospital I was so scared and the nurses and doctors explained ever thing so well they are all so lovely and kind.

The nurses are so friendly, I feel safe and comfortable here.

Although the majority of patients indicated that they usually or always responded to getting assistance when they needed it, the small number of comments made have been where patients felt there was a delay. Patients most often attribute delays to staff shortages and notice how busy staff are.

The only fault I experienced was with the delayed response on ringing the alarm button. I do understand the staff are very busy but it is frustrating when you need something urgently.

There could be more additional staff as critical duties leave other patients waiting for assistance

On all wards I have found shortages of staff prevent nurses from fulfilling their caring role. There is not time for making sure the bed is comfortable etc. Sometimes staff shortages cause delays in medication, particularly the administration of controlled drugs. Call buttons are not answered.

What are we doing to manage risk and maintain health and safety?

- Nurse Staffing Levels Act (Wales) 2016, introduced and information displayed outside wards.
- The Corporate Nursing Team have developed a procedure to ensure a consistent approach to the provision and use of and type of locks used at the entrance to wards or department.
- The Patient Property Policy has been revised in 2017 and 2019. It is available on the Health Board Intranet site.

Standard 2.2 Preventing Pressure and Tissue Damage

People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage.

Table 7

Standard 2.2 Preventing Pressure and Tissue Damage		RAG % 2016	RAG % 2017	RAG % 2018
	For this episode of care, is there documented evidence that the patient's skin condition has been assessed and discussed with the patient or advocate?	90.71%	90.43%	92.32%

	For this episode of care, where the patient has been identified as requiring assistance with looking after their skin, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	88.13%	92.46%	85.82%
	For this episode of care, is there documented evidence that the baby's skin integrity has been assessed?	100%	100%	80%
	For this episode of care, where the baby has been identified as requiring assistance with looking after their skin integrity, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last 24 hours?	100%	33%	100%
	OVERALL RAG	**89.7%**	**91%**	**89.7%**

There is a Health Board requirement that the skin integrity of all inpatients is assessed within 6 hours of admission to hospital. Overall, the assessment of patient skin condition has improved slightly since last year. Despite this, care planning and agreed timescales for evaluation, for patients with identified needs, has decreased by 6.5% since last year. Maternity services reported 100% compliance for reviewing and evaluating care plans for babies who require assistance looking after skin integrity.

Good practice

- Comments suggest that risk assessments are undertaken on admission and are updated weekly as required by the Health Board procedure.
- Intentional rounding and the use of the SKIN bundle.

Opportunities for Improvement

- To ensure that skin integrity of all patients is assessed and documented within 6 hours of admission.
- To ensure that all patients identified as being at risk of developing pressure damage have an up to date and individual care plan in place.

Service User Perspective

Table 8

Service User Question	Date	Never	Sometimes	Usually	Always	Overall
During your stay. Were you given help and advice on how to prevent damage to your skin?	2017	10.51%	6.06%	14.34%	69.09%	83.34%
	2018	12.32%	7.73%	17.87%	62.08%	79.95%

What are we doing to promote improvements in prevention of pressure and tissue damage?

- The Health Board Pressure Ulcer (HAPU) Task and finish group was convened in March 2017 to drive improvements in pressure ulcer prevention. This is led by the Director of Nursing and reports to the Nursing and Midwifery Board. To date the main focus of the group has included:

- Influencing the contents of the All Wales Guidance on 'pressure ulcer reporting and investigating' and All Wales Review Tool.
- Membership on the Total bed management contract group and roll out of bed/mattress changes across UHB
- Revision of the Pressure Ulcer Prevention Patient Information leaflet.
- Revision of the Health Board Pressure Ulcer prevention policy and procedure
- Update of UHB audit document

- The number of Health Care Acquired Pressure Ulcers (HAPU) is a key performance indicator at monthly professional nursing performance reviews as well as for the performance reviews for Clinical Boards.
- Work is progressing at a local and national level to improve the consistency of reporting the number and grade of pressure ulcers through an electronic indecent reporting system (currently e- datix at the Health Board). Once this work is complete, it will streamline the reporting requirements which is currently via e-datix for all pressure ulcers, as well as Serious Incident and Safeguarding systems for grades 3, 4 and unstageable pressure ulcers.
- All grades 3 and 4 and unstageable pressure ulcers are investigated by Clinical Boards using a national tool and share findings and lessons learnt through their local Quality, Safety and Experience Committees.
- The Annual National STOP pressure ulcers campaign was supported in November 2018.
- Annual prevalence audit to be carried out in February 2019.
- Posters that highlight pressure ulcer grading system to be piloted in MCB and evaludated.
- Tissue Viability Nurse Specialist provide training sessions for the prevention of pressure ulcers at ward level as well as classroom based.
- Prevention of Pressure ulcers has been included as a key priority in the Nursing and Midwifery Framework launched in October 2017.

Standard 2.3 Falls Prevention

People are assessed for risks of falling and every effort is made to prevent falls and reduce avoidable harm and disability.

Table 9

Standard 2.3 Falls Prevention		RAG % 2016	RAG % 2017	RAG % 2018
	For this episode of care, is there documented evidence the patient's mobility has been assessed and discussed with the patient or advocate?	96.9%	95%	93.49%
	For this episode of care, where the patient has been identified as requiring support and/or assistance with mobility, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last within the agreed timescale?	89.41%	90%	90.56%
	For this episode of care, is there documented evidence the patient's risk of falls has been assessed and discussed?	93.14%	94%	96.49%
	For this episode of care, where the patient has been identified as being at risk of falls, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	84.92%	87%	83.99%
	OVERALL RAG	**91.4%**	**91.7%**	**91.5%**

For Standard 2.3, Falls Prevention, there has been very little variation in compliance for the past three years. .
Most areas are reporting that patients identified at risk of falls have an up to date plan of care and this is due in part to the implementation of a multifactorial assessment tool and integral care plan.

What are we doing to promote improvements in the prevention of falls?

- The Health Board will be participating in future rounds of the national falls & frailty audit planned for 2019. This will further enable us to understand where improvements are required.
- Clinical Boards have begun introducing falls simulation training
- The number of inpatient falls are reported through Clinical Board performance review. In accordance with the Nurse Staffing levels Act (Wales) 2016, falls is one of the key performance indicators to be used in the triangulated process to determine nurse staffing levels.
- In 2019, the UHB's Falls Delivery Group will continue its' collaboration with Canterbury District Health Board.
- Falls prevention has been included as a key priority in the Nursing and Midwifery Framework launched in October 2017.

Service User Perspective
There are no specific service user questions for this standard, and comments have not been made.

Standard 2.4 Infection Prevention and Control (IPC) and Decontamination

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.

Table 10

Standard 2.4 Infection Prevention and Control (IPC) and Decontamination		RAG % 2016	RAG % 2017	RAG % 2018
	Are staff able to give examples of the correct procedure for infection control?	98.97%	99.07%	99.06%
	Are staff able to give examples of the correct procedure for isolating patients?	98.87%	98.81%	99.8%
	Are baby baths cleaned after each use and stored dry?	85.71%	100%	100%
	Are all patients given the opportunity to wash or cleanse their hands with hand wipes prior to eating food?	74.07%	74.39%	76.54%
	Can staff demonstrate the safe and hygienic handling and storage of breast milk?	100%	100%	100%
	Is there evidence that equipment that is "not in use" is stored according to infection control policy and there is documented evidence to show that it has been cleaned?	100%	100%	100%
	Is hand gel available within the clinical area?	100%	100%	100%
	Is PPI equipment (gloves, apron, masks etc. available in the clinical area)	100%	100%	100%
	Are staff compliant with immunisation training?	-	-	100%

	OVERALL RAG	**90.8%**	**91.9%**	**93.10%**

Overall, the audit data suggests good practice is being observed. However, the score of the provision of hand hygiene opportunities for patients prior to meal times remains low year on year.

Despite the comments made stating that patients are offered a variety of options, for example, use of wet wipes, walk to the sink, provision of alcohol gel, the scores indicate that improvement is required to ensure that all patients are given the opportunity to cleanse their hands prior to meals. The reasons provided for poor compliance are that patients are self-caring and can walk to the sink, and that the practice is not enforced. In response to last year's audit, some areas introduced hand wipes. However, some wards indicate that this has attracted negative feedback from patients.

Good Practice

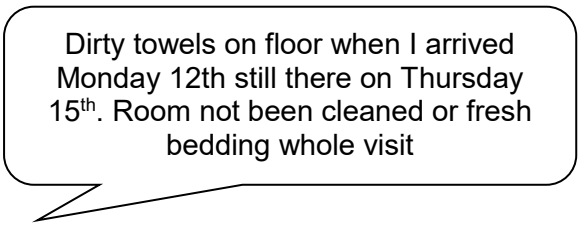
- Wet wipes are provided for patients for hand hygiene pre meals
- Staff are able to give examples of correct procedures for infection control.
- "I am clean" tape is used to indicate that equipment is being stored clean and ready for use

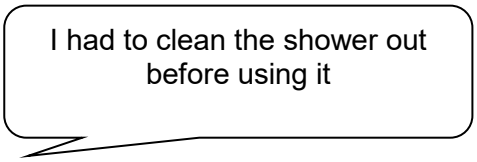
Service User Perspective

Table 11

Service User Question	Date	Never	Sometimes	Usually	Always	OVERALL
Throughout your stay/attendance, how often did you feel that the clinical area was kept clean, tidy and not cluttered?	2016		1.06%	17.60%	81.34%	98.1%
	2017	0.11%	2.05%	17.56%	80.27%	97.83%
	2018		2.32%	12.77%	84.91%	97.68%

There are a variety of comments made regarding the cleanliness and tidiness of the environment of care and they suggest that we are not getting it right all of the time in all areas of our hospital facilities:





What are we doing to improve the standard of Infection Prevention and Control?

- The Infection Prevention and Control (IPCD) team conduct validation audits, and focus on areas where outbreaks or periods of increased incidence of infection occur. Feedback is provided to clinical staff when IP&C Hand Hygiene Audits are conducted, and education sessions are offered in areas where compliance is suboptimal.
- The IPCD submits the results to the Clinical Board Quality, Safety and Experience Committees, which include a breakdown of compliance per staff group.
- Environmental issues and outstanding maintenance requests are reported through the Ward Inspections undertaken by the Corporate Nursing team.

- The provision of hand hygiene pre meals is one of the principles of protected meal times, and is monitored during internal inspections.
- Infection Prevention and Control has been included as a key priority in the Nursing and Midwifery Framework launched in October 2017.

Standard 2.5 Nutrition and Hydration

People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury.

Table 13

Standard 2.5 Nutrition and Hydration		RAG % 2016	RAG % 2017	RAG % 2018
	Prior to eating, are patients that require help, assisted into a suitable position?	100%	100%	100%
	Prior to meal service, are bed tables and communal areas cleared and tidied prior to eating?	90.67%	94.52%	92.11%
	Are patients meals placed within easy reach?	97.4%	100%	98.7%
	Is there evidence that the systems in place to enable staff to identify patients with special eating and drinking requirements are being implemented and their effectiveness evaluated?	91.43%	94.03%	98.55%
	Are water jugs changed 3 times daily?	67.27%	67.8%	78.69%
	Is fresh drinking water available for patients?	98.67%	94.05%	98.80%
	Are drinking water jugs and glasses within the patient's reach?	98.46%	98.41%	98.33%
	During a 24 hour period, are a minimum of 7 beverage rounds are carried out within your clinical area?	59.68%	70.31%	78.46%
	Does a Registered Nurse co-ordinate every meal time?	80.88%	86.57%	86.76%
	Is there evidence that all members of the nursing team are engaged in the mealtime service?	95.45%	92.31%	92.42%
	Is a range of snacks available for patients who have missed a meal or who are hungry between meals?	96.25%	98.75%	100%
	Is there a system in place to allow family/friends to assist with meal times?	95.71%	98.55%	98.59%
	Have all women had their Body Mass Index recorded at booking?	100%	100%	100%
	Is there evidence in the nursing documentation that the babies nutritional needs have been assessed within 24 hours of their admission?	100%	100%	100%
	Is there a system in place to allow parents to feed their babies at feeding times?	100%	100%	100%
	Is there documented evidence of IV fluid administration as prescribed for the surgical procedure?	-	87%	100%
	Do patients have access to healthy snacks or drinks?	-	-	100%
	Is there access to hot meals for patients that are awaiting for inter hospital transport or referral to other specialty?	-	-	100%
	OVERALL RAG	**90.3%**	**91.9%**	**94%**

Adequate nutrition and hydration promotes:

- A reduced length of stay

- Wound healing
- Reduction in complications associated with poor nutrition such as pressure sores or chest infection.

This standard highlights the gradual improvements that are being made each year. Most notably, clinical areas are carrying out beverage rounds more frequently and are improving the frequency at which water changes are undertaken. Although a 10% improvement has been noted in the past two years, further improvements are required to ensure a good experience for patients across the health board.
In 2017, improvements were noted in ensuring a Registered Nurse coordinates meal times. This improvements has been maintained, but has plateaued in 2018.

The areas for improvement reflect the findings of last year's audit, with improvement in compliance required in particular for the provision of hot drinks in evenings, provision of fresh water, and ensuring that a Registered Nurse coordinates every meal time. Despite this, the comments made support that there are examples of good practice across the Health Board

Good Practice

- A variety of systems have been put in place by nursing staff to identify patients with special requirements for eating and drinking , for example, red tray, information boards. Incremental improvements continue to be noted in the recognition of patient eating and drinking requirements.
- Nutrition and hydration bed plan is prepared by the nursing and therapy staff for the Ward Caterer to indicate dietary needs of patients.
- Protected meal times are implemented.
- Patients are assisted to use dining rooms/ day rooms for their meals. Where a day room is not available, patient tables and chairs are moved to create a "dining room" within the ward area.
- Nurse top up water jugs where required.
- Nurses provide hot beverages and snack rounds for patients.

In accordance with the comments made, there are also opportunities to improve the patient experience, thus ensuring that they receive adequate nutrition and hydration whilst they are in our care:

Opportunities for Improvement

- To ensure that water jugs are changed a minimum of 3 times daily
- To clarify the roles of nursing and housekeeping staff to ensure that a minimum of 7 beverage rounds are undertaken in clinical areas (compliance against this standard improves every year)
- To ensure that meals and beverage rounds are supervised by a Registered Nurse
- To ensure that the principles of protected meal times are enforced in all in patient areas.
- Meal time process is monitored by the Dietetic teams as well as during internal inspections undertaken by the corporate nursing team.

Service User Perspective

The survey scores indicate that the majority of patients are happy with the provision of food and drink and that they are provided with support when required. Overall satisfaction has remained above 90% for all questions. The percentage of patients indicating that they 'Always' receive the necessary help/support is at its highest level.

Table 14

Service User Question	Year	Never	Sometimes	Usually	Always	OVERALL
Throughout your stay, how often did you feel that you were given help with feeding and drinking if you needed this?	2016	2.08%	4.69%	17.51%	77.08%	96.06%
	2017	1.49%	2.73%	13.15%	82.63%	95.78%
	2018	2.17%	2.17%	10.56%	85.09%	95.65%
Throughout your stay/attendance, how often did you feel that you were provided with fresh drinking water and plenty of drinks when you need them?	2016	1.31%	1.14%	9.14%	88.42%	97.49%
	2017	0.87%	1.37%	10.43%	87.33%	97.76%
	2018	0.94%	1.56%	9.67%	87.83%	97.50%
Throughout your stay, how often did you feel that you were provided with nutritious food and snacks?	2016	0.72%	4.69%	17.51%	77.08%	94.43%
	2017	1.18%	5.74%	16.94%	76.14%	93.08%
	2018	1.75%	6.11%	18.32%	73.82%	92.15%
Throughout your stay, did you have access to an area where you could make hot drinks and prepare simple meals? (paeds/neonates question)	2016	19.35%	-	6.45%	74.19%	80.65%
	2017	16.67%	-	5.56%	77.78%	83.33%
	2018	-	-	-	100%	100%
Throughout your stay, how often did you feel that you were given support with feeding your baby when you needed it? (paeds/neonates question)	2016	*Information not available*				-
	2017	-	-	-	100.00%	100%
	2018	5%	-	15%	80%	95%

Patients provide a variety of comments about the quality, choice and provision of food provided by the Health Board:

- Food is lovely and every cup of tea is lovely and hot
- Lack of vegetarian food
- The food is often cold and tasteless
- I think the hot food should arrive hot. Sometimes it's not even warm.
- I have to ask for fruit so often, I now just get some bought in from home
- The food is often dry, without any gravy or condiments.
- I was advised to eat nutritious food, but as a vegetarian most food was unavailable to me.

It is a challenge to provide a menu to suit all tastes and preferences and comments that the food was excellent or poor illustrates this challenge. General comments regarding food and drink include the following:

What are we doing to improve and maintain the standard for nutrition and hydration?

Practical measures are being taken to ensure that patients are supported to eat and drink adequately whilst they are receiving care in the Health Board:

- Action for improvement and monitoring improvement is led by the Executive Lead for Nutrition and Hydration.
- LEAF (Leave Everything and Feed) implemented introduced to some clinical areas.
- Regular mealtime audits are undertaken by the dietetic team and reported to the Nutrition and Catering Steering Group.
- John's campaign introduced across various wards and relatives/carers encouraged to provide assistance at meal times.
- 'Carers Café' introduced in mental health service for older people to encourage patients and carers to socialise during drink/meal times.
- Patients in Mental Health Rehabilitation at Hafan Y Coed are involved in cooking and have created a successful stall within the hospital to sell their meals.
- Compliance with the All Wales Nutritional Assessment Indicator is checked across the Health Board on a monthly basis and audit outcome is discussed as part of the agenda for the Clinical Board Directors of Nursing professional review with the Executive Nurse Director.
- A new process has been developed to clarify the responsibility of nurses and therapy staff to ensure that the Nutrition Bed Plan is completed. This is to ensure that catering staff have up to date information on the dietary and support requirements of patients. This information forms part of ward safety briefings.
- Coloured crockery has been introduced to all areas across the Health Board to improve the mealtime experience for all patients. Areas where the crockery is already available has received positive feedback for patients and staff. Patient feedback has included that the design of the new crockery helps them maintain the ability to feed themselves.
- Nutrition and hydration has been included as a key priority in the Nursing and Midwifery Framework launched in October 2017.

Standard 2.6 Medicines Management

People receive medication for the correct reason, the right medication at the right dose and at the right time.

Table 15

Standard 2.6 Medicines Management		RAG % 2016	RAG % 2017	RAG % 2018
	Are all medication charts completed with the following information: patient demographics, weight and allergies, and it is clear whether there is more than one medication chart?	83.13%	85.25%	91.31%
	Is the patient's identity checked visually and verbally prior to giving medication?	97.33%	95.35%	98.02%
	Are all medications checked by two qualified nurses?	100%	85.71%	100%

	Has the nurse witnessed the patient taking the medication given to them?	97.59%	98.8%	98.85%
	Is there evidence that medication is taken in a timely manner and is not left on lockers/around patient beds?	95.95%	98.65%	92.50%
	Are all drug cupboards/trolleys locked and secure as per local policy?	94.68%	93.27%	97.12%
	Has a Medication Safety Audit been conducted and action plan fedback? (paediatric areas only)	-	83.33%	57.14%
	OVERALL RAG	**95.3%**	**94.1%**	**95.10%**

For this standard, it is clear from the comments made that staff are continuing to improve practise.

Good Practise

- Monthly medications audits are undertaken by pharmacy teams and results are fed back to Sister/Charge Nurse
- In most areas, medications are not left at the bed side.
- Patients are supported to be independent with their medications as part of the rehabilitation process.

Opportunities for improvement

- To ensure that the medication chart for all patients is completed with the required detail.
- To ensure that the locks on all cupboards are maintained and repaired.
- To ensure that the signature of both checking nurses in paediatric wards is recorded on the medicines chart.
- To ensure that paediatrics areas reliably undertake medication safety audits and action plans.
- To ensure that patients are supervised taking their medication and that medication is not left at the bed side in any ward.

Service User Perspective

For this standard, there were no specific service user survey questions. Only four patients made any comments relating to medication. These comments related to administration delays due to staff shortages, increased confusion caused by medication and a lack of explanation about what was being prescribed.

What are we doing to improve the Standard Medicine Management?

- Actions for improvement will be led by the Medical Director through the Health Board Medicines Management group
- The Health Board Medicines Code has been launched bring together all medicines related policy and procedure in one document.
- Monthly medication standards audit undertaken by pharmacy teams.
- Medicines errors are discussed at performance review between Clinical Boards and the Executive Management team
- Medicines Management checks undertaken during every ward inspection undertaken by the Corporate Nursing team and findings are communicated to the Pharmacy Nurse Advisor.
- An annual Safe Storage of Medicines Audit, with appropriate action plans if any issues are identified. Improvements in compliance with safe storage has been seen in the internal inspections undertaken.
- Medicines errors are included on the Quality , Safety and Experience Dashboard

- Medicines Management has been included as a key priority in the Nursing and Midwifery Framework launched in October 2017.

Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

Table 16

Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk		RAG % 2016	RAG% 2017	RAG% 2018
	Can staff demonstrate they know the procedure if a safeguarding concern is identified?	97.32%	94.95%	98.32%
	Are babies securely and appropriately labelled?	100%	100%	100%
	Are all staff aware of what to do in the event of a baby abduction?	100%	100%	100%
	Within the clinical area, babies are safe and secure while on the unit and parents are informed of security arrangements on admission?	100%	100%	100%
	Are all staff within the unit compliant with safeguarding training for children? (paeds only)	-	83.33%	83.33%
	Are all staff within the unit compliant with POVA training for adults?(paeds only)	-	50%	100%
	Can staff demonstrate that know the safeguarding lead nurse for their area and how to contact them? (paeds only)	-	97%	100%
	Is there written evidence that the safeguarding supervision has been documented in the family card, where applicable (paeds only)	-	-	96%
	OVERALL RAG	97.4%	92.6%	97.70%

Operational Perspective

Nearly all questions within this standard have rendered a high sore and where narrative has been provided, it indicates that the safety and security of service users is taken seriously. Overall the comments made indicate that staff have attended safeguarding training, and know what to do in the event of a safeguarding issue. In comparison to last year, there appears to be even greater awareness across the workforce as to how to contact the safeguarding teams.

Data regarding compliance with training requirements is available through ESR.

Good Practice

- Security tags are attached to the ID bands of babies: care plan available in maternity that needs to be signed daily to indicate that this check has been completed.
- Safeguarding team produce a quarterly newsletter which promotes awareness and provides updates to the workforce.
- Security Audits are undertaken in Maternity wards on monthly basis.
- Safeguarding has been included as a key priority in the Nursing and Midwifery Framework launched in October 2017

Service User Perspective

There are no specific questions for service users regarding safeguarding and comments made regarding safety have already been included for Standard 2.1.

Standard 2.8 Blood Management

People have timely access to a safe and sufficient supply of blood, blood products and blood components when needed.

Table 17

Standard 2.8 Blood Management		RAG % 2016	RAG % 2017	RAG % 2018
	All staff involved in direct nursing care should have been trained in Blood Transfusion Administration. (NICU only)	100%	100%	90%
	Can staff demonstrate they know the safe administration of blood, blood products and blood components?	-	87%	90%
	How many staff are compliant with training on the administration of blood, blood products and blood components?	-	-	86.11%
	OVERALL RAG	**100%**	**88.60%**	**89.00%**

The first question for this standard applied only to the Neonatal suite of questions. Results relating to the provision of further training will be reviewed by the blood transfusion link nurse.

Standard 2.9 Medical devices, Equipment and Diagnostic Systems

Health services ensure the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems.

Table 18

Standard 2.9 Medical devices, Equipment and Diagnostic Systems		RAG % 2016	RAG% 2017	RAG% 2018
	Are any Manual Handling aids and slings regularly checked for wear and tear?	97.07%	97.42%	98.37%
	Are any Developmental Care aids regularly checked for wear and tear?	100%	100%	100%
	Is all equipment used up to date with maintenance and calibration?	94.57%	97.95%	97.60%
	OVERALL RAG	**95.8%**	**97.7%**	**98.10%**

The high rating for Standard 2.9 Medical Devices, Equipment and Diagnostics Services shows continued improvement every year. The consistent green RAG rating is demonstrates that ward staff are proactive in ensuring that equipment is checked and maintained regularly.

Good Practice

- Equipment audits are undertaken by the Manual Handling Department, and comments state that inspections are undertaken 6 monthly by link nurses.
- Single patient use, disposable manual handling slings are used.

- One comments states that the HCSM audit acts as a reminder that equipment checks are required.

Opportunities/Plans improvements are required

- All wards and departments are required to establish a systematic checking process to ensure that all equipment is within date of maintenance checks and servicing.

Service User Perspective

There were no service user survey questions relating to this standard.

Standard 3.1 Safe and Clinically Effective Care

Table 19

Standard 3.1 Safe and Clinically Effective Care		RAG% 2016	RAG% 2017	RAG% 2018
	Where there is doubt about the patient's capacity to make a decision, an assessment of capacity has been undertaken and there is documented evidence of this	87%	90%	94%
	Where it has been identified that the patient lacks capacity to make decisions, there is evidence that best interest decisions have been documented and that the patient and their families have been involved (UHW emergency assessment unit only)	-	30%	0%
	Where it has been identified that a patient lacks capacity, is there evidence that there is an up to date plan of care	67%	76%	82%
	Is there documented evidence that where a patients liberty has been restricted, that a DOLS application has been made	84%	86%	95%
	Where it has been identified that a patients liberty is restricted, is there evidence that there is an up to date plan of care?	62%	77%	87%
	Are staff able to demonstrate they are aware of the Paediatric Best Practice guidelines and how to access them	-	63%	74%
	Is there evidence that Child & Family records are written in SOAP? (child community only)	-	-	96%
	Is there evidence that the FRAIT assessment has been undertaken at all core contacts, and inward transfers? (child community only)	-	-	100%
	Is there evidence of the child's appearance and home conditions related to the Framework for Assessment? (child community only)	-	-	100%
	OVERALL RAG %	75.40%	81.6%	90.70%

With the exception of question two, which relates to emergency care areas, improvements have been made across this standard. For the last three years, improvements in the assessment of mental capacity, completion of DOLS applications and care planning has been achieved, to the extent that compliance has increased by over 15%.

The second question applies to the emergency care areas only. The low score recorded relates the fact that a review of 5 patient records indicated that they all had capacity.

For patients with DOLs in place, the care is planned to meet the overall needs of the patient and the review and decision making regarding the DOLs is clearly documented within the DOLs documentation and an additional plan of care is therefore not routinely used in the Health Board. Good examples regarding record keeping ensuring that DOLs are reviewed and updated within the prescribed time scales have been observed during ward inspections undertaken across the Health Board. Many areas are incorporating DOLS processes as part of preceptorship programmes for newly registered nurses.

The last question in this section was added to this year's audit on request of the All Wales Health Visiting forum specifically for Community Children's Directorate.

Service User Perspective

There were no service user survey questions relating to this standard.

Standard 3.2 Communicating Effectively

In communicating with people health services proactively meet individual language and communication needs.

Table 20

Standard 3.2 Communicating Effectively	RAG % 2016	RAG % 2017	RAG% 2018
For this episode of care, is there documented evidence that the patient's ability to achieve effective communication has been assessed and discussed with the patient or advocate?	92.05%	90.84%	89.30%
For this episode of care, where the patient requires assistance to achieve effective communication, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	81.15%	89.91%	90.79%
For this episode of care, is there documented evidence that the parent's ability to achieve effective communication has been assessed?	100%	0%	100%
Is a nurse present to support the patient during formal senior contact between healthcare professionals (for Paeds) doctors/consultants/GPs and patients?	93.18%	93.81%	96.81%
For this episode of care, is there documented evidence that an assessment of the carer's needs has been considered?	63.56%	64.54%	72.57%
For this episode of care, is there documented evidence that an assessment of the parent's needs i.e. emotional, social, financial and psychological have been considered? (NICU only)	100%	0%	100%
Do patients whose first language is not English have access to a translation services?	-	-	100%
Do Deaf patients have access to working hearing loop equipment?	-	-	100%
Is there pathways to fast track patients with dementia/Alzheimer's/learning difficulties? (emergency care only)	-	-	100%
OVERALL RAG	**83.7%**	**84.8%**	**88.70%**

Operational Perspective

Despite continuous improvement, this standard has generated one of the lowest scores for the audit. Consideration towards assessing the needs of carers is the standard that requires most improvement.

The comments provided indicate that good practice is undertaken and that documentation needs to be improved to facilitate good team to team communication as well as to evidence that good practise is undertaken.

Good Practice

- Although a formal carer's assessment is not completed, carers are involved in Multidisciplinary team meetings.
- Where required, nurses are available to provide support to patients during consultations. Antenatal women and chaperoned by midwives and midwives are always present on ward rounds within their area.
- John's Campaign introduced within some clinical areas.
- Carer's procedure published in January 2019.
- Weekly psychosocial meetings held in Paediatrics.

Table 21 Service User Perspective

Service User Question	Year	Never	Sometimes	Usually	Always	OVERALL
During your stay were you able to speak to staff about your worries and concerns	2016	-	-	20%	80%	100%
	2017	-	-	14%	86%	100%
	2018	-	-	-	100%	100%
During your stay, were you able to speak Welsh to staff if you needed to?	2017	27.62%	8.57%	8.57%	55.24%	63.81%
	2018	22.76%	13.79%	8.97%	54.48%	63.45%

Patients report that they are *always* able to speak about their worries and concerns. This is highest rating the UHB has attained for this patient question and it has been with the greatest number of completed user surveys.

Only one patient commented about the use of Welsh language:

> *"I would like to have more Welsh speaking health visitors at surgery"*

Further comments regarding communication have been included in standard 4.2: patient Information, and 6.1, Planning Care to Promote independence

What are we doing to improve Effective communication?

- Standardising the patient information at the ward entrance by introducing "Hot Boards". Implementation is planned for February 2018.
- Patient feedback is received through a number of sources and reported via Quality, Safety and Experience Committee.
- The Health Board Welsh Language Steering Group have been proactive in encouraging and facilitating staff to use simple phrases in Welsh, with examples provided on what can be used available on the newly revised Welsh Language Intranet pages.
- The Welsh Language Steering Group has recently responded to the Welsh Language Commissioner's Office to detail how the UHB is working towards meeting required standards.

Standard 3.3 Quality Improvement, Research and Innovation

Services engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and effectiveness of services.

Table 22

	Standard 3.3 Quality Improvement, Research and Innovation	RAG % 2016	RAG % 2017	RAG 2018
	Staff are supported to engage in regular audits	-	100%	81.90%
	Staff have knowledge of national and local initiatives	-	-	100%
	Is there evidence that staff have knowledge of quality assurance	-	-	100%
	OVERALL RAG	**100%**	**100%**	**93%**

This question applies only to the Neonatal suite of questions and has rendered a 100% score year on year. The Bliss baby audit is completed on a bi- annual basis.

Standard 3.4 Information governance and Communication Technology

Health services ensure all information is accurate, valid, reliable, timely, relevant, comprehensible and complete in delivering, managing, planning and monitoring high quality, safe services.

Health services have systems in place, including information and communication technology, to ensure effective collection, sharing and reporting high quality data and information with a sound information governance framework.

Table 23

	Standard 3.4 Information governance and Communication Technology	RAG % 2017	RAG % 2018
	Can staff demonstrate they know how to ensure that confidential patient information is stored safely and securely	100%	100%
	Can staff demonstrate they know how to report and accident or near miss via the DATIX reporting system and where applicable conduct an investigation	100%	100%
	Staff compliance with IG	-	89.17%
	OVERALL RAG	100%	96.80%

The 2 questions above applied only to Paediatric Areas. Comments were not provided to support the figures which demonstrate that staff know how to store patient information safely, and know how to report an accident or a near miss.

There are no service user questions for this section.

Standard 3.5 Record Keeping

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.

Table 24

	Standard 3.5 Record Keeping	RAG % 2016	RAG% 2017	RAG% 2018
	For this episode of care, are the patient's demographic details clearly recorded (and where required, has a photograph) on the entire patient's documentation?	98.75%	96.54%	98%
	For this episode of care, is there documented evidence that each plan of care has been assessed and discussed with the patient or advocate?	83.16%	78.97%	83.60%
	Is there a clear plan of care following all episodes of care throughout the pregnancy and postnatal period?	100%	100%	100%
	For this episode of care, are the contact details of the first point of contact recorded in the patient's documentation?	97.39%	97.59%	98.84%
	Is the patient's preferred language clearly indicated in the nursing documents?	84.84%	81.17%	83.90%
	Does the patient's documentation capture their preferred name and/or title?	86.74%	84.66%	81.37%
	For this episode of care, where the patient has an identified swallowing problem, is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	81.25%	93%	80.00%
	Have the baby's dependency needs been individually assessed within the last 24 hours?	100%	100%	100%
	Dependency needs been staffed according to their levels of care?	100%	100%	100%
	For patients who require a food chart, is there evidence that they are being kept up to date.	94.76%	96.45%	94.43%
	For patients who require a food chart, is it signed by a registered nurse for each 24 hour period?	85.8%	84.41%	81.77%
	For patients who require a fluid chart, is there evidence that they are kept up to date?	92.49%	80.80%	89.53%
	Fluid charts are signed by a registered nurse	67.59%	49%	72.59%
	Is there documented evidence that, where indicated, the presence of a chaperone has been considered	-	77%	70%
	OVERALL RAG	**89.3%**	**87.9%**	**88%**

Keeping clear and accurate records is a requirement for Healthcare Professionals under their relevant Codes and guidance:

"ensure that all documentation (including clinical records) formally

recording your work is clear, accurate and legible"
(General Medical Council Good Medical Practice 2012)

"keep clear and accurate records relevant to your practice "
(NMC Code: 2015)

"you must keep accurate records"
(Health and Care Professions Council Standards of Conduct, Performance and ethics 2008)

Standard 5 covers a diversity of record keeping issues ranging from documenting the first point of contact, patient's preferred language to checking if a registered nurse has signed fluid and food charts of a daily basis. There is also an overlap with elements of Standard 4.1 Dignified Care

The overall RAG rating for Record Keeping is green but the amber ratings achieved for individual questions indicate that improvement is required, in particular around patient assessment and documentation. This is recurring theme from previous audits undertaken, and this is despite comments indicating that regular documentation audits are undertaken.

Good Practice

- Individual care plans are available but it is not documented if patient or advocate is aware.
- Planned care and treatment plan reviews in place in mental health wards.
- Chart checkers are nominated daily and talks to the nurse responsible for the documentation deficit where required.

Opportunities for Improvement

- The patients preferred name needs to be documented.
- It is essential that the patient's preferred language is documented: narrative suggests that this is done only if the service user does not speak English.
- Work has been undertaken, through CSIG to ensure that the Registered Nurse/ Midwife countersigns fluid and food charts. Improvement has been observed, but needs to continue throughout 2019.

Service User Perspective

There were no service user questions relating to record keeping.

What are we doing to improve the standard of record keeping?

The need to improve the standard of record keeping is a familiar theme from previous HCSM audits undertaken and good record keeping is a thread that seems to pull through many of the 22 Health and Care standards. Practical measures that are being taken by the Health Board are:

- The Health Board are supporting the development of the All Wales Digitalisation of Nurse documentation project, to be rolled out in 2019.
- A nurse informatics lead has been appointed to introduce e-documentation across the UHB. Wards have been identified to pilot the use of All Wales electronic documentation/
- CSIG are continuing with their work to establish what documents are core to all patients with the aim to standardise these if there are variations across the Health Board
- The Corporate Nursing team will continue to audit the standard of documentation as part of the internal inspection programme

- Corporate nursing team are developing a “learning package” to provide clarity on what is a good standard of documentation.
- Record keeping is has been included as a key priority in the Nursing and Midwifery Framework launched in October 2017.

Standard 4.1 Dignified Care

People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.

Table 25

Standard 4.1 Dignified Care		RAG% 2016	RAG% 2017	RAG% 2018
	If a patient's language of need is Welsh, do staff know how to access a Welsh speaking member of staff?	90.32%	96.15%	96%
	If a patient’s language is not English, do staff know how to access an interpreter	-	100%	100%
	For this episode of care, is there documented evidence that the patient's cultural needs have been assessed and discussed with the patient or advocate?	73.10%	64.47%	61.92%
	For this episode of care, is there documented evidence that the patient's spiritual needs has been assessed and discussed with the patient or advocate?	68.06%	65%	62.03%
	Is there a facility for patients to talk in private to staff (e.g. a quiet room or office)?	95%	94.9%	95%
	Is there a quiet room for patients to spend time with their visitors away from their bedside?	89.04%	94.37%	94.74%
	Are there facilities to preserve a mother’s dignity if she wishes to express or feed at the cotside i.e. patient screens?	100%	100%	100%
	Within the clinical area, are all the bays single sex bays?	86.76%	88.14%	88.89%
	Do all patients have access to single sex toilet and washing facilities?	81.18%	80.77%	88.10%
	Is there a facility to preserve patient's dignity by communicating to others that care is in progress?	94.57%	94.12%	94.17%
	Within the clinical area, are washing and bathing facilities suitable for all Patients?	79.52%	83.33%	100%
	Within the clinical area, are toilet facilities suitable for all service users?	85.87%	88.78%	100%
	Does the clinical area allow patients to bring in personal items to assist with patient orientation/familiarity?	100%	100%	100%
	For this episode of care, is there documented evidence that the patient's normal sleep pattern and needs have been assessed and discussed with the patient or advocate?	84.2%	91.21%	81.11%
	For this episode of care, where the patient has an identified sleep issue or sleep has been recorded as poor/disrupted is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	81.93%	90%	76.31%
	Where the baby has an identified disrupted sleep/rest issues, there is evidence that there is an up to date plan of	-	100%	100%

	care which is being implemented and evaluated and has been reviewed within 24 hrs?			
	Does the clinical area allow for a period of 'quiet time' during the day to ensure that babies have a period of rest/sleep period?	100%	100%	100%
	Does the clinical area allow for the noise levels to be controlled at the cot-side especially during periods of rest and sleep?	100%	100%	100%
	Does the clinical area allow for the lighting particularly during periods of rest and sleep to be individually controlled at the cot side?	100%	100%	100%
	Are lights in sleeping areas, other than the over the bed night lights, switched off or dimmed at night?	98.61%	98.57%	100%
	For this episode of care, is there documented evidence that the patient's pain has been discussed and assessed using an appropriate pain assessment tool?	81.35%	84.02%	88.71%
	For this episode of care, where the patient has an identified problem with pain is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	83.14%	86.67%	84.87%
	For this episode of care, is their documented evidence that the baby's comfort has been discussed and assessed using a developmental care tool?	100%	100%	100%
	For this episode of care, where the baby has been an identified problem with comfort is their evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last 24 hrs?	100%	100%	100%
	For this episode of care, is there documented evidence that the patient's concerns/anxieties or fears has been assessed and discussed with the patient or advocate?	82.47%	87.19%	81.62%
	For this episode of care, where the patient has expressed concerns, anxieties or fears, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	81.72%	80.36%	82.05%
	For this episode of care, is there documented evidence that the patient's hygiene needs have been assessed and discussed with the patient or advocate?	95.7%	96.71%	92.68%
	For this episode of care, where the patient's hygiene needs have been identified is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	92.94%	91.76%	88.58%
	Are patients given the opportunity to go to the toilet before eating?	95.59%	97.01%	98.55%
	For this episode of care, is there documented evidence that the patient's foot and nail condition has been assessed, and discussed with the patient or advocate?	63.73%	68.10%	66.10%
	For this episode of care, where the patient has an identified risk or requires assistance with foot or nail care, is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	63.67%	80.42%	70.95%
	For this episode of care, is there documented evidence that the patient has been assessed using an evidence based oral health tool with respect to their oral health needs?	65.43%	61.85%	65.38%
	For this episode of care, where the patient has an identified risk or requires assistance with oral health, is there evidence that there is an up to date plan of care which is	74.4%	82%	77.75%

	being implemented and evaluated and has been reviewed within the agreed timescale?			
	For this episode of care, is there documented evidence that the patient's toilet needs/continence has been assessed and discussed with the patient or advocate?	91.65%	92.03%	90.34%
	For this episode of care, where the patient has been identified as requiring assistance with their toilet/continence needs, is there evidence that an appropriate assessment has taken place with an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	91.3%	90%	86.1%
	Baby's family ethnicity has been recorded	-	-	80%
	There is written evidence that Health Visitor Observations and Assessment of the Infant (HOAI) was commenced	-	-	95%
	Is there written evidence that Family Resilience Assessment Instrument Tool has been completed at 1-6 weeks?	-	-	100%
	OVERALL RAG	**84.4%**	**86.5%**	**86.2%**

Operational Perspective

The operational questions for Standard 4.1 Dignified Care covers a range of issues which promote the dignity and respect of patients and are closely aligned with **Standards 3. 2 Communicating effectively 4.2 Patient information** and **Standard 6.1 Planning Care to Promote Independence**. This standard has scored an overall green rating (86.2%) and is one the lowest scoring standards of the HCM audit.

Much of the areas for concern within this standard will be addressed by driving up the standard of completion of the patient assessment document which prompts nursing staff to ask key questions and to indicate whether a plan of care is required around the activities of daily living such as sleeping, spiritual and cultural needs. Of note, the Service user survey questions relating to Dignified Care have scored highly.

As there is such a diversity of themes within this standard, the themes from the will be discussed individually.

1. Assessment of Cultural and Spiritual needs

The commentary provided suggests that there are pockets of good practice where the cultural and spiritual needs of patients are assessed on admission. However, this clearly needs to improve. Some comments indicate that staff may be unsure of what constitutes ‘cultural’ or ‘spiritual’ needs. Some clinical areas mistake spiritual care to exclusively refer to a patient’s religious need.

Service User Perspective

There were no specific service user survey questions, and no comments were made relating to cultural and spiritual needs.

2. Environment of Care

For the operational audit, the focus on the environment of care is on bathroom and toilet facilities. Service Users however, have provided comments on the general environment of care.

The main comments provided for the Operational audit are similar to last year:

- Suitable bathing and washing facilities are not available for all in patient service users and that some ward areas are waiting for the refurbishment programme to reach their area.
- Bathrooms already refurbished have been upgraded to a high standard and significantly improving the patient experience.
- Comments indicating that there may be a delay in undertaken repair work on bathroom facilities are out of order.
- Single sex toilet and washing facilities are not available in all areas, and that the facilities are considered unisex. In other areas, staff controlled signage is used so that use of toilet and bathroom facilities can be changed between male and females in accordance with the number and location of the sexes.
- Facilities are available for patients to talk in private with staff, as well as facilities for service users to spend time away from the bed side. For one area, however, the patient bed room is used due to lack of private areas within the care environment and this is deemed unsuitable.

Service User Perspective

Table 26

Service User Question	Year	Never	Sometimes	Usually	Always	OVERALL RAG%
Throughout your stay/attendance, how often did you feel that if you needed help to use the toilet that we responded quickly and discreetly?	2016	1.59%	2.79%	24.10%	71.51%	95.53%
	2017	0.32%	2.88%	18.53%	78.27%	96.81%
	2018	0.4%	4.44%	20.20%	74.95%	95.15%
Patients felt that they had their hygiene needs met	2016	0.38%	1.73%	10.75%	87.14%	97.85%
	2017	-	1.60%	11.38%	87.02%	98.40%
	2018	0.37%	1.11%	9.28%	89.24%	98.52%
Throughout your stay, did you have access to wash and shower? (parent question only)	2016	-	-	4%	96%	100%
	2017	-	-	7.14	92.86%	100%
	2018	-	20%	-	80%	80%

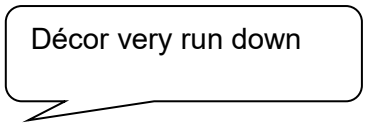
There is one service user question relating to toileting, and is pleasing to see that the majority of patients were happy with the assistance that they received and comment that staff respond quickly to their requests. There were however, a couple of comments that suggest that we may not be getting right all of the time. These primarily relate to broken facilities or an insufficient number of toilets.

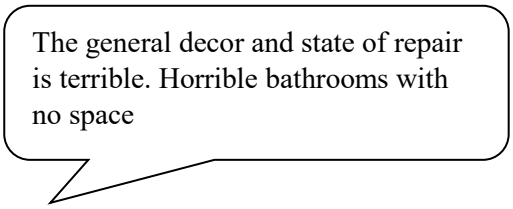
Disappointing that some toilets and showers been out of use for long time

Should be more toilets and showers. The ones that are here are too far away.

It is also pleasing to note that 98%> of patients felt that they had their hygiene needs met.

Service users made a number of general comments relating to the suitability of the hospital environment to promote and maintain dignified care, and the comments are similar to what they provided for last year's audit:





What are we doing to improve the Environment of care?

The following activities are being undertaken to maintain and drive up the standard of the environment to maintain and promote dignified care:

- Work with Health Inspectorate Wales and respond to the findings and recommendation made following Dignity and Essential Care Inspections.
- Rolling programme of Ward inspections undertaken by the Corporate Nursing team.
- Rolling programme of upgrading ward toilet and bathroom facilities using a scoring matrix to prioritise ward bathrooms requiring urgent attention.

3. Sleep and Rest

For the questions relating to sleep and rest and the overall scores have worsened since the last audit. Further improvements would be achieved by ensuring that the sleeping patterns of all patients are assessed on admission and a care plan implemented where necessary. There appears to be a disparity between the operational and user responses. Clinical areas rate their actions to promote sleep far higher than patients/parents.

Good practice

There are minimal comments made to highlight practice around sleep

- Sleep charts used
- 'Quiet times' of day implemented in some clinical areas.

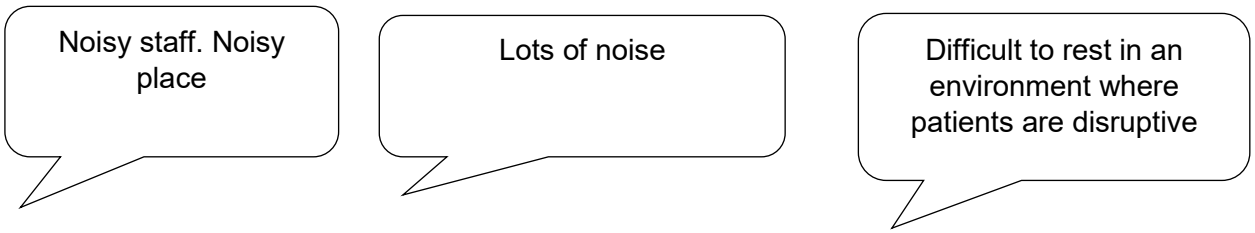
Service User Perspective

Table 27

Service User Question	Year	NEVER	SOMETIMES	USUALLY	ALWAYS	OVERALL RAG
Throughout your stay, how often did you feel that you were able to get enough rest and sleep?	2016	2.29%	14.12%	34.54%	49.05%	83.37%
	2017	3.29%	15.96%	30.52%	50.23%	80.75%
	2018	3.27%	18.91%	29.27%	48.55%	77.82%

The response to this question rendered one of the lowest scores (for questions relating to all areas) from the service user survey and reflects the outcome of previous HCSM audit/ FOC User Surveys undertaken.

General Patient feedback has highlighted a variety of reasons which impact upon their ability to sleep/rest



Other reasons given for poor sleep are:

- Lights are on late
- Unable to sleep due to excess noise from other patients.
- Staff talking loudly
- Machines making noises

There were specific sleep related user questions for paediatric and neonatal areas

Table 28

Service User Question	Year	Never	Sometimes	Usually	Always	OVERALL RAG %
Throughout your stay were there facilities for you to stay overnight with your baby free of charge?	**2016**	8.82%	2.94%	-	88.24%	88.24%
	2017	5.56%	5.56%	5.56%	83.33%	88.89%
	2018	-	-	20%	80%	100%

The Noah's Ark Childrens' hospital provides a facility for parents to sleep alongside the child or baby and during a ward inspection undertaken by the Corporate Nursing team, parents report verbally that they were delighted with the facility. Also the availability of Ronald Mc Donald House is providing home from home accommodation for families where they can spend time away together from the wards. Services users did not provide comments to support the outcome of this question.

What are we doing to improve the patient experience for sleep and rest?

Practical measures have been identified to improve patient experience of sleep whilst in hospital:

- An analysis of the data relating to noise at night indicates that a handful of areas generate especially low scores from users.
- Supporting patients with day time activities, which are described in more detail further along in the report.
- Some ward ensure that lights are dimmed before 11pm.
- Natural waking is being used on a small number of general wards with the aim to focus on the patient needs and not on the ward routine.

4. Pain

In 2017, 100% of parents reported that their child 'usually' or 'always' received pain relief in a timely manner. This year's audit has seen further improvements and 100% now report that their child 'always' receive pain relief in a timely manner. Paediatric areas are to be commended on discussing the comfort of babies and planning care, with the relevant questions rendering the highest possible score and that pain charts are completed routinely.

Within Obstetrics, pain scores are documented on the observations chart as well as the patient's hand held record.

For adult areas, comments indicate that there are a variety of practises , with some areas utilising pain charts, captured on intentional rounding tools, verbal discussions with patients, and although pain assessment is not documented, there is evidence on the medicines chart that pain relief has been given.

Service User Perspective

The majority of patients were satisfied with the level of care provided to them regarding management of pain, and the opportunity to comfort their baby during painful procedures.

Table 29

Service User Question	Year	Never	Sometimes	Usually	Always	OVERALL RAG
Throughout your stay, how often did you feel that you were made to feel comfortable?	2016	0.17%	1.41%	12.85%	85.56%	98.37%
	2107	-	1.69%	13.68%	84.63%	98.31%
	2018	0.67%	2.18%	11.07%	86.07%	97.15%
Throughout your stay/attendance, how often did you feel that you were, as far as possible, kept free from pain?	2016	0.60%	3.61%	14.83%	80.96%	95.79%
	2017	0.34%	2.59%	20.52%	76.55%	97.08%
	2018	1.14%	3.79%	16.86%	78.22%	95.08%
Were you encouraged to hold your baby and supported to be in regular skin to skin care	2016	19.05%	9.52%	4.76%	66.67%	71.43%
	2017	7.14%	7.14%	14.29%	71.43%	85.71%
	2018	28.57%	-	28.57	42.86%	71.43%
During your stay, when your child needed pain relief, did they receive it in a timely manner?	2016	-	7.69%	19.23%	73.08%	92.31%
	2017	-	-	7.69%	92.31%	100%
	2018	-	-	-	100%	100%

It is assuring to report that in spite of the clear need to make improvements in this area patients report that 95% of the time they 'always' or 'usually' were kept free from pain. In addition when asked if they were made to feel comfortable 97% said this occurred 'always' or 'usually' (table 27).

Service users have provided a lot of complimentary and positive feedback in respect of pain management. Despite a 2% reduction in scoring against this standard, in comparison to last

year's audit, no comments have been made about poor experiences or suggestion to improve pain management.

What are we doing to improve the management of pain?

Pain assessment and management charts suitable for patients who were unable to self-report their pain, for example, due to cognitive impairment or inability to communicate have previously been introduced to the Health Board. Further work will now be taken by the Health Board CSIG to establish how best to increase awareness of the tools provided.

- A variety of formal and informal training sessions for Pain Management are provided to registered nurses, health care support workers, students, and the wider multi-disciplinary team. The sessions are well attended and evaluate well.

5. Foot and Nail Care

A formal tool is not used within the Health Board to assess the condition of the patient's foot and nails and comments provided indicate that the existing documents, intentional rounding, Water low risk assessment for pressure ulcers are used. Comments indicate that work is being undertaken at ward level to drive up the standard of foot and nail care.

- Foot questionnaire is in use in one area.
- Feet and nails are assessment on a daily basis whilst meeting hygiene needs.
- Referral to podiatry service when required.
- Staff trained to undertake social nail cutting.

In summary, areas are reporting that nail and foot care is being incorporated in an overall assessment of hygiene needs and pressure area care as part of the overall agenda of improving foot health and reducing harm from falls.

Service User Perspective

There were no Service User survey questions relating to foot and nail care

Opportunities for Improvement

- There is a need for improvement in documentation .The Patient Assessment document acts as prompt to ask patients about their feet and nails.

6. Mouth Care

The Health Board achieved a RAG rating of amber for the 2 questions relating to Oral Care and hygiene scoring 65% for assessment and 78% for care planning. This is consistent with the findings of previous audits.

The need to improve compliance with mouth care assessment and care planning has featured in the last few audits and there has been a lack of a suitable assessment tool and care plans. To this end, the All Wales Adult Mouth Care Assessment and care plan was launched at the end of May 2017 to all areas across the Health Board. In order to rationalise the number of documents completed by nurses and midwives, completion of the assessment at this Health Board is in accordance with the response to screening questions included on the patient assessment document.
Despite this, a number of comments indicate that more work is required to increase awareness of the availability of the All Wales documents.

Good Practice

- Assessment and care plan for mouth care available in some areas

- Involvement of the Community Dental Team (OSCAR)
- Mouth care is Included within Intentional rounding
- The need for regular mouth care is included in care plans
- Adoption of the All Wales Adult Mouth Care Assessment has been successful in some clinical areas.

Service User Perspective

Table 30

Service User Question	Year	Never	Sometimes	Usually	Always	OVERALL RAG %
During your stay, if required, were you given help with your mouth care?	2016	2.69%	3.58%	18.21%	75.52%	93.73%
	2017	3.14%	4.45%	17.28%	75.13%	92.41%
	2018	4.23%	1.95%	14.66%	79.15%	93.81%

It is reassuring that the majority of patients responded to usually or always to receiving help to make sure that mouth, teeth and gums were kept clean. There were no comments made regarding the provision of mouth care

What are we doing to Improve Mouth care?

- A list of essential mouth care products, that include ordering codes and costs has been reviewed and circulated to Clinical Boards.
- The CSIG will consider how best to further raise awareness of the All Wales Mouth Care Assessment tool and care plan and to provide clarity around when it needs completing.
- Health Board representatives are supporting the development of an All Wales mouth care assessment paediatric tool.
- Discussion are to commence on the inclusion of mouth care provision into existing education programmes.

7. Service User Perspective for Dignity and Respect

Whilst the standard Dignified Care has been identified as a key area for improvement from the operational audit, it is reassuring that the majority of patients (98%) who responded felt that they were treated with dignity and respect 'always' or 'usually' during their attendance or hospital stay (Table 31). This reflects the findings each year since the introduction of the FOC audit in 2008.

Table 31

Service User Question	Year	Never	Sometimes	Usually	Always	OVERALL RAG %
Throughout your stay/attendance, how often did you feel that you were treated with dignity and respect?	2016	0.3%	2.09%	13.45%	84.16%	97.55%
	2017	-	1.44%	12.10%	86.46%	98.56%
	2018	0.28%	1.31%	8.33%	90.07%	98.40%

Throughout your stay/attendance, how often did you feel that you were given the privacy that you need?	2016	0.9%	1.9%	18.98%	78.16%	97.08%
	2017	0.22%	3.46%	17.19%	79.13%	96.32%
	2018	0.43%	3.61%	12.99%	82.97%	95.96%
During your stay were staff polite to you	2016	-	1.38%	11.23%	87.38%	98.57%
	2017	0.11%	1.11%	11.37%	87.40%	98.77%
	2018	0.15%	1.33%	12.26%	86.26%	98.53%
Were staff kind and helpful?	2016	-	1.55%	11.16%	87.29%	98.41%
	2017	-	1.13%	10.36%	88.51%	98.87%
	2018	-	1.24%	6.77%	91.99%	98.76%

As is consistent across all HCS audits, the majority of the comments made by the Service Users for the 2018 audit are about the attitude and behaviour of staff:

I have been treated with the utmost dignity and respect

Staff are helpful, polite and caring. They treat me with respect

Staff have been so kind and helpful to relive my anxiety.

I felt valued by all staff

Although negative comments about staff are in the minority, they indicate that further work is needed to ensure that **all** patients feel they are treated with dignity and respect.

Some staff aren't as friendly as others

Busy staff vary in care. Some staff are good some are bad.

Service users also responded that they were given the privacy that they needed and nearly all responded to *"always*" and "*usually*". There was an appreciation of the difficulty in maintaining privacy whilst being interrupted by other patients. A number of patients indicated that they would prefer single sex wards.

What are we doing to ensure that Health Board staff are supported to deliver care in a dignified manner?

The dignity agenda is complex and is interwoven within core work programmes being taken forward as well as being interwoven across the 22 Health and Care Standards. The following activities are undertaken to ensure that the dignity and respect of people who use our service is every day business for the Health Board:

- Work with Health Inspectorate Wales and respond to the findings and recommendation made following Hospital Inspections. The reports and action plans are in the public domain.
- The Internal Inspection Programme led by the Corporate Nursing team have completed an inspection to all wards and departments since April 2017 and comment on the patient to staff and staff to staff interactions.
- Dementia Care training is well attended.
- The Health Board has a set of revised values which inform every day staff behaviour. The values serve as a reminder to all of staff of the standards of behaviour accepted at all times towards each other as well as towards the people who use our service. The workforces who embrace the values are rewarded through our staff recognition awards.
- Commitment of staff employed at the Health Board have been recognised at national awards events year on year.
- The achievements of nurses and midwives is celebrated and shared at the biannual Health Board Nursing and Midwifery conference as well as at local celebration events within Clinical Boards.
- Patient feedback, which is coordinated by the Patient Experience team is received from a number of sources and is reported at Quality, Safety and Experience Committee.
- When concerns are raised about behaviour or care, the Health Board take responsibility to put things right. This can be informal action taken at local level or formal as a serious incident, or through the Whistleblowing policy or Disciplinary policy. Also, the Freedom to Speak up through to the Chair of the Health Board is always available should staff feel that this is the most appropriate route to take.
- The Health Board is responding to the requirements of the Nursing Staff (Wales) Act 2016, with a requirement to formally report to Board. The aim of the Act is to ensure that the right number of staff are available to deliver care to patients, based on the triangulation of patient acuity date, clinical indicators and professional judgement.
- Communicating with Dignity training which is incorporated into induction programme.
- Liaison Psychiatry for Older People are working across the UHB to support patient with cognitive impairments/ dementia or behaviours that challenge.

8. Activities

Although there are no specific questions regarding activities within the audit, patients are requesting the provision or activities away from the bedside. Several patients made comments about feeling bored and suggested:

- More TVs should be made available to relieve boredom
- The availability of music or headphones would be beneficial

What are we doing to support patient to alleviate boredom?

- Health Board Volunteers service is enabling an increase in the level of activity and stimulation for patients.
- Refocusing and activities nurses enabling activities and trips for mental health service users.
- Liaison Psychiatry for Older People are working across the UHB to support patient with activities and psychological engagement.

Standard 4.2 Patient Information

People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.

Table 32

Standard 4.2 Patient Information		RAG% 2016	RAG % 2017	RAG% 2018
	Is there evidence to demonstrate that patient identifiable information is treated in a confidential and secure manner?	97.89%	97.17%	94.43%
	For this episode of care, is there written evidence in the patient's clinical notes that the patient's consent to the sharing of information with others has been obtained?	69.16%	70.87%	69.45%
	Does your unit inform parents that information regarding their baby may be shared with other professionals to ensure appropriate care?	100%	100%	100%
	Is there evidence of information available for women and their families on infant feeding?	100%	100%	100%
	Does the clinical area offer translation services and/or professional interpreters to parents?	100%	100%	100%
	Does the clinical area have written information available in a language and format appropriate to their local community?	100%	100%	100%
	In the clinical area, is there information available regarding unit facilities, local amenities, parking, visiting, local support groups and arrangements for going home?	100%	100%	100%
	Are parents provided with information on how to access further information, including useful websites e.g Bliss, local Neonatal services?	-	100%	100%
	Is the CYP/ parent/carer aware of the names nurse who is responsible for the patients care during the stay?	-	100%	100%
	All records are kept securely	-	-	100%
	OVERALL RAG	**85%**	**86.3%**	**84.3%**

For this standard, the top two questions apply to all areas whilst the others apply only to the paediatric and obstetric areas. Nearly all questions have rendered a high score, but the overall RAG for the standard is amber (84.3%). The reason for this is that 30% of clinical areas indicated that they do not document that the service user has consented to sharing their information with others. It is however pleasing to see that the sharing of the baby's information with other professionals is always discussed with parents.

Good practice

- Lockable trolleys are used to store patient records.
- Consent is gained when it's in the patient's best interest to share information.
- Confidential waste bins are provided on wards.
- Electronic system used where only staff have access.
- Privacy screens used on computers.
- Patient Status at a glance board no longer includes the patient's full name.

Opportunities for Improvement

- A section is already provided on the Patient Assessment document for service users to sign that they consent to the sharing of their information.
- The CSIG will provide clarity on whether there is a requirement for all patients to provide consent to share information, or only for those where the information is shared outside of the Health Board.

Service User Perspective

Table 33

Service User Question	Year	Never	Sometimes	Usually	Always	Overall RAG %
Throughout your stay/attendance, how often did you feel that you and those that care for you were given full information about your care in a way that you could understand?	2016	1.41%	6.73%	23.63%	68.23%	91.69%
	2017	1.14%	9.34%	23.69%	65.83%	94.06%
	2018	1.08%	3.62%	11.84%	83.46%	95.3%
Throughout your stay, how often did you feel that we kept you informed of any delays in, for example, appointment times, discharge?	2016	3.64%	6.38%	24.59%	65.39%	89.76%
	2017	2.33%	9.44%	24.49%	63.75%	88.24%
	2018	4.01%	8.85%	24.87%	62.27%	87.14%
Throughout your stay, how often did you feel that we gave you sufficient information regarding unit facilities, local amenities, parking, visiting, local support groups and arrangements for going home? (paediatrics only)	2016	11.76%	8.82%	14.71%	64.71%	79.41%
	2017	1.14%	9.34%	23.69%	65.83%	94.06%
	2018	-	-	9.09&	90.91%	100%
Throughout your stay, how often were encouraged to be present during the ward round? (paeds only)	2016	14.29%	14.29%	25%	46.43%	71.43%
	2017	-	22.22%	-	77.78%	77.78%
	2018	27.27%	-	36.36%	36.36%	72.72%

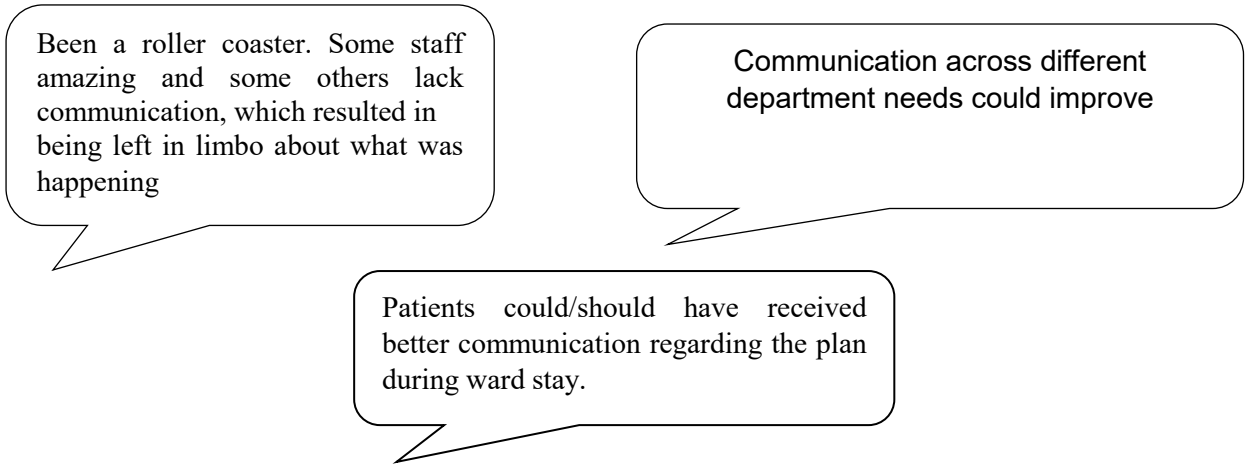
A number of the Service User Survey questions fall into the standard Patient Information and the majority of patients who responded were satisfied with the quality and frequency of information given and the manner in which it was provided. 83% of patients felt that they were ‘always’ given full information about their care and a further 12% felt that this ‘usually’ occurred.

Impressed at how different departments joined up and discussed with each other. This was reassuring and gave me confidence

Although he may not always understand, staff took time to explain and care for him in a way that did not feel rushed.

Gave me an update on waiting times

Nevertheless, a small number of comments made indicate that we are not getting it right at all times;



What are we doing to maintain and improve the standard of keeping patient's informed?

- The UHB continues to provide a suite of communication courses. Communicating with Dignity and respect programmes are available for Health care support workers working in clinical and administrative roles and Enhanced Communication skills programmes for registered practitioners and leaders and managers.
- Patient information boards ("Hot Boards") have been rolled out to ward entrance across the Health Board includes a "you said, we did section" to demonstrate to patients and carers that we act on feedback provided.

Standard 5.1 Timely Access

Table 34

Standard 5.1 Timely Access		RAG% 2016	RAG% 2017	RAG% 2018
	Is there evidence that the CYP has been correctly triaged on admission?	-	86%	94%
	Is there written evidence that the Primary Birth Visit was completed within 10-14 days?	-	-	100%
	Overall Percentage	-	-	96.70%

The above question only applied to paediatric areas and relates to the requirement to record of core information on the child and young person's admission to hospital.

There are no specific questions for the service users and no comments made regarding triaging of the CYP.

Standard 6.1 Planning Care to Promote Independence

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional wellbeing.

Table 35

Standard 6.1 Planning Care to Promote Independence	**RAG% 2016**	**RAG% 2017**	**RAG% 2018**

	For patients with no known diagnosis of dementia, delirium or other cognitive impairment at admission, there is documented evidence that within 72 hours of admission, the following screening question has been asked, Have you/has the patient been more forgetful in the past 12 months to the extent that it has significantly affected your/their daily life?	67.41%	75.85%	74.62%
	For this episode of care, is there documented evidence that the patients cognition has been assessed?	-	-	80%
	For this episode of care, where the patient has an identified care need in respect of cognitive impairment, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	77%	83.92%	77.69%
	For patients with no formal diagnosis of learning disability, is there documented evidence that the patient has been assessed for a formal diagnosed learning disability?	-	67%	43%
	Where the patient has been identified as having a formal diagnosed learning disability, is there evidence that there is an up to date learning disability passport?	-	88%	71%
	Where the patient has been identified as having a formal diagnosed learning disability, is there evidence that the learning disabilities care bundle is being implemented and evaluated?		82%	71%
	For this episode of care, where the patient has been assessed under the Mental Health Measure to be a relevant patient, has a Care Treatment Plan been completed?	92%	89.23%	96%
	For this episode of care, is there written evidence in the CYP's clinical notes that the CYP/ parent / carer has been given an E discharge letter and the discharge arrangements explained?	-	67%	76%
	For this episode of care, is there documented evidence that the baby has an up to date Developmental Care assessment?	100%	100%	100%
	Where appropriate, do all babies have written evidence of a discharge plan from the point of admission and are continually reviewed, involving both parents and a multidisciplinary team?	-	0%	40%
	Is there an individual Positive Behaviour plan in place prescribing individual restrictive practices that can be used to support the patient if need be (mental health only)	93.33%	86.67%	82.22%
	For this episode care, is there documented evidence that the patient's level of independence has been assessed and discussed with the patient or advocate?	92.41%	95.49%	92.86%
	For this episode of care, where the patient has been identified as requiring support and/or assistance to maximise independence, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	90.56%	91.11	92.91%
	Where appropriate, do all patients have written evidence of a discharge assessment and plan?	92.33%	91.64%	88.86%
	Where appropriate, is there written evidence that the patient's family/carer has been involved in discharge planning?	87.78%	87.05%	88.38%
	For this episode of care, is there documented evidence that the mother is shown how to make feeds and sterilise bottles and teats prior to going home?	100%	100%	100%
	For this episode of care, is there documented evidence that the mother is shown parent craft skills prior to going home?	100%	100%	100%

	Does the clinical area allow for parents to room in with their baby prior to going home?	100%	100%	100%
	Does the clinical area have access to mirrors for patients to use?	96.25%	91.89%	94.67%
	Does the clinical area have supplies of toiletries for patients who have been admitted without them?	96%	98.67%	96.05%
	Does the clinical area have access to appropriate baby clothes for babies who have been admitted without them?	100%	100%	100%
	Does the clinical area have access nappies and baby toiletries for babies who have been admitted without them?	100%	100%	100%
	Where required, is there written evidence that the CYP developmental needs have been assessed/discussed with the CYP or advocate?	-	93%	48%
	OVERALL RAG	**89.1%**	**89.3%**	**87.30%**

Standard 6.1, Planning Care to Promote Independence covers a range of issues from the provision of clothing and toiletries to screening for dementia.

In reviewing the data, the majority of areas indicated that they did not have patients with learning disabilities and therefore the questions were not applicable. For the 6 areas that responded to the questions, and thus generated the compliance score, the comments provided indicate that there were no patients with learning disabilities on the ward at the time, and therefore the question may have been responded to incorrectly.
Overall, the audit outcome indicates that staff are planning care to promote patient independence and the comments provided suggests that staff are going over and above what is required of them to improve the patient experience.

Good Practice

- Read about Me is being completed for patients with cognitive impairment.
- Mental Health wards use positive behaviour plans, as well as risk management and intervention plans when required.
- Going home talks given pre discharge and discharge checklists utilised
- Family involvement in discharge meetings
- Majority of patients under a Mental Health Measure has a care plan in place (96%)
- Patient assessment document is used to record the patient's level of independence
- Toiletries purchased by nursing staff or from ward funds.

Service User Perspective

The results shown in table 36 indicate that the majority of patients are satisfied with the help given to them to be independent.

Table 36

Service User Questions	Year	Never	Sometimes	Usually	Always	Overall % RAG
Throughout your stay/attendance, how often did you feel that you were given help to be as independent as you can and wish to be?	2016	0.18%	2.3%	19.47%	78.05%	97.47%
	2017	0.52%	4.06%	17.93%	77.49%	95.42%
	2018	0.94%	2.03%	13.26%	83.78%	97.04%

During your stay, Were you and your partner well supported in the care of your baby?	2017	-	-	7.14%	92.86%	100%
	2018	-	-	14.29%	85.71%	100%
During your stay, were you able to have unrestricted access to your child/baby?	2017	4.00%	4.00%	8.00%	84.00%	92%
	2018	-	-	18.18%	81.82%	100%
During your stay, were you involved as much as you wanted to be in decisions about your discharge?	2017	3.11%	8.56%	20.04%	68.29%	83.33%
	2018	3.93%	7.42%	17.03%	71.62%	88.65%

The results of the user survey indicate that service users are being treated as individuals and being supported to be independent. Users have not provided additional comments to support the data.

Whilst approximately 10% of patients 'never' or 'sometimes' feel involved in decisions about discharge, only two patients provided additional comment about problems that they encountered. Their comments indicate that information could be shared more clearly:

> Sometimes there's mixed messages about discharge, which makes me a little confused.

> Discharge planning didn't go to plan. Some more guidance would have helped

What are we doing to help service users maintain their independence?

There are a range of activities being undertaken across the UHB to ensure that patients are supported to be independent and these have been discussed under the other standards, for example:

- There have been a number of improvements introduced to ensure that patients with learning disabilities are supported to be independent.
  - "Improving General Hospital Care of patients with a learning Disability" saving 1000 lives care bundle was launched at the Health Board in 1st February 2017.
  - Learning Disability Champions have been introduced and supported to improve standards across the UHB.
  - The Health Board are the first in Wales to have an automatic flagging system to alert staff when a patient having a learning disability is admitted to our care. This flagging is an alert on both Emergency Unit Work station and the Clinical Workstation. Key documents and contact details are also embedded into the systems.
  - modified NEWS chart to aid early escalation of deteriorating patient
  - the traffic light assessment document
  - an immediate risk assessment care plan
  - Liaised with Welsh Ambulance Service Trust to ensure all unplanned admissions of patients with a learning disability are brought to UHW site.

- Read About Me was launched at the Nursing and Midwifery Conference in October 2017 for completion for all patients with cognitive impairment across the Health Board.
- Upgrading bathroom and toilet facilities
- Volunteer support
- Luncheon clubs / activities and introduction of new crockery
- Activities Nurses within Mental Health Services and activities coordinators within Medicine Clinical Board.
- Liaison Psychiatry for Older People service introduced across UHB, with mental health staff supporting patients on general wards.
- The CSIG group will lead on a renewed focus on driving up the standard of completion of the Patient Assessment document so that care can be appropriately planned to promote and maintain independence.

Standard 6.2 Peoples Rights

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.

Table 37

The operational audit questions shown in table 37 were included in the Maternity and Paediatrics audit only.

Standard 6.2 Peoples Rights		RAG% 2016	RAG% 2017	RAG% 2018
	For this episode of care, is there documented evidence that mothers who require breastfeeding support and/or assistance has been assessed and discussed?	90%	100%	80%
	For this episode of care, where the mother has been identified as requiring support and/or assistance to establish breastfeeding on the unit, prior to going home, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last 24 hours?	80%	100%	80%
	Are there age appropriate playrooms for children/young people?	100%	100%	85.71%
	The clinical area allows personal items to be brought in	100%	100%	100%
	Is there documented evidence that the CYP and their parents/carers have been involved in the decision making process regarding the CYP care?	-	74%	80%
	Is there evidence that staff are aware of the rights of the clients?	-	-	100%
	OVERALL RAG	**96.5%**	**92.8%**	**89.30%**

A reduction in documented evidence of breastfeed support and care planning was noted in the records reviewed.
Comments indicate that although CYP and their parents/ carers are involved in the decision making process, this not always recorded.

Service User Perspective

Table 38

Service User Questions	Year	Never	Sometimes	Usually	Always	Overall
	2016	-	-	20%	80%	100%

During your stay, were you given enough support and information about your chosen method of feeding (maternity standard)	2017	-	-	50%	50%	100%
	2018				100%	100%

All parents surveyed in maternity services reported that they *always* have enough information and support about their chosen method of feeding

Standard 6.3 Listening and Learning from Feedback

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response.

Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback.

Table 39

Standard 6.3 Listening and Learning from Feedback		RAG % 2016	RAG% 2017	RAG% 2018
	In the clinical area, is there accessible information regarding how patients/relatives/advocates can raise a formal or informal concern?	92.39%	93%	96.19%
	Does the clinical area allow parents to regularly feedback their experience of the service	100%	100%	100%
	Does the clinical area allow parents to be involved in the planning and development of service improvements?	100%	100%	100%
	Do the patients have access to patient satisfaction questionnaires and/or written or verbal feedback mechanisms	-	-	100%
	Is feedback routinely sought from CYP and their parents / carer relating to their experience	-	-	100%
	Staff know what action to take if a CYP/parent/carer raises concerns	-	-	100%
	OVERALL RAG	92.6%	93.1%	96.70%

As with the findings of previous audits, it is pleasing that the majority of wards and department provide information on how to raise formal or informal concerns. The comments made regarding this standard focus only on the provision of Putting Things Right leaflets made available on ward notice board, Carer's tables and also in poster format on ward and department notice boards.

What are we doing to improve the service user experience of raising a concern?

- As a Health Board, we encourage the raising of concerns as we learn so much from the experiences of patients, visitors and carers. The Concerns Team will support people throughout the process. The Community Health Council can provide independent advocacy and the posters in the UHB provide the contact details of both the Concerns Department and the CHC.

Service User Perspective

The overall scores in table 40 indicate that the majority of patients felt that they were being listed too.

Table 40

Service User Questions	Year	Never	Sometimes	Usually	Always	Overall
During your stay, did you feel we listened to you	2016	1.18%	4.38%	19.19%	75.25%	94.31%
	2017	0.35%	5.27%	17.45%	76.93%	94.38%
	2018	0.77%	3.07%	11.52%	84.64%	96.16%

In addition, table 21 indicates that 100% of patients feel able to discuss their worries and concerns.

Standard 7.1 Workforce

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

Table 41

Standard 7.1 Workforce		RAG % 2016	RAG % 2017	RAG% 2018
	Are all clinical staff wearing staff identification badges?	91.67%	93.52%	97.30%
	Are all clinical staff complying with the All Wales Dress Code?	93.75%	94.44%	94.59%
	OVERALL RAG	92.7%	94%	95.90%

Operational Audit

In accordance with the comments made for this standards, staff are to be commended for their efforts to ensure that staff are complying with the All Wales Dress Code. Comments indicate that monthly audits are undertaken, and in some areas, a reminder is done as part of the morning safety brief. From the scores, however it is clear that more improvement is needed to ensure that staff are wearing ID badges whilst undertaking their duties.

Service User Perspective

There are numerous comments made by service users regarding the availability of staff. Comments are often made about staff shortages and the need for more staff to provide assistance.

There could be more additional staff as critical duties leave other patients waiting for assistance

Staff are often so busy dealing with problems that more are needed to help when I need help urgently

Sometimes it frustrating that the ward is so understaffed

What are we doing to make sure that there are sufficient staff to provide dignified and safe care to patients?

- It can sometimes be a challenge for staff to attend to the patients' needs at the time of their request as they may already be addressing the needs of other patients. Call bell response times are reviewed as part of the internal inspection programme.
- The Health Board is responding to the requirements of the Nursing Staff (Wales) Act 2016, with a requirement to formally report to Board. The aim of the Act is to ensure that the right number of staff are available to deliver care to patients, based on the triangulation of patient acuity date, clinical indicators and professional judgement. The Act (2016) replaces the CNO principles and aims to strengthen accountability for the efficacy, safety and quality of workforce planning and management.
- The Health Board continue to collect acuity and dependency data twice yearly in general medicine and surgery inpatient areas which will help inform the staffing agenda. This is in line with Nurse Staffing Act (Wales) 2016
- The Health Board is continuing to actively recruit nurses and midwives locally as well as participating in National recruitment drives.
- In response to concerns raised regarding compliance with the all Wales dress Code, "Dress Code" have been undertaken since April 2017, with Clinical Boards providing feedback on compliance during Clinical Board Director of Nursing Professional Performance Review sessions with the Executive Nurse Director.
- A programme of ward inspections will continue throughout 2018 and the inspection includes checking for IDs and that the correct standard of dress is worn.

6 Conclusion

The Health and Care Standards Monitoring audit 2018 has generated information to measure the quality of fundamental aspects of care delivered to our service users across the Heath Board. The audit provides assurance to Board Members where compliance is reported as high and best practice can be shared as well as identifying the improvements to be made across the relevant standards. Although there will be a key focus on Standard 4. 1, Dignified Care, there are elements across all standards that require actions for improvement.

The audit is no longer reported to the Office of the Chief Nursing Officer for Wales however teams can continue to use the audit tools to monitor and measure standards and effects of improvement work taken forward in their local action plans. The audit results provide us with an opportunity to celebrate the excellent care provided and the positive experiences reported by our patients and service users. It also enables us to prioritise our quality improvements and continued support and development to improve the experience of our staff. Patients have expressed high levels of satisfaction with the standards of care they have received from staff within the UHB and we strive to continually enhance their experiences.

"The care he has received has been outstanding. Their patience with us as a family, with worries and concerns, has been valuable and first class. Thank you."

Recommendations

Actions for Improvements (for all elements that scored less than 85% compliance rate)

Standard (Where applicable)	Element	Recommendation

1.1 Health Promotion, Protection and Improvement	Operational	All patients to be asked as part of the admission process regarding smoking habits and where applicable, offered information in relation to smoking cessation
	Operational	All patients to be asked as part of the admission process regarding alcohol intake and where applicable, offered relevant health promotion information and signposting
	Operational	All patients to be asked as part of the admission process regarding illicit substances use and where applicable, offered relevant health promotion information and signposting
	Operational	To establish a process where fire exists are regularly checked to ensure that they are working and not obstructed.
2.2 Preventing Pressure and Tissue damage	Operational	The skin of all patients (adults and children/babies) to be assessed and where required a plan of care completed
	Service User	Service users should be offered help and advice on how to prevent damage to their skin
2.4 Falls Prevention	Operational	All service users require a fall intervention plan that is reviewed and evaluated within required timeframes
2.4 Infection prevention and control	Operational	Service Users to be offered and supported to cleanse their hands prior to meal times
2.5 Nutrition and Hydration	Operational	Water jugs changing and beverage frequency to be raised with catering manager and agenda for next nutrition and catering audit group meeting
	Operational	Continue to promote the engagement of all staff with protected mealtimes and beverage rounds and the need for RNs to provide supervision for meal and beverage rounds
	Operational	Internal Inspection process to continue to review compliance with protected meal times, and checking that all patients are provided with the support required
	Service User	To present the service user feedback on nutrition and hydration to the Nutrition and Catering Steering Group
2.6 Medicines Management	Operations	Within paediatric areas, medication safety audits to be undertaken
2.9 Medical devices, Equipment	Operational	The CISG to propose a systematic checking process to ensure that all equipment is within date of maintenance checks and servicing
3.1 Safe and Clinically Effective Care	Operational	To ensure that patients receive a proportionate assessment on admission using the Patient Assessment document
	Operational	The assessment of capacity and best interest decisions are clearly documented in the patient record
3.2 Communicating Effectively	Operational	To ensure that patients receive a proportionate assessment on admission using the IA document
	Operational	Assessment of carer need should be considered at all stages of patient pathway and necessary referrals undertaken.
	Operational	Using internal inspections as the vehicle, to audit compliance with documenting the need for carers assessment through Patient Assessment documentation completion
	Service user	In accordance with Welsh Language Act, raise awareness of the active offer, and promote the use of the Welsh Language Intranet page for simple ideas and common Welsh phrases.
3.5 Record Keeping	Operational	Using internal inspections as the vehicle to ensure that patients receive a proportionate assessment on admission using the Patient Assessment document, and that individual plan of care is developed

		To support the development of the All Wales e-documentation project
4.1 Dignified Care	Operational	Continue to raise staff awareness of the importance of undertaking a proportionate assessment of patients using the Patient Assessment document and reflect the outcome of assessment in an individual plan of care.
	Operational	The CSIG to develop a plan to further raise awareness of the All Wales Mouth Care assessment tool and care plan (with the exception of longer stay areas and Mental Health Wards where a regular dental service is provided)
	Operational and Service user	CSIG to identify clinical areas with low service user ratings in responses to sleep/rest. CSIG to revisit the findings of previous audits and focus on practical solutions to help limit avoidable noise in clinical areas.
	Service Users	To ensure that the annual HCSM audit report is available to all staff to allow for learning and reflection on the comments made by patients regarding dignity and respect.
4.2 Patient Information	Operational	To ensure that the Patient Assessment document section consent to share information is completed for all patient episodes.
6.1 Planning Care to promote Independent	Operational	Support embedding the 'Patient Passport" across the Health Board
		To ensure that patients and their family/carers are involved in discharge planning
		For clinical areas to support and promote the work of learning disability champions.
	Operational and Service User	To ensure that patients and family/ carers are involved the discharge process throughout the patient's journey
	Service User	For patients with a cognitive impairment, to ensure that Red about Me is completed on the patient's admission to hospital
General	Service User	Reinforce key principles of the Nursing and Midwifery Code (2015)
	Operational	Reinforce of the requirement under the NMC Code (2015) to keep accurate records.
	Operational	For clinical Boards to review their local findings, and in collaboration with the Clinical Standards and Innovation group (CSIG) develop an action plan and monitor progress through the CSIG meeting.

Appendix 1 Health and Care Standards Monitoring Audit User Experience

User Experience Survey 2018

	Never	Sometimes	Usually	Always	Overall RAG
How would you rate your overall experience? (Where 1 is very bad and 10 is excellent)	-	-	-	-	92%
During your stay, how often did you feel that you were treated with dignity and respect?	0.28%	1.31%	8.33%	90.07%	98.40%

During your stay, how often did you feel that you were given enough privacy?	0.43%	3.61%	12.99%	82.97%	95.96%
During your stay, do you feel people were polite to you?	0.15%	1.33%	12.26%	86.26%	98.52%
During your stay, if you asked for assistance did you get it when you needed it?	0.45%	4.96%	19.10%	75.49%	94.59%
During your stay, how often did you feel that if you needed help to use the toilet, that we responded quickly and discreetly?	0.40%	4.44%	20.20%	74.95%	95.15%
During your stay, how often did you feel that we kept you informed of any delays, for example, appointment times, tests, treatment, discharge?	4.01%	8.85%	24.87%	62.27%	87.14%
During your stay, were you able to speak Welsh to staff if you needed to?	22.76%	13.79%	8.97%	54.48%	63.45%
During your stay, did you (and your child) feel safe?	0.15%	0.73%	7.14%	91.98%	99.12%
During your stay, were you made to feel comfortable?	0.67%	2.18%	11.07%	86.07%	97.14%
During your stay, were you, as far as possible, kept free from pain?	1.14%	3.79%	16.86%	78.22%	95.08%
During your stay, were you provided with fresh drinking water and plenty of drinks when you needed them?	0.94%	1.56%	9.67%	87.83%	97.50%
During your stay, was the clinical area kept clean, tidy and not cluttered?	-	2.32%	12.77%	84.91%	97.68%
During your stay, were you provided with nutritious food and snacks?	1.75%	6.11%	18.32%	73.82%	92.14%
During your stay, were staff kind and helpful?	-	1.24%	6.77%	91.99%	98.76%
During your stay, were you given help with feeding and drinking if you needed it?	2.17%	2.17%	10.56%	85.09%	95.65%
During your stay, were you able to get enough rest and sleep?	3.27%	18.91%	29.27%	48.55%	77.82%
During your stay, were your personal hygiene needs met?	0.37%	1.11%	9.28%	89.24%	98.52%
During your stay, if required, were you given help with your mouth care?	4.23%	1.95%	14.66%	79.15%	93.81%
During your stay. Were you given help and advice on how to prevent damage to your skin?	12.32%	7.73%	17.87%	62.08%	79.95%

During your stay how often did you feel that you and those that care for you, were given full information about your care in a way that you could understand?	1.08%	3.62%	11.84%	83.46%	95.30%
During your stay, were things explained to you in a way that you could understand?	1.14%	2.56%	10.98%	85.32%	96.30%
During your stay, did you feel you understood what was happening in your care?	0.97%	3.19%	13.94%	81.90%	95.84%
During your stay, how often did you feel that you were given help to be as independent as you can and wish to be?	0.94%	2.03%	13.26%	83.78%	97.04%
During your stay, did you feel that you were listened to?	0.77%	3.07%	11.52%	84.64%	96.16%
During your stay, were you involved as much as you wanted to be in decisions about your care?	1.94%	2.81%	12.85%	82.40%	95.25%
During your stay, were you given sufficient information regarding the unit facilities	-	-	9.09%	90.91%	100.00%
During your stay, were you encourage to be present during the ward round?	27.27%	-	36.36%	36.36%	72.72%
During your stay, were you able to have unrestricted access to your child/baby?	-	-	18.18%	81.82%	100.00%
During your stay, were there facilities for you to stay overnight with your child/baby free of charge?	-	-	20.00%	80.00%	100.00%
During your stay, were you encouraged to hold your baby and supported to participate in regular skin to skin care (kangaroo care)?	28.57%	-	28.57%	42.86%	71.43%
During your stay did you have access to facilities to wash and shower?	-	20.00%	-	80.00%	80.00%
During your stay, did you have access to an area where you could make hot drinks and prepare simple meal?	-	-	-	100.00 %	100.00%
During your stay, when your child needed pain relief, did they receive it in a timely manner?	-	-	-	100.00 %	100.00%
During your stay, were you given enough support and information about your chosen method of feeding?	-	-	-	100.00 %	100.00%

During your stay, were you given support with feeding your baby when you needed it?	5.00%	-	15.00%	80.00%	95.00%
During your stay, were you able to talk to staff on the unit about your worries and concerns?	-	-	-	100%	100%
During your stay, Were you and your partner well supported in the care of your baby?	-	-	14.29%	85.71%	100.00%
During your stay, Did you and your partner feel well prepared by us to become confident parents?	-	-	15.79%	84.21%	100.00%
During your stay, were you involved as much as you wanted to be in decisions about your discharge?	3.93%	7.42%	17.03%	71.62%	88.65%
If you had a baby in the last 12 months did your Health Visitor help you understand how your baby will develop and grow?	4.55%	-	9.09%	86.36%	95.45%
During your contacts with the Health Visiting service did your Health Visitor help you understand how to respond to your baby?s needs e.g. crying, sleeping, comforting?	0.66%	2.63%	7.89%	88.82%	96.71%
During your contacts with the Health Visiting Service did you and your partner feel well prepared by us to become confident parents?	0.28%	2.49%	10.80%	86.43%	97.23%
During your contacts with the Health Visiting Service, did you find it easy to contact your Health Visitor if needed?	0%	4%	8%	87%	95%
During your contacts with the Health Visiting Service, did you feel that your Health Visitor helped you make healthy choices for you and your family?	0.54%	3.54%	12.26%	83.65%	95.91%

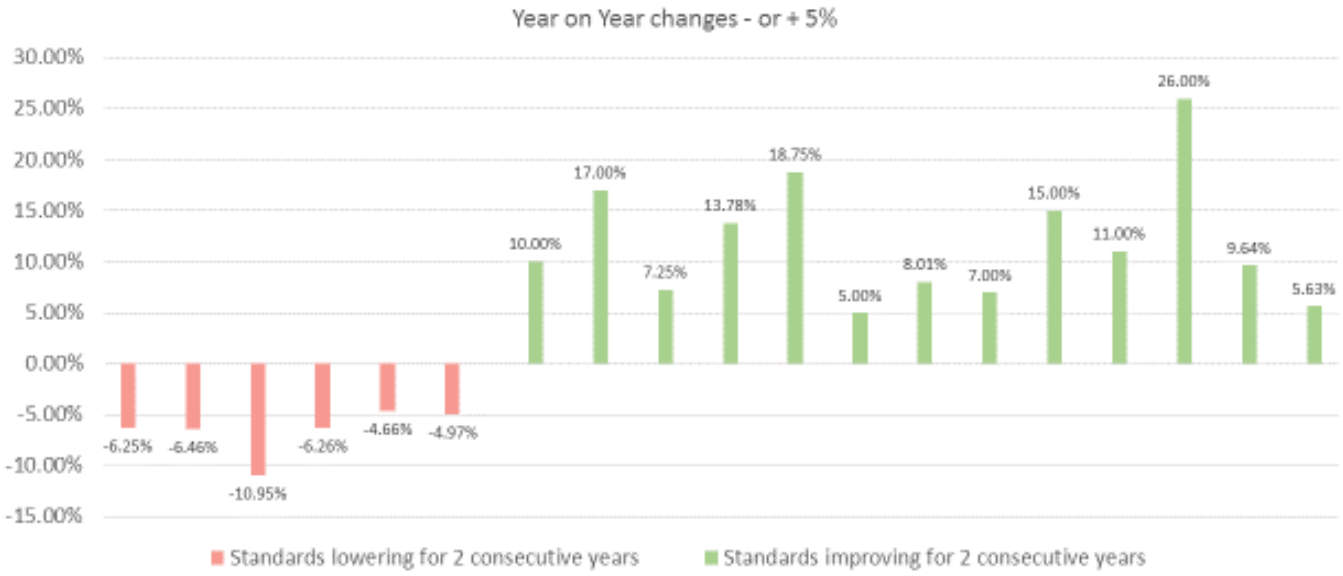
Standard of Compliance	Level of Control	Level of Control Descriptors		Suggested Actions
0-10%	No Awareness	Failure to demonstrate awareness/compliance with any of the requirements set by the standards.	IMMEDIATE ACTION REQUIRED	1. Review by Executive Nurse Director, Assistant Director of Nursing and Lead Nurse responsible for the area - **within 10 days of report** 2. Appraise the Ward Manager - **to be undertaken within 2 weeks of report** 3. Carry out Root Cause Analysis using the 10 steps Triangulation framework [see reverse]- **within 24-48 hrs of report** 4. Set Clear Objectives with supportive measures using PDSA improvement methodology - **will be reviewed on a weekly basis**
11-30%	Minimal Awareness	A low degree of awareness/compliance with the requirements set by the standards, but no approaches have been developed to address them		
31-50%	Moderate Awareness	There is recognition of the key issues to be addressed and there is a range of options identified to address them.		
51-60%	Responding	Steps are being taken to address the key issues with evidence of practical application. In the very early stages of compliance	REVIEW IN 2-3 MONTHS	1. Carry out Root Cause Analysis using the 10 steps Triangulation framework [see reverse]- **within 10 days of report** 2. Set clear objectives using PDSA improvement methodology- **will be reviewed on a fortnightly basis**
61-84%	Developing	Demonstrable evidence that work is ongoing to achieve compliance.		
85-90%	Practicing	There are well-developed plans being implemented that address the key issues with evidence of evaluation and benchmarking leading to continuous improvement. **High level of compliance**	REVIEW IN 8 MONTHS	1. Carry out Root Cause Analysis using the 10 steps Triangulation framework [see reverse]- **within 10 days of report** 2. Set clear objectives for ongoing monitoring using PDSA improvement methodology – **should be reviewed on a monthly basis**
91-100%	Leading	There is evidence of innovative practice, which is being shared across and beyond the organisation to others. They are further developing their approaches to ensure long term sustainable improvement. **Full compliance**		

Health & Care Standards Audit 2018

Comparison against previous years

(Table 1)

Number of standards with changes +/-5% over three consecutive audits



(Table 2)

Standards that have reduced by 5%> in three years

Care Standard	Reduction over three years
• Fire restraint doors are free from obstruction or closed	-6.25%
• Patients documentation captures their preferred name	-6.46%
• Patient's cultural needs assessed and discussed with the patient/ advocate	-10.95%
• Patient's spiritual needs has been assessed and discussed with patient/ advocate	-6.26%
• Patients with hygiene needs have up to date plan of care which is implemented- evaluated- reviewed within timescale	-4.66%
• Patients requiring assistance with their toilet/continence needs have evidence of assessment, care plan that is implemented and evaluated within timescale?	-4.97%

(Table 3)

Standards that have improved by 5%> in three years

Care Standard	Increase over three years
• Providing smoking cessation information	10.00%
• Care planning & evaluation for people with illicit substance misuse problems	17.00%
• Staff are able to identify patients with special eating requirements	7.25%
• Water jugs are changed 3 times daily	13.78%
• A minimum of 7 beverage rounds are carried out	18.75%
• Snacks are available for those who miss a meal or who are hungry	5.00%
• Medication charts are correctly and fully completed	8.01%
• Documented evidence of capacity assessments	7.00%
• Care planning for people lacking capacity	15.00%
• DOLS applications for patients deprived of liberty	11.00%
• Care planning communication needs	9.64%
• Staff wear ID badges	5.63%

REPORT TITLE:	**Patient Safety Solutions**							
MEETING:	Quality Safety and Experience Committee					**MEETING DATE:**	**16th April 2019**	
STATUS:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	
LEAD EXECUTIVE:	Executive Nurse Director							
REPORT AUTHOR (TITLE):	**Patient Safety Facilitator**							

PURPOSE OF REPORT:

SITUATION:

This report has been written to provide the Committee with an update on the UHB's position relating to Patient Safety Solutions, which include alerts and notices from Welsh Government.

REPORT:

BACKGROUND:

The UHB regularly receives alerts and notices from Welsh Government. These cover a range of patient safety issues. Each notice or alert contains a list of actions to be completed before compliance can be declared. The timescale given to undertake these actions varies according to the complexity of the actions required. By the specified deadline, the UHB must report a position of compliance, non-compliance or not applicable.

The notices/alerts are issued to all Welsh Health Boards and Trusts. Each organisation's compliance status is published on a monthly basis by Welsh Government.

An internal flowchart is in place to compliment the UHB's Safety Notices and Important Documents Policy and ensure the UHB complies with necessary Welsh Government requirements.

The UHB participated in an event hosted by Welsh Government and the Delivery Unit in November 2018 where Health Boards and Trusts shared their progress and challenges with Patient Safety Solutions over the previous 12 months.

ASSESSMENT:

The Committee should be advised that there are several elements to each Patient Safety Solution (PSS). In all cases where the UHB is currently reporting non-compliance, the UHB has further work to undertake against one or two elements of the PSS i.e. there is partial compliance

with elements of each PSS. In all cases there are other mitigating factors in place to address the patient safety risks.

Since the last report to Committee in September 2018, the UHB has declared compliance with:

- PSN026 – Positive patient identification
- NPSA 24 – Standardising wristbands improves patient safety
- PSN044 – Resources to support safer care for full-term babies
- PSN045 – Resources to support safer modification of food and fluid
- PSN046 – Resources to support safer bowel care for patients at risk of autonomic dysreflexia
- PSN048 – Risk of harm from inappropriate placement of pulse oximeter probes

The current overall compliance with all Patient Safety Solutions where the deadline has passed is 93% (compliant with 51 out of 55).

Two Safety Solutions have been recently issued by Welsh Government. Work is underway on these alerts and notices ahead of the compliance deadline:

- PSA009 – Wrong selection of orthopaedic fracture fixation plates
- PSN047 – Management of life threatening bleeds from arteriovenous fistulae and grafts

The UHB has been unable to declare compliance with the following Safety Solutions:

- **PSA008 – Nasogastric tube misplacement: continuing risk of death and severe harm**
  Cardiff and Vale UHB is one of five Welsh NHS organisations currently non-compliant with this alert. Further to review of the UHB's action plan for the National Safety Standards for Invasive Procedures (NatSSIPs), additional work to address the outstanding components on this Alert will be taken forwards via the NatSSIPs working group. The particular issue to address with the Alert relates to uptake of competency-based training for all staff who undertake the procedure, regardless of seniority.

- **PSN030 – The safe storage of medicines: Cupboards**
  Cardiff and Vale UHB is one of seven Welsh NHS organisations currently reporting non-compliance with this notice. This Notice is subject to further consideration by Welsh Government.

- **PSN040 – Confirming removal or flushing of lines and cannulae after procedures**
  Cardiff and Vale UHB is one of two Welsh NHS organisations currently reporting non-compliance with this notice. Further to review of the UHB's action plan for NatSSIPs, additional work to address the outstanding components on this Notice will be taken forwards via the NatSSIPs working group. The outstanding issue to address relates to amending the 'sign out' section of WHO surgical safety checklists in operation. In the surgical setting, it was recognised that addressing this during 'sign out' did not remove the risk of residual medication remaining in cannulae in the recovery area and so an adaptation was made. The UHB is currently undertaking a review of all Directorate WHO checklists for this to be considered.

- **PSN043 – Supporting the introduction of the Tracheostomy Guidelines for Wales** Cardiff and Vale UHB is one of four Welsh NHS organisations currently reporting non-compliance with this notice. Further to review of the UHB's action plan for NatSSIPs, additional work to address the outstanding components on this Notice will be taken forwards via the NatSSIPs working group. Ensuring the guidelines are applied in the community setting requires further consideration. An audit of all patients in the community who have a tracheostomy is currently being undertaken.

The table in Appendix 1 provides details of UHB compliance against all the current Patient Safety Solutions

RECOMMENDATION:

The Committee is asked to **CONSIDER** the update provided within the report.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	**X**	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	**X**
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	X	Long term		Integration		Collaboration		Involvement		

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable

Appendix 1 – Summary of Patient Safety Solutions for Cardiff and Vale UHB

Patient Safety Alerts				
PSA Ref.	**Date Issued**	**Title**	**Date for response to WG**	**Compliance Status**
PSA 009	Feb 2019	Wrong selection of orthopaedic fracture fixation plates	15/5/2019	(Not yet due for response)
PSA 008	May 2017	Nasogastric tube misplacement: continuing risk of death and severe harm	30/11/2017	**Non-compliant**
PSA007	January 2017	Restricted use of open systems for injectable medication	01/08/2017	Compliant
PSA006	January 2017	Risk of death and severe harm from error with injectable phenytoin	10/03/2017	Compliant
PSA005	July 2016	Minimising the risk of medication errors with high strength, fixed combination and biosimilar insulin products	14/10/2016	Compliant
PSA004	July 2016	Ensuring the Safe Administration of Insulin	28/10/2016	Compliant
PSA003	May 2016	Update to National Patient Safety Agency (NPSA) alert for safer spinal (intrathecal), epidural and regional devices	01/07/2016	Compliant
PSA002	September 2014	The prompt recognition and initiation of treatment for sepsis for all patients	28/11/2014	Compliant
PSA001	June 2014	Legionella and heated birthing pools filled in advance of labour in home settings	30/06/2014	Compliant

Patient Safety Notices				
PSN Ref.	**Date Issued**	**Title**	**Date for response to WG**	**Compliance Status**
PSN048	February 2019	Risk of harm from inappropriate placement of pulse oximeter probes	29/03/2019	Compliant
PSN047	December 2018	Management of life threatening bleeds from arteriovenous fistulae and grafts	26/05/2019	(Not yet due for response)
PSN046	October 2018	Resources to support safer bowel care for patients at risk of autonomic dysreflexia	29/03/2019	Compliant
PSN045	August 2018	Resources to support safer modification of food and fluid	01/04/2019	Compliant
PSN044	May 2018	Resource to support safer care for full-term babies	21/10/2018	Compliant
PSN043	May 2018	Supporting the introduction of the Tracheostomy Guidelines for Wales	03/10/2018	**Non-compliant**
PSN042	April 2018	Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids	11/06/2018	Compliant
PSN041	March 2018	Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders	23/04/2018	Compliant
PSN040	January 2018	Confirming removal or flushing of lines and cannulae after procedures	12/09/2018	**Non-compliant**
PSN039	January 2018	Safe Transfusion Practice – Use a bedside checklist	15/02/2018	Compliant
PSN038	October 2017	Risk of severe harm and death from infusing Total Parenteral Nutrition too rapidly in babies	08/12/2017	Compliant
PSN037	April 2017	Resources to support the safety of girls and women who are being treated with Valproate	06/10/2017	Compliant
PSN036	November 2017	Reducing the risk of oxygen tubing being connected to air flowmeters	04/08/2017	Compliant
PSN035	August 2017	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	16/10/2017	Compliant
PSN034	September 2016	Supporting the introduction of the National Safety Standards for Invasive Procedures (NatSIPPs)	28/09/2017	Compliant
PSN033	June 2016	Risk of death and serious harm from failure to recognise acute coronary syndromes in Kawasaki disease patients	27/07/2016	Compliant

PSN032	May 2016	Risk of patient harm from an interaction between miconazole and coumarin anticoagulants	09/06/2016	Compliant
PSN031	April 2016	Risk of Patient Safety Incidents Resulting from Errors in the British National Formulary for Children 2015-2016 and British National Formulary 70	31/05/2016	Compliant
PSN030	April 2016	The safe storage of medicines: Cupboards	26/08/2016	**Non-compliant**
PSN029	March 2016	Standardising the early identification of acute kidney care	04/04/2016	Compliant
PSN028	February 2016	Medicines Reconciliation - Reducing the risk of serious harm	30/03/2016	Compliant
PSN027	February 2016	Risk of severe harm or death when desmopressin is omitted ordelayed in patients with cranial diabetes insipidus	08/04/2016	Compliant
PSN026	April 2016	Positive Patient Identification	13/05/2016	Compliant
PSN025	February 2016	Risk of death or severe harm due to inadvertent injection of skin preparation solution	04/04/2016	Compliant
PSN024	January 2016	Risk of using different airway humidification devices simultaneously	01/03/2016	Compliant
PSN023	January 2016	The importance of vital signs during and after restrictive interventions/manual restraint	12/02/2016	Compliant
PSN022	December 2015	The risk of harm from the inappropriate use and disposal of fentanyl patches	31/01/2016	Compliant
PSN021	December 2015	Risk of death and serious harm by falling from hoists	15/02/2016	Compliant
PSN020	October 2015	Minimising risks of omitted and delayed medicines for patients receiving homecare services	27/11/2015	Compliant
PSN019	August 2015	Harm from delayed updates to ambulance dispatch and satellite navigation systems	30/09/2015	Compliant
PSN018	August 2015	Risk of severe harm and death from unintentional interruption of non-invasive ventilation	31/08/2015	Compliant
PSN017	July 2015	Risk of using vacuum and suction drains when not clinically indicated	31/08/2015	Compliant
PSN016	July 2015	Risk of inadvertently cutting in-line (or closed) suction catheters	31/08/2015	Compliant
PSN015	July 2015	The storage of medicines: Refrigerators	31/08/2015	Compliant

PSN014	July 2015	Patient Safety Notice: Residual anaesthetic drugs in cannulae and intravenous lines	31/08/2015	Compliant
PSN013	July 2015	Managing risks during the transition period to new ISO connectors for medical devices used for enteral feeding and neuraxial procedures	13/08/2015	Compliant
PSN012	May 2015	Advice sheet: Adrenal insufficiency (Addison's disease) in adults - information for general practitioners	12/06/2015	Compliant
PSN011	May 2015	Patient Safety Notice: Risk of associating ECG records with wrong patients	18/06/2015	Compliant
PSN010	May 2015	Patient Safety Notice: Failure to act on known contraindications to Low Molecular Weight Heparins	25/06/2015	Compliant
PSN009	April 2015	Awareness of NICE Clinical Guidelines on head injuries	28/05/2015	Compliant
PSN008	April 2015	Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder	28/05/2015	Compliant
PSN007	April 2015	Risk of death or serious harm from accidental ingestion of potassium permanganate	31/05/2015	Compliant
PSN006	March 2015	Risk of hypothermia for patients on continuous renal replacement therapy	30/04/2015	Compliant
PSN005	December 2014	Risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid/opiate treatment	30/01/2015	Compliant
PSN004	December 2014	Risk of death and serious harm from delays in recognising and treating ingestion of button batteries	19/01/2015	Compliant
PSN003	December 2014	Placement devices for nasogastric tube insertion DO NOT replace initial position checks	31/01/2015	Compliant
PSN002	July 2014	The Surgical Management of Urinary Incontinence and Pelvic Organ Prolapse	31/07/2014	Compliant
PSN001	July 2014	Risk of harm relating to interpretation and action on Protein Creatinine Ratio (PCR) results in pregnant women	31/07/2014	Compliant

Outstanding NPSA Notices			
Date Issued	**Title**	**Date for response to WG**	**Compliance Status**
June 2009	Risk to patient safety of not using the NHS Number as the national identifier for all patients	18/09/2009	Compliant
July 2007	Early identification of failure to act on radiological imaging reports	28/02/2008	Compliant
July 2007	Standardising wristbands improves patient safety	18/07/2009	Compliant

Report Title:	Falls Prevention						
Meeting:	Quality and Safety Committee				**Meeting Date:**	16/4/19	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Dr Fiona Jenkins, Executive Director of Therapies and Healthcare Sciences						
Report Author (Title):	Assistant Director of Therapies and Healthcare Sciences/Strategic Lead for Falls Prevention						

SITUATION

Falls and falls-related injuries are a major public health concern, and are a one of the biggest causes of morbidity and mortality for older people in the home, community and in hospital settings.

The purpose of this paper is to brief the Board on the significant amount of work that has been done to date and to describe the proposed approach to falls prevention in Cardiff and the Vale of Glamorgan, providing an update on the launch of the Falls Prevention Framework and the outcome of the 1st Community Falls Prevention Alliance workshop held in March 2019.

BACKGROUND

Falling is not an inevitable part of ageing, as there are many interventions which if put in place can substantially reduce the risk of having a fall. Research has shown that interventions can reduce the rate and risk of falls by as much as 30%, and also provide cost-effectiveness and a return on investment.

Profile of falls and related injuries in Cardiff and Vale UHB:

Data analysis by Lightfoot has identified that there were:

- 500-600 attendances (including Paeds) in ED in UHW as a result of falls each week
- 250-300 of these were under 75 yrs. of age
- 70-90 were over 75 yrs. of age; 70% are discharged with no discernible pathway or destination for further interventions
- 30% are admitted with an average length of stay 10-25 days.

Of concern 40-50 of those patients aged 75+ discharged from ED following a fall, will re-attend ED taking up 1-5 consultant episodes and will be readmitted with subsequent length of stay of between 20-60 days at a later date.

In addition Lightfoot has identified that there are 7 patients aged 75+ admitted per week with fractured neck of femur (#NoF), with an average length of stay of 20-45 days, occupying 30-50 beds at any one time. This compares to Canterbury who have 9 #NoF per week taking up 25-40 bed days.

Falls place a significant burden on other parts of the system including:

- The Welsh Ambulance Service attended 5670 falls incidents (April 2017 to March 2018)
- 5041 referrals with an identified falls risk were received by the Community Resource Teams (April 2017 to March 2018)
- In 2017/18 at least 68 falls-risk patients referred to CRTs were admitted to hospital whilst

awaiting assessment
- In 2018, there were 3649 inpatient falls incidents reported via Datix (compared to 3772 in 2017 and 3660 in 2016), 52 of these were recorded as Serious Incidents (compared to 51 in 2017 and 63 in 2018). In the first quarter of 2019 there have been 865 inpatient falls incidents reported and 7 Serious Incidents. The 2019 rates are therefore currently lower than the previous three years.

ASSESSMENT:
The UHB has developed the 'Falls Framework: Reducing Risk and Harm' to reduce falls and their impact via a whole systems design. The key focus is on primary prevention and the community falls pathway.
The framework was launched at the Clinical Senate on the 8th March 2019. It takes a triple track approach to Regional Partnership falls prevention and management, incorporating the five Regional Partnership Board tiers under the three approaches of:
- Primary prevention and healthy ageing
- Community services prevention and management
- Inpatient services prevention and management

The framework encourages the '7A' principles:
- Raise **Awareness** of falls risks
- **Ask** people about falls risks
- Have timely **Access** to appropriate services for individuals' different needs
- **Assess** people for multifactorial falls risks in line with evidence base
- **Act** on those assessments to treat people with multifactorial interventions in line with the evidence base
- Regular **Analysis** of what we're doing, how we're doing, and impacts of changes we make
- Work together with other services and the individuals to produce the other 6 A's through **Alliancing**

The UHB has recently entered into a partnership with Canterbury District Health Board. As part of the HealthPathways and Alliancing approach a Community Falls Prevention Alliance has been set up to address the primary prevention, healthy ageing and community services prevention and management aspects of the framework. This community alliance has received funding from the Health Foundation Innovation fund to facilitate its set up and evaluation.

The framework also recommends that an Inpatient Falls Prevention Alliance is set up to focus on the Inpatient services aspect of the framework and to overlap with the Community Alliance. The UHB has already made significant progress in implementing a number of schemes such as Model Ward, Get me Home and End PJ Paralysis which all contribute to promoting independence and preventing decline.

The Community Falls Prevention Alliance held its first session on the 25th March 2019, bringing together representatives from multiple services and organisations in Cardiff and the Vale of Glamorgan. The next session is the 24th April 2019, at which the plan is to begin developments of pathway mapping that can aid the setup of falls on Health Pathways, identify gaps in service and suggestions for service redesign.

At the Clinical Senate presentations were given on falls-related work streams already underway in the UHB. Further updates on these are provided below:

- *Stay Steady Clinics*: There are currently 2 clinics running in Cardiff: one in Llanishen and one in Splott. There are no clinics in the Vale. Attendance numbers in Cardiff have been increasing and showing positive outcomes on review of attendees.
- *Simulation Training for inpatient staff*: This is now open to all inpatient wards and representatives from several Clinical Boards have attended a 'train the trainer' session to facilitate uptake. However, actual uptake of sessions being run remains very low and under-utilised. It is vital that this is taken up by wards as it will address the majority of the issues that we find arise on inpatient falls incident forms.
- *Staying Steady Schools*: This Bevan Exemplar scheme is now preparing for the second year of sessions to take place in October 2019. The scheme has been shortlisted in the 'Working in Partnership' category for this year's HSJ Patient Safety Awards (judging May 2019, awards July 2019).

ASSURANCE is provided by: The UHB falls group overseeing the development of the falls framework and involvement of the clinical boards and patient safety team in undertaking the health standard assessment.

RECOMMENDATION

- Share, spread and embed the new *Falls Framework: Reducing risk and harm* across the UHB
- Continue the development of the Community Falls Prevention Alliance Scope development of an Inpatient Falls Prevention Alliance to address inpatient falls prevention and management
- Encourage uptake and embedding of Simulation Training for inpatient staff
- Implement second running of Staying Steady Schools scheme for 2019
- Roll out Stay Steady Clinics and improved WAST referral pathways to CRT across UHB (Transformation Bid funding dependent)
- Continue to improve links and availability of strength and balance exercise groups in the community to improve long-term outcomes

The Committee is asked to:

- Note the progress made by the Falls Delivery Group in the development of the Framework and Community Falls Alliance.
- Endorse the recommendations outlined above

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Equality and Health Impact Assessment Completed:	Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Healthcare standard 2.5 – Primary Outcome:- People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury**						
Meeting:	UHB Board				**Meeting Date:**		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Fiona Jenkins						
Report Author (Title):							

SITUATION

This report provides the committee with an overview of the UHB's approach to assessment of compliance against the Health and Care Standard 2.5.

In 2018-19 the corporate review of the standard has enabled us to give the assurance that the UHB is 'Progressing towards the standard'

REPORT BACKGROUND

The primary outcome of people supported to meet their nutritional and hydration needs is multifactorial and Health Board evidence is based on the following driver diagram

http://www.wales.nhs.uk/governance-emanual/health-and-care-standards-supporting-gui-14 Appendix 1

Additionally the Patient Nutrition, Hydration and Catering Experience Management Action Plan has been developed to continue to gather evidence and address the 10 key recommendations set out in the Public Accounts Committee report on Hospital Catering and Patient Nutrition ensuring that all elements of Nutrition and Hydration Standard 2.5 are being met.

A review of the actions outlined in the action plan document are monitored, reviewed and reported to the Nutrition and Catering Steering Group.

ASSESSMENT

Good progress has been made in many areas notably staff catering and public health with reference to the delivery of the corporate health standard framework.
The implementation of a model ward across 4 wards within the Health Board has enabled a standardisation of nutrition and hydration practices across the inpatient setting. Data is being gathered in real time around outcomes following a successful bid to the UHB Health Charity. Model ward has also been accepted as a Bevan Exemplar and for a pathways to portfolio research grant.

Further evidence for this assessment has been collected through the audits and a cohort of questions to the clinical boards to provide a level of assurance against the standard.

The refreshed two week menu cycle has been embedded across the UHB as well as specific menus to meet the needs of maternity and specialist clinical areas.

Highly coloured crockery arrived for all areas of the Health Board in April to improve the mealtime experience of our patients.
Appendix 2
Nutrition education training has been delivered across the UHB to a range of staff including qualified nursing health care support workers and facilities staff. Nutrition nurses have a rolling programme of training for nasogastric tube placement, gastrostomy aftercare and competencies delivered to both qualified nurses and medical students 48

Training	Frequency	Staff Group	Numbers attending
'Online'			
All Wales Food and Fluid chart e-learning	On line	Available to all staff groups	
Induction/Foundation			
Nurse Foundation Training inc sessions on enteral feeding, ONS and HCS 2.5	X4 per year (3 hours)	Newly qualified Band 5 staff (not women and children's services)	X20-30 per group at each
HCSW Induction training	12 per year	HCSW	20 at each
General Nutrition and Dietetics			
Agored Unit NH22CY024	xFour per year	HCSW	X 6-8 at each
Essential Ward Based Catering training inc allergen updates	Ongoing, all sites	WBC and supervisors	Have delivered 7 sessions this year x 10 staff at each
IDDSI updates for WBC	All sites, x1 event	WBC and supervisors	100 staff in total and ongoing

The following are the collated responses from a recent CHC visit food and drink review.
Appendix 3

ASSURANCE is provided by:

The following collated responses have been sourced from the Health Care Monitoring System within corporate nursing

1) **What is your clinical boards percentage compliance to**
a. **Undertaking nutrition risk screening within 24 hours of admission?**

Children & Women- 99.59%
Medicine- 93.83%
Mental Health- 86.67%
Specialist- 95.72%
Surgery- 96.36%

b. Weighing patients within 24 hours of admission?

Children & Women- 100%
Medicine- 93.53%
Mental Health- 98.82%
Specialist- 95.51%
Surgery- 89%

2) Describe the strategies within your clinical board to ensure that inpatients are prepared for a mealtime with respect to:

a) Preparing the environment
Patient tables/trolleys are cleared of any clutter and cleaned, and placed near the patient. Some areas have lunch clubs and will ask patients to join a group of patients to socialize whilst having their meals

All of our wards try to protect mealtimes with varying degrees of success; the Health Board fully supports the principles of John's campaign in families' involvement at mealtimes.

b) Preparing the patient
Patients are assisted to wash hands or use hand wipes, ensure that they are positioned correctly to eat meals and ensure appropriate oral care/dentures are available. This was a particular focus within the model ward. Mobilising patients to and from bathroom facilities before and after meals supports the Health Board's focus on preventing deconditioning.

C) Supervision of the mealtime
The principles of John's campaign and the Model Wards for Nutrition & Hydration has a renewed focus on mealtime supervision and roles and responsibilities.
Directorates employ protected mealtimes wherever possible barring emergencies/urgent patient issues, except unscheduled care. Carers are able to support patients during meal times if required. Patients being specialled are supported by their nurse.
Bed plan identifies patients requiring assistance and identified at safety briefing.
Parents supervise their own children at meal times, if parents not present which is rare, then play specialists/HCSWs supervise
Where possible qualified staff are allocated to oversee mealtimes but again this is dependent on to acuity of the patients on the ward. The Nutrition & Hydration Bedplan is available in all areas across the UHB. Nurse handover information and safety briefings includes key information from the bed plan.

3) Health standard 2.5 states 7 beverage rounds should be undertaken within a 24 hour period. Facilities services are responsible for 6 of these, nursing teams should undertake the 7th at bedtime. Across your clinical board what is the percentage compliance with a nursing bedtime drinks round?

Children & Women- 66.67%
Medicine- 73.08%
Mental Health- 100%
Specialist- 63.64%
Surgery- 86.67%

Results from dietetic nutritional screening audit attached. This was presented to the Nursing clinical standards and innovation group. Model ward data showed significant improvements in screening within 24 hrs of admission compared to baseline
Appendix 4 and 5

RECOMMENDATION

The Board is asked to:

Note the following improvements in actions that were identified as key deliverables for 18/19 from audit work and direct questioning;

- Roll out of model ward to additional wards currently achieved over 4 wards A4 C6 E2 and E4
- Explore where within the Core Patient Risk Assessment booklet a tick box is best incorporated which asks the question 'Has the patients been asked about their dietary needs on admission and has this been recorded on the bedplan?' This will be incorporated in to the e-nursing documentation
- Continuation of annual nutritional audits to allow comparison with self-reported compliance from the clinical boards - continuing
- Evaluation of new 2 week menu and enhancement to incorporate finger foods and special provisions for MHSOP and longer stay areas
- Roll out across the UHB coloured crockery for adults and paediatrics and audit its use achieved
- Continue to increase the uptake in attendance of nasogastric tube and gastrostomy study days and competencies
- Champion the nutrition and hydration training for the multidisciplinary team and incorporate additional multi-media messaging around nutrition and hydration practices.
- Implementation on the actions of the Patient Safety Notice (PSN045) with introduction of International Dysphagia Diet Standardisation Initiative (IDDSI) and ceasing use of 'soft'
- Food allergen risk assessment review of the menu through coding
  Dietetics co-chair for the work for an All Wales screening tool linked to e-documentation
- Implementation of Nutrition and Dietetic service in the emergency unit at UHW for the Winter period. Scheme finished on the 31st March 2019

New challenges

- The Nutrition & Hydration Bed plan to be embedded in ward routine and processes as the tool that is used to record patients dietary needs and for the Nursing and Midwifery Board to mandate its use for all wards across the UHB requires further work
- Ward managers take up the role of supporting the implementation of the bed plan on the ward through raising awareness of the benefits of using the tool and auditing its use on the ward
- Review the role of the qualified nurse in overseeing the meal service and develop a role profile
- Ensure new descriptor for dysphagia (IDDSI) knowledge is embedded across the Health board
- Development of a suite of models of delivery for nutrition training offer in the light of reduction in nurse induction time
- Address concerns highlighted in the CHC visit and HIW report around nutrition and hydration at front door following. No funded dietetic service in the Emergency Unit
- Subject to business case approval the Implementation of All Wales catering IT system

- Roll out of model ward for Nutrition and Hydration to other wards in the UHB subject to a funding stream

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	y	6. Have a planned care system where demand and capacity are in balance	y
2. Deliver outcomes that matter to people	y	7. Be a great place to work and learn	y
3. All take responsibility for improving our health and wellbeing	y	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	y
4. Offer services that deliver the population health our citizens are entitled to expect	y	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	y
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	y

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	y	Long term	y	Integration	y	Collaboration	y	Involvement	y

Equality and Health Impact Assessment Completed:	No *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

2.5 Nutrition and Hydration 1

Primary Outcome

People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury

Criteria

People's nutritional needs and physical ability to eat and drink are assessed, recorded and addressed. They are reviewed at appropriate intervals and are referred to Nutrition and Dietetic services as required for specialist advice and support.
People with swallowing difficulties are assessed by a Speech and Language Therapist and where necessary training in assisting people to swallow food or drink is safely given.

Where food and drink are provided: a choice of food and drink are offered which is prepared safely and meets the nutritional, therapeutic, religious and cultural needs of all: and is accessible 24hours a day. People are provided with therapeutic diets in accordance with their medical needs and are encouraged to eat nutritious, varied and balanced meals hygienically prepared and served at regular times.

If a meal is missed, alternative food is offered and /or snacks and drinks accessible at any time.

Evidence

- All Wales Nutritional Care Pathway is embedded in daily practice.
- Nutritional screening is completed in accordance with policy.
- Wards have weighing scales and height measures in good working order.
- Swallow assessments are completed and recorded within 24 hrs of admission.
- Training is given in assisting people to swallow .
- Audit reports recommendations are acted upon.
- Food & Fluid charts are completed in accordance with policy.

- Food & drink procurement complies with All Wales procurement contracts and EU food labelling legislation.
- Patients receive information about meal service i.e. access menus and information about meal and beverage times.
- All Wales Standards for Accessible Communication and Information for People with sensory loss is acted upon. Patients with sight loss are given menu info in a format that meets their needs.
- All menus are fully compliant with All Wales Menu Framework to meet Food & Fluid Standards.
- The range of menus available demonstrate therapeutic, religious and cultural needs of staff ,patients, visitors and carers are addressed and 24 hr access to food and drink is facilitated through provision of snacks at ward level.
- Communication occurs between nursing and catering services to ensure the correct meals are provided to all patients as specified on the up to date Nutrition & Hydration bed-plan.
- Healthy options are provided and promoted to staff and patients where appropriate
- Patient experience and satisfaction survey are used to monitor and improve the patient meal and beverage service.
- Independence with eating and drinking is promoted for all patients.
- A registered nurse supervises the meal and beverage service and nursing staff routinely engage in the mealtime process.

- Snacks are available for patients who are hungry between meals or miss meals.
- Higher energy snacks are available for those patients with increased needs

2.5 Nutrition and Hydration 2

Primary Outcome

People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury

Criteria

Evidence

Criteria	Evidence
Food and drink are served in an acceptable setting, with minimal interruption attractively presented and at the right temperature.	•Protected mealtimes is embedded in ward routine. •Dining rooms are used to encourage social interaction where possible. •Patients are positioned correctly prior to receiving meals and bed tables and communal areas are cleared and tidied in readiness for meals. •Meals are placed in easy reach for all patients who are eating •Patients are given the opportunity to go to the toilet, wash and cleanse their hands with hand wipes prior to eating meals. •Patients with sight loss are supported throughout the mealtime, by describing the meal and where it is on the plate and where water jugs are located for ease of access.
If eating and /or drinking cause people difficulties, they receive prompt assistance to eat or drink, encouragement and appropriate aids or support. Carers and family members who wish to support people at mealtimes are encouraged and enabled to do so.	•Patients are asked if they require assistance at mealtimes routinely. •Assisting patients to eat and drink is made a priority task within daily ward routine. •Carers and family members are welcomed at mealtimes to assist relatives. •Provision of feeding and drinking aids are provided where necessary.
Fresh drinking water is available at all times and water and appropriate fluids are encouraged throughout the day for people to meet their hydration requirements, except when restrictions are required as part of treatment.	•All staff are aware of the importance of drinking regularly and actively promote it. •Water jugs are changes 3 times a day. •Water jugs and glasses are accessible to everyone. •Where patients need help to access water there is an agreed. process to ensure assistance is offered regularly.
People are supported who require artificial nutrition support via enteral and parenteral routes.	`Prompt referral is made to Nutrition and Dietetics service when patients require artificial feeding via the enteral or parenteral route.

Cardiff and Vale UHB

Terms of Reference and Operating Arrangements

Nutrition and Catering Steering Group

CARDIFF AND VALE UNIVERSITY HEALTH BOARD
NUTRITON AND CATERING STEERING GROUP
TERMS OF REFERENCE

1. INTRODUCTION

1.1 The UHB's Standing Orders provide that '*The Board may and, where directed by the Assembly Government must, appoint Committees of the LHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*'.

2. PURPOSE

2.1 The purpose of the Nutrition and Catering Steering Group is to:

- To assure the Board that the nutritional care and needs of all patients and staff are identified, managed and delivered in the context of Health and Care Standards 2.5 nutrition and hydration. This assurance will be demonstrated by the delivery of the requirements of Trusted to Care report , All Wales Nutrition and Catering Inpatient Standards for Food and Fluids, and any other standards relating to catering, nutrition and hydration;
- To consider and respond to the work to achieve the Corporate Health Standard;
- To monitor the Public health restaurant & healthy retail Standards to ensure that patients, staff and visitors have access to healthy food;
- To ensure the broader public health agenda is considered
- To receive internal/external reports and form appropriate action plans;
- To review user feedback and outcomes of adverse events to enhance the patient experience;
- To inform the Board of any constraints or concerns regarding the above assurance
- To provide strategic direction which enables the delivery of high standards of patient experience, relating to nutrition and hydration.

3. DELEGATED POWERS AND AUTHORITY

The Group will, in respect of its assurance role, seek confirmation that systems and processes are designed and operating efficiently and effectively within all relevant Division's to ensure the provision of high quality nutrition and catering services and care.

Further the group will ratify procedures and written control documents

within the delegated authority from the Quality and Safety and Experience Committee.

3.1 Work programme:

To achieve this, the Group's work programme will be designed to ensure that, in relation to all aspects of nutrition and catering:

- Lead in the implementation and assessment of Health and Care Standards 2.5;
- To develop and implement a communication network to actively engage the wider workforce involved in the provision monitoring and quality of services provided to patients to meet their nutritional and dietetics requirements;
- To develop strategies to ensure catering, clinical services, management and finance work together to improve the nutritional and dietary support of patient by providing services targeted to patients' needs and expectations;
- To ensure clinical boards take appropriate actions on the outcome of monitoring and auditing which will result in an ongoing evaluation of policies and delivery of procedures in the light of evidence based practice and other indicators;
- The development of a framework in which screening, assessment of patients' requirements, hospital food, nutritional support, monitoring and audit are an integral part of patient care;
- To ensure the workforce is appropriately, trained, supported and responsive to the needs of the patients, ensuring that professional and legal standards are met;
- Work Programme to ensure the needs of the wider non-patient population are met e.g. to ensure implementation of the healthy retail criteria are met;
- To support and enable the delivery of the Food Action Plan;
- To receive the minutes/action plans of the Catering Steering Group, to ensure a system of assurance that standards policy etc are being met;
- To develop a set of key internal and external quality performance indicators which will be regularly monitored, assessed and reported on.

3.2 Access

The Chair of the Group shall have access to all Executive Directors and other relevant senior staff.

3.3 Sub Groups

The Group may establish sub groups and task and finish groups to carry out specific aspects of business and feed their activity into the Group.

4. MEMBERSHIP

4.1 Members

The group will comprise of:

- **Chair**: Executive Director Therapies and Health Science
- **Vice Chair**: Head of Dietetics
- Head of Operational Services
- Independent member
- Operational Service Manager(s)
- Clinical Board Senior Nurse Representatives (Medicine, Surgery, Mental Health, PCIC, Specialist Services, Women and Childrens)
- Medical representative
- Patient experience
- Member of Patient Quality and Safety team
- Dietetic representative
- Head of Speech and Language Therapies (or representative)
- Staff Side representative
- Public Health representative
- Member of Cardiff and Vale Community Health Council
- School of Healthcare Studies (Cardiff University) representative

(Each member to indentify one designated deputy)

4.2 Attendees

Other representatives may be requested to attend from time to time as required by the Group Chair.

4.3 Secretariat

The Secretariat function for the Group will be provided by the Dietetic service.

5. STEERING GROUP MEETINGS

5.1 Quorum

At least five members of the Group (or deputy) must be present to ensure the quorum of the Group, one of whom should be the Group Chair or Vice Chair.

5.2 Frequency of Meetings

Meetings shall be held no less than quarterly and otherwise as the Chair of the Group deems necessary – consistent with the UHB's annual plan of Board Business.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 The Steering Group will report to the Quality, Safety and Experience Committee

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Group Chair shall:

Through the Quality, Safety and Experience Committee bring to the attention of the Board any significant matters under consideration by the group.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 **Section A - Introduction**; sub section **Applying Standing Orders**) states the following;

The Standing Orders of the LHB (together with the Standing Financial Instructions and the Values and Standards of Behaviour Framework) will as far as they are applicable, also apply to meetings of any formal committees established by the Board, including any Advisory Groups, sub committees, joint committees, and joint-sub committees.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Group.

Date: September 2017 **Date for review: September 2018**

Report Title:	**BENEFITS OF COLOUR ENHANCING THE PATIENTS MEALTIME: EVALUATION OF MELAMINE BLUE CROCKERY**								
Meeting:	Charitable Funds Committee						**Meeting Date:**	19 March 2019	
Status:	**For Discussion**		**For Assurance**		✓	**For Approval**		**For Information**	
Lead Executive:	Fiona Jenkins								
Report Author (Title):	Head of Nutrition and Dietetics								

SITUATION

The Charitable Funds Committee requested an evaluation of the benefits noted as a result of the use of blue crockery purchased with funds from the Cardiff and Vale Health Charity.

REPORT

BACKGROUND

Two tone blue crockery, including plates, bowls, and cups, have been introduced on wards across all Cardiff and Vale UHB. Evidence shows that vibrant colour and a high colour contrast between food, plate and table helps to increase appetite and food intake. Appetite is often affected during a hospital admission leading to a reduction in food intake which can increase the time taken to recover.

The introduction of the crockery across all sites in the Health Board was completed on the 15 June 2018. The first phase saw an introduction of the crockery across the University Hospital Llandough, Barry Hospital and wards B6 and A4 at the University Hospital of Wales.

The crockery was next rolled out to the Noah's Ark Children's Hospital for Wales, with the remainder of the UHW site, Rookwood Hospital and St. David's Hospital being completed by 15 June 2018.

This service initiative is an example of how different departments within the UHB have worked collaboratively with both each other and the charity to achieve our long-term, preventative, health and wellbeing goal.

ASSESSMENT

The roll out of the crockery was successful using the phased approach as there was over 10,000 pieces needing to be distributed across the Health Board and facilities and dietetics worked together to achieve this.

The benefits to patient experience include:

- The crockery incorporates a non-slip base and a deep lipped rim which stabilises the plate and enables patients to be more independent, it limits the need for additional adaptations or staff support and is effective at each meal time. This enhances patient dignity independence and meal time experience, and supports the patient's safety.
- The blue crockery is made from melamine which mimics china, and enables food to stay hotter for longer, important for those patients that need increased lengths of time to eat or drink.
- Improved meal presentation as the bright colour gives a homely and relaxed feel to mealtimes. The improved appearance of the food has been proven to stimulate patients eating and hydration.

- The colour contrast between the food and the crockery allows patients to see the food more clearly, which again, increases their appetite.
- The coloured crockery can increase food intake due to the colour contrast. This has beneficial impacts on patient nutrition. Further, this means that it can reduce food waste across the UHB .

Patients reported
‘’very eye catching, it gives a nice homely feel’’
‘’ the plate is easier to eat from, I don’t have to chase my plate around the table now’’
‘’the cups are so much easier to hold and pick up’’

Staff reported
’the plates look so much nicer, so the food looks nicer, and patients are happier’’
‘’we can get so much more in the cups, so patients are drinking more’’
‘’The crockery is wonderful, from the colour and design perspective, patients can access their food and drinks more independently with increased confidence now’’

The crockery distributed in the first phase has now been in circulation for over 18 months. Some wear and tear is starting to appear on the crockery and we are in negotiation with the company to address these as they are under a lifetime guarantee.
Despite a lifetime guarantee this does not include damage from dropping and microwave use. They are not designed to be used in a microwave.

Also due to the look of the new crockery the Health Board has experienced some thefts of the crockery and there are plans to develop a business model which enables patients or relatives to purchase a set of the crockery and reinvest the income in the UHB stock so we have sustainability of the supply chain. The income achieved through this route would be invested in the UHB crockery.

RECOMMENDATION

The Committee is asked to note :

- There is potential for developing a business model which enables patients to purchase the crockery and reinvest the income to the UHB stock so we have sustainability of the supply chain.

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB’s objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities	Y	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	Y	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	Y	8. Work better together with partners to deliver care and support across care sectors, making best use of our people	

		and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	Y	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	Y
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	Y

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	Y	Long term		Integration		Collaboration		Involvement	Y

Equality and Health Impact Assessment Completed:	Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Food and Drink Review

Community Health Council Report

March 2019

Cardiff & Vale UHB

Response
to
Recommendations

Cardiff and Vale UHB response to CHC Food and Drink Review March 2019

Part 1 Introduction

We welcome the feedback from the review and note the improvement from 58% positive feedback to 77%.

Please see our collated responses to the six areas considered and the resulting recommendations:

Part 2 Understanding the patients' needs

Recommendation 1a: to carry out an audit to test the consistency of policy and practice relating to the way staff share information about patients' food and drink needs

An annual audit will be undertaken and will be part of the workplan of the Nutrition and Catering Steering committee, chaired by Fiona Jenkins Executive Director of Therapies and Health Sciences.

Recommendation 1b: to provide a report to the CHC detailing the results of the audit and explaining any differences or inconsistencies in policy and/or practice between wards and hospital sites

The nutrition and hydration bed plan is the Health Board safety tool for documenting and communication of nutrition and hydration needs between the dietitian, nurse, speech therapist and catering staff.

It is a computer generated information tool sited on clinical workstation and fundamental to the success of providing the right meal to the right patient. It is printed off each day for the Ward based Caterer and guides food and drinks services to patients.

It is available in all clinical areas, it is easy to populate and can be linked to nursing handover sheets.

Training is provided to all newly qualified staff regarding its importance and use in the clinical setting. Audits over the last few years have shown that its use is improving across the HB, and through training, ward based caterers are made aware that they should not serve meals and drinks without this patient safety information.

The 'Read about Me' document is also used to inform staff of the individual patients likes and dislikes, which includes the food that patients enjoy. This has been rolled out across the UHB

Wards may also have additional methods of informing ward staff of patient's specific dietary requirements, through individualised nutritional care plans over the bed signs, and at a glance boards. The preferred route is through the nutrition and hydration bed plan

The UHB undertakes the Health Care Standards Audit twice yearly which incorporates the standard for Nutrition. This also asks for real time experience and is published throughout the UHB and to Board via the Quality & Safety Committee

Part 3 Informing patients' choices

Recommendation 2: to ensure that all in-patients receive a copy of 'Eating Well in Hospital - What You Should Expect' or a similar document

Ward based patient information folders are available across all wards within the UHB that provides the reader with information regarding the meal and drink services that can be expected whilst on the ward. However they do not contain menu information currently.

Recommendation 3*: to ensure that all patients receive a copy of the current menu on their arrival on the ward and to offer replacement copies if needed

The main patient menu was changed in Feb 2018 from a one week menu cycle to a two week menu cycle, introducing new recipes and extra meal choices. This was in response to patient feedback about monotony and repetition especially within the longer stay units and sites across the health board.

It was identified that the new menu would take some to embed within the catering service, and would probably require site specific amendments, to ensure the food choices and nutritional needs of specific cohorts of patients were fully met and addressed.

It was agreed not to print the menus until such time as the menus for each area had been finalised to avoid wasting resources. Menu posters for each clinical area as well, as internet access to the menu was felt the most prudent and effective means of conveying information to patients in each clinical area. Posters have been refreshed twice in the last year.

It is now felt that the final menus for each areas/site has been finalised and the Health Boards plan is to produce a patient friendly, patient facing menu.

Recommendation 4: to ensure that all patients have the chance to see menus with pictures of the different food options before they order (via pictorial menu or tablet computer)

This is a service enhancement on the service model currently operating now and would require significant investment. However we are piloting a Model Ward on four wards across C&V that utilises such a system and that can facilitate timely menu choices. A review will take place to see its effectiveness and costs involved and a business case developed if deemed appropriate, following evaluation of this system.

The potential for this IT solution is far reaching and is likely to include information terminals at bed sides that would have site specific patient menus loaded with pictures, full allergen and diet information and self-ordering capabilities, including the

ability to state portion sizes, and access to specific meals such as Kosher and Halal or allergen free meals.

Recommendation 5a: to ensure that all day-patients are informed about what food and drink is available on arrival

The UHB will review the signage and booking in to the day services/ outpatient areas to ensure patients are informed on food and beverage provision on arrival

Recommendation 5b: to improve food and drink signage in day-patient areas

Hospital provisions are always being reviewed and the provision of outlets and vending has been significantly enhanced at C&V UHB . Location finding and signage has been updated to reflect this and aids the users to find alternative food and drink provision if required around the UHB. We constantly have user feedback from several sources regarding these site service provisions and review our services and information/signage accordingly.

Part 4 Creating a positive environment for eating and drinking

Recommendation 6*: to remind staff to encourage patients to wash their hands before eating at every mealtime and carry out an audit to check compliance

This standard is being captured via the Health and Care Standards Audit and the findings will be shared with the nursing staff and remedial action plan to follow if required.

There are various initiatives across the UHB focusing on a positive environment during mealtimes to include, Johns Campaign, Natural Wakening, Protected Meat times and improvements to the social environments for eating meals.

During training, all caterers are informed of the importance of good hand hygiene (5 points to hand washing posters are in every kitchen). They are also informed of the importance of wearing the correct food safe and safety PPE during food preparation and meal services. These are constantly reviewed and update training is given to catering staff. Hygiene along with hand hygiene is also audited by the EHO for compliance on a regular basis.

Recommendation 7: to urgently remind all staff of the importance of avoiding use of the term 'soft diet' and to update the CHC on progress in implementing Patient Safety Notice 045.

The term 'soft' to define which particular elements of the main menu are easier to chew, is to be phased out by 31st March 2019.

All IDDSI terminology is to be used from 1st April 2019 onwards.

IDDSI have only recently released the guidance for the easier to chew foods.

Since publishing, the HB has moved forward with re-coding meals on the main menu, providing training for catering staff, and raising awareness amongst nursing. The Health Board will be fully compliant by April 2019. Information on this is included in the ward based Caters Training pack and nursing staff have been engaged in the process..

Recommendation 8: to take steps to improve the availability and quality of separate dining areas on in-patient ward

Where physical space is available, these facilities would be promoted for patient use for dining. On the model wards for Nutrition and hydration day rooms, have been utilised as dining rooms to promote social dining facilities. This will continue to be explored within the Capital Estates programme.

Recommendation 9: to remind all staff to encourage patients to get away from their beds at mealtimes

The Health Board has made considerable changes over the last 2 years to improve the patients eating experience with the introduction the blue freedom crockery across all HB sites. The blue crockery enhances presentation, give patients clear visibility of their food, and its unique design aids independence for all adult and paediatric patients.

A key priority within the health board is to prevent patient deconditioning.

The initiative, End PJ Paralysis has been successfully promoted across the UHB which has now evolved into 'Get Up, Get Dressed, Get Moving' campaign to focus on prevention of deconditioning. The model ward pilot across 4 wards within medicine actively promotes the use of the dining room for patients to eat in at each meal time. Where there are no natural dining areas staff have been innovative with ways in which they can create a social dinning atmosphere. Whilst this is a pilot on 4 wards the positive patient feedback and improvements in oral intake etc. are used in established nurse training.

There are some excellent examples of social dining across the Health Board especially in rehabilitation areas where it is recognised that socialising and eating are essential to recovery and rehabilitation.

Where available these facilities would be promoted for patient use for dining. Model Ward as a principle takes this aspect into the design and recommends this whenever the physical layout facilitates and is widely encouraged by all teams.

Recommendation 10: to take steps to reduce the background noise-level on wards during mealtimes

The UHB is focused on ensuring the principles of Protected Mealtimes are adhered to create a positive mealtime environment and experience

.**Recommendation 11: to clarify what guidance is given to wards regarding permitted interruptions during protected mealtimes**

The nursing staff are committed to ensuring that all meal times are protected from the daily routines to create a positive mealtime environment and experience. However there are exceptions such as the clinical condition allows and individual patient needs.

Part 5 Meeting patients' food and drink needs

Recommendation 12: to improve the amount of choice available at breakfasts

Recommendation 13: To improve the availability of healthy options including a broader range of salads.

Every Menu launch considers this factor inclusively across the teams. This is discussed and assessed with the following factors which need to be balanced: Nutritional standards, Food procurement, Food / Ward Service and Delivery, Implementation and Cost. The Model Ward on trial at C&V has also considered this as an important factor and additional hot breakfast choices are being trialled with good intermediate results and feedback being obtained.

All patients are able to order meals from a menu before meal services, this guides the catering staff with what and how much to prepare and deliver to the wards to minimise food waste..

3 courses are available for patients to choose from at every meal time, and comprises of a starter, main meal and a dessert options.

It is acknowledged that patient only have one choice of starter at lunch time (fruit juice) this is due to supply issues of soup from the company and logistical issues with production across the different sites.

Soup is a more frequently requested as a main menu item, especially post-surgery and amongst our frail elderly patients, catering are able to facilitate provision outside of the menu.

At every meal time there are 3 main meal and dessert options to choose from, plus an A La Carte menu that provides additional meal choices for patients either with very specific dietary requirements, and for those patients in the longer stay areas of the health board that have fatigued of the main menu options.

Some shorter stay surgical or assessment unit's areas across the UHB do have limited choices for lunch, due to the nature of the patient and patient length of stay. There is work ongoing to improve the communication between nursing and caterers regarding bed occupancy to prevent over or under production of food. It is hoped that the Catering IT solution will add precision to ordering and waste reduction in the near future.

The UHB menu does include a greater range of dishes that would appeal to a more traditional taste; however the new menu has introduced a greater number of modern

dishes that would appeal to a younger cohort of patient. These include dishes such as Pork and pineapple Balti, beef curry, chilli con carne, Pasta, Chicken Arrabiata etc.

Significant work has taken place to improve the presentation of meals to patients including the introduction of new crockery, as well as presentation guidelines for catering staff. This forms part of the work on the model ward pilot, and will be expanded out to all wards and sites

A reduction of processed meats within the menu took place when the menus changed in 2017, to ensure compliance with the guidance from the All Wales Food and Fluid Standards.

The sweet trolley that went around the wards at Llandough stopped a few years ago when the retail outlets in the main entrance opened. The plan is to relaunch the WRVS trolley with a range of nutritious healthy snacks that comply with retail outlets food standards

There are 3 meal time drinks rounds and 4 in-between meal drinks rounds each day. It is the responsibility of the ward caterer to undertake 6 of the 7 rounds and to ensure the hydration station is fully stocked for each round.

Recommendation 14: to engage with young patients to explore ways to make the menu more appealing to them

From valued feedback, we have already listened to our children and teenage patients and provide an alternate but limited option in our Children's Hospital. Our trial Model Ward and a new IT system could also enhance this and standardise menus to enable us to offer more flexibility and choice. Any such system however would require investment and a business case to be fully supported.

For sites where the client group is largely younger and longer stay, such as Rookwood Hospital or Maternity, the menu has been altered to include a greater number of modern dishes, as well as more salads and snack meals.

There is a constant review of dishes produced through the central processing unit with planned development of more vegetarian and vegan dishes which can be accessed both through the main menu, and the A La Carte menu.

We are currently reviewing the range of gluten free and allergen free meals that we offer patients through the main and A La Carte menu. It is hoped to increase the range of allergen free meals and training is currently being delivered to ward based catering staff to ensure all patients are appropriately advised which main menu items would also be suitable for specific dietary restrictions.

The main patient menu does include a choice of salads or snack type meals such as jacket potato and filling, soup and sandwich, or omelettes at almost every meal time. Surveys and patient feedback in the past, as well as usage figure have shown that the roast meals and casseroles are generally the most popular menu dishes, and are most frequently requested across all sites.

All the recipes and dishes used within the main patient menu are All Wales Menu Framework (AWMF) compliant and approved by the shared services procurement dietitian. The main emphasis of the menu is to support patients nutritionally at a time when their appetite can be compromised and requirements are altered, the menu seeks to providing a balance between meeting the needs of those who are nutritionally compromised, and those in the recovery phase whose appetites are good .

Recommendation 15: to engage with patients to find out if they would like to access sandwiches during the night

Sandwiches are widely available during the night. Clinical staff can access if and when needed by patients

There are a wide range of snacks available after hours when caterers are not present and these can be accessed through the clinical teams on request. To ensure that this is transparent to our patients C&V UHB will look into producing a "Food Information Poster" for each ward to publish and make available to all patients.

Recommendations 16: to explore the possibility of offering easy access snack areas on wards where patients could help themselves to snacks and drinks during the day and night

Recently the HB has purchased new hydration station trolleys for all wards and sites, to ensure that all patients are offered a variety of hot and cold drinks and there is clear visibility to the patient of the range of snacks available to choose from at each drinks round.

Recommendation 17: to ensure that all patients are fully informed about what snacks are available during the day and night.

Nursing staff are aware that they can offer a range of snacks out of hours as per patient request

.**Recommendation 18: to put in place systems to check that every patient is offered an evening snack**

Nursing staff are aware that they can offer a range of snacks out of hours as per patient request.

Recommendation 19*: to ensure that all patients are offered fresh fruit as a snack on all wards and to provide a broader range of healthy snacks

We are aware that patients value the access to fresh and prepared fruits across the day. As part of the model ward pilot, preparation and service of fresh fruits, fruit juices and fruit pots form part of the daily activities, which patient value and enjoy. It is hoped that this practice will be expanded out to all ward areas in the near future.

There are constraints around Environmental health in terms of additional washing and preparation of fruit and this is being explored with infection control

Recommendation 20: to put in place systems that ensure that all patients who miss a meal are offered a replacement meal

The new proposed IT system will flag up to the catering supervision teams any patients who have not had a meal or missed a meal on any day. These patients will be offered under Model Ward conditions a suitable alternative food option later on in the day. Outside of meal times there are various choices of food that can be offered to patients without compromising food safety and nutritional standards. These options include cereals, biscuits, cheese, crackers, cakes, bread and butter.

All nursing staff are aware that they are able to obtain meals and snacks for patients who have missed the general mealtimes due to their clinical condition or clinical pathway.

Out of Kitchen working hour's, the access to food and meals is an issue that we are trying to overcome especially on the Mental Health for Older Peoples wards (MHSOP) we recognise that this is not ideal and we do have some environmental health and food safety issues to overcome first, before we can move forward. The Dietetic Catering and Nursing teams are in discussion regarding a way forward.

Access to a meal if missed at a meal time should be straight forward providing the kitchen is open and working. It is recognised that there needs to be ward based information for nursing instructing them how to access these missed meals. This will be actioned.

Part 6 Providing High Quality Service

Recommendation 21: To ensure that patients are always able to order their meals on the same day

This type of service is radically different to the one that is currently offered across both C&V and Wales Health Boards. We are pleased to say however that we have invested in a pilot that addresses this capability and make full use of order on the day processes through our Model Ward Programme in four wards across C&V. This is a step change enhancement on the service currently operating and would require

significant investment in IT and ward based resources; however our pilot is going strong and is being performance managed. A review will take place to see its cost effectiveness and a business case developed if necessary following full evaluation of this system. Any change to this IT system has complex implications to Procurement, Food Production and Service Implications.

It is usual practice for ward based caterers to ask patient what they would like to eat from the menu no more than one meal in advance, the practice of previous day ordering or weekly ordering should not occur. However, this practice is a requirement for the St David's Hospital site. This is a PFI site and as such the model of service is dictated in the sevice specification. It is hoped that the Catering IT solution will allow patients to choose much closer to their meal services.

Despite ongoing projects or initiatives to manage end of service waste, there is always an element of flexibility within the food ordered to allow for patients to change their mind at the point of service.

Patients are able to provide feedback to the health Board through the 2 minutes of you time surveys, or social media platforms such as Facebook or twitter. It is hoped that the Catering IT solution would offer patients the ability to provide feedback at the point of service and enable us to collate trends in different areas/sites

Part 7 Ensuring patients have enough to drink

Recommendation 22: to ask all patients about their preferred portion sizes on arrival and to share this information with catering teams

The Model Ward and its new IT system on trial facilitates patients requesting portion sizes to meet their appetite. We are reviewing whether to switch on in the IT system portion requirements based on the patient's portion preference. This will be evaluated to see if the patient consumes more food and whether food waste is reduced.

Currently there is ongoing training to caterers regarding serving patients the most appropriate portion size to ensure the All Wales Food and Fluid Standards are met. This training includes how to support patients with smaller appetites and how to manage end of service waste by serving second portions where clinically appropriate.

Recommendation 23: to ensure that all patients who finish their meals are offered second helpings

As the report and also internal finding suggest, at Cardiff & Vale is a limited option and we, strive to ensure patients have access to additional food as required. The Model Ward also has this in its principles and second helping should be widely available, as are snacks, fruit or sandwiches.

Recommendation 24: To carry out an audit to test whether wards are meeting the requirements to offer seven to eight beverages per day and to change water jugs three times a day.

Currently on all wards across C&V we provide six beverages in a day. These are provided by our catering staff. A further seventh beverage round is then provided by clinical staff later on in the evening. In addition to this, our ward based caters provide two "water jug" rounds with nursing providing the third. This is being measured twice yearly by the Health and Care Standards Audit.

Recommendation 25: To confirm whether the Health Board is running the 'Drink a Drop' campaign or similar.

The Health Board is not currently delivering the drink a drop campaign. However the hydration of all patients across sites is promoted and the wider multidisciplinary team are encouraged to offer patients drinks at any available opportunity

Model wards for nutrition and Hydration are also addressing the hydration of ward based staff and ensuring their hydration needs are also met.. A recent audit showed that staff go without a drink for many hours During the mid morning and afternoon milkshake round on model wards staff are also encouraged to have a drink of water or squash offered by the dietetic assistant / facilities team.

Nutrition and Hydration week of the 11th to the 15th of March 2019 has been our additional opportunity to showcase the importance of hydration to all staff, carers and visitors across the Health Board.

The model wards for Nutrition and Hydration are a multidisciplinary initiative being piloted for one year on four wards in the UHB funded by UHB charitable funding stream. A performance score card has been developed to measure the cost benefits of the investment, the patient/carer experience and the affordability of this level of investment for the programme to be rolled out across the UHB. .

Conclusions

We are particularly pleased that you have noted the Health Board has recently introduced a model ward programme and your associated comments in relation to it. Almost all the recommendations that are made are elements that we have brought together on model wards to address.

'This aims to improve the patient experience of food and drink in hospital. We have seen positive signs that staff on the model wards are enthusiastic about setting high standards. We hope that the Health Board will expand the programme to improve standards and consistency across all hospital sites.'

UHW WAASP & Weighing Audit

December 2017

Emily Capener, Dietitian
Kate Thomas, Dietitian

Executive Summary
An audit of weighing and nutritional risk screening compliance was undertaken across 27 adult wards over one day in an audit including 652 patients. A randomly selected 15% of patients were nutritionally risk screened by the Dietetic team to compare accuracy with ward scores and risk categories. Performance was measured against audit standards which indicate patients should be nutritionally risk screened and weighed within 24 hours of admission and then at regular intervals throughout their hospital stay. An average 83% had a nutritional risk score (WAASP) within 24 hours of admission, range 61% to 100%. An average 52% had a weight within 24 hours of admission, range 8% to 100%. An average 82% of patients had a 'current' WAASP score, range 50% to 100%. . An average 60% of patients had a 'current' weight, range 16% to 100%. 39% of patients nutritionally screened by dietetics were screened in a different risk category. 13 of these patients, 13% of the sample should have been referred to Dietetics according to a high risk score but had not been. Were this percentage was extrapolated to reflect a UHW Adult inpatient population of ~700 beds it would equate to a significant 273 patients being screened in the wrong risk category and 91 patients missing referral to the Dietitian. Work is needed to address accuracy of nutritional risk screening and performance against weighing standards.

Background
The importance of screening for risk of malnutrition is well recognised with the accepted recommendation that *'every patient is screened for malnutrition on admission and at intervals according with best practice. Any patient identified as such is assessed regularly and appropriate action taken'* (WAG 2004, NICE 2006).
Furthermore, to achieve Welsh Health and Care standard 2.5 criteria stipulate that *'People's nutritional needs and physical ability to eat and drink are assessed, recorded and addressed. They are reviewed at appropriate intervals and are referred to dietetic services as required for specialist advice and support'.*
Local guidance supports these national frameworks. The locally developed and validated 'WAASP' tool is the accepted nutritional risk screening tool for use in Adult inpatients throughout Cardiff and Vale UHB (Appendix 1), with the exception of mental health.

Audit Standards
1. All patients should be screened for malnutrition within 24 hours of admission
2. All patients should be screened for malnutrition throughout their admission to hospital as directed by their WAASP score (repeated weekly)
3. All patients should be weighed within 24 hours of admission
4. All patients should be weighed weekly throughout their admission

Method
All adult UHW wards were included in this audit with the exception of Critical care (A3N, A3S, B3S, PACU, CITU) where blanket dietetic referral is in place and AAU, SAU and SSSU where patients are not classified as inpatients. Maternity where they do not routinely use the WAASP screening tool and data was not collected from C5.
All ward managers and deputy ward managers were made aware that the audit would be taking place via an email sent 48 hours prior to the audit.
The audit was done over 1 day, Wednesday 6th December 2016. All adult team Dietitians were involved in the data collection using the attached proforma (Appendix 2). Instructions were provided to help ensure consistency in audit practice. A timetable was drawn up directing staff to the area they would be auditing.

Separate ‘validation’ teams were put together with the exclusive role of screening a minimum 10% randomly selected sample of patients. These teams each included one experienced senior Dietitian and one experienced Dietetic Support Worker, familiar with nutrition risk screening patients in their day to day job. The random patient selection was done by picking folded numbers from an envelope, tombola style. The patient in the bed number corresponding to the number selected was then nutritionally risk screened by the dietetic validation team. Where the selected bed was empty a new number was selected. Bed numbering schemes were agreed so that they followed the same pattern on each ward. The dietetic validation WAASP scores were then compared with the ward WAASP scores to check accuracy (Appendix 3).

Results

A total of 652 adult patients were included in this audit from 27 different wards.

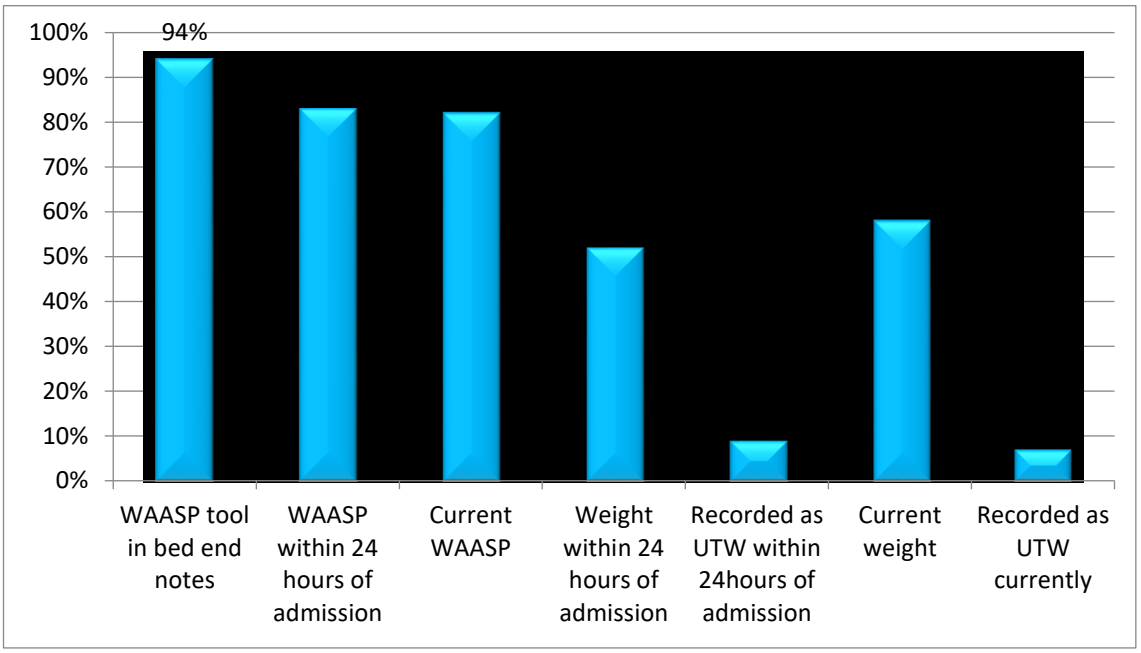


Chart 1: Average audit results over 27 UHW wards

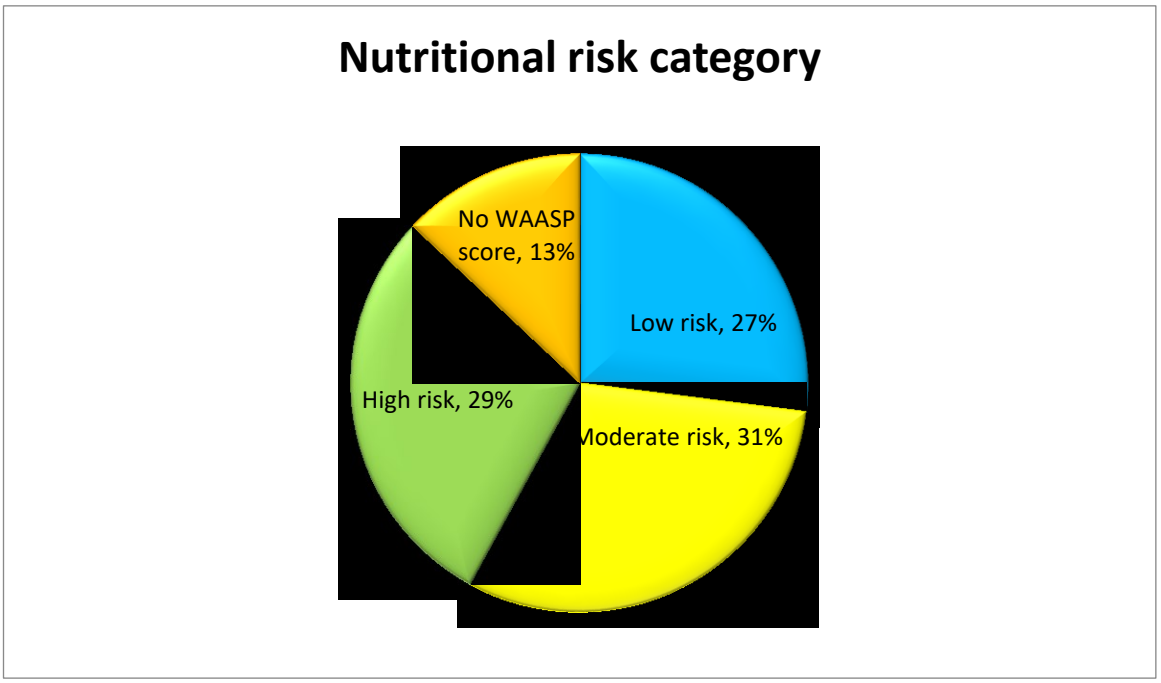


Chart 2: UHW nutritional risk category from ward WAASP score

For the purposes of further analysis, data was examined in the following categories: medicine, surgical and 'other' specialist services. Individual ward data can be found in Appendix 4 and ward rankings in Appendices 5 and 6.

Medicine

Across the medical wards an average 80% of patients were WAASP screened within 24 hours of admission. Practise ranged from 61% (A7) to 100% (A6S).

85% of patients had a current WAASP score, range 71% (A7) to 100% (A6S).

29% of patients were weighed within 24 hours of admission, ranging from 10% (MDU) to 46% (A4). If including UTW patients means an average of 39% with weight/UTW, ranging from 15% (MDU) to 69% (A6s).

An average 43% of patients had a current weight; range 16% (MDU) to 75% (A6S). If including UTW patients results in an average of 50% with weight/UTW, ranging from 20% (B7) to % (100) (A6S).

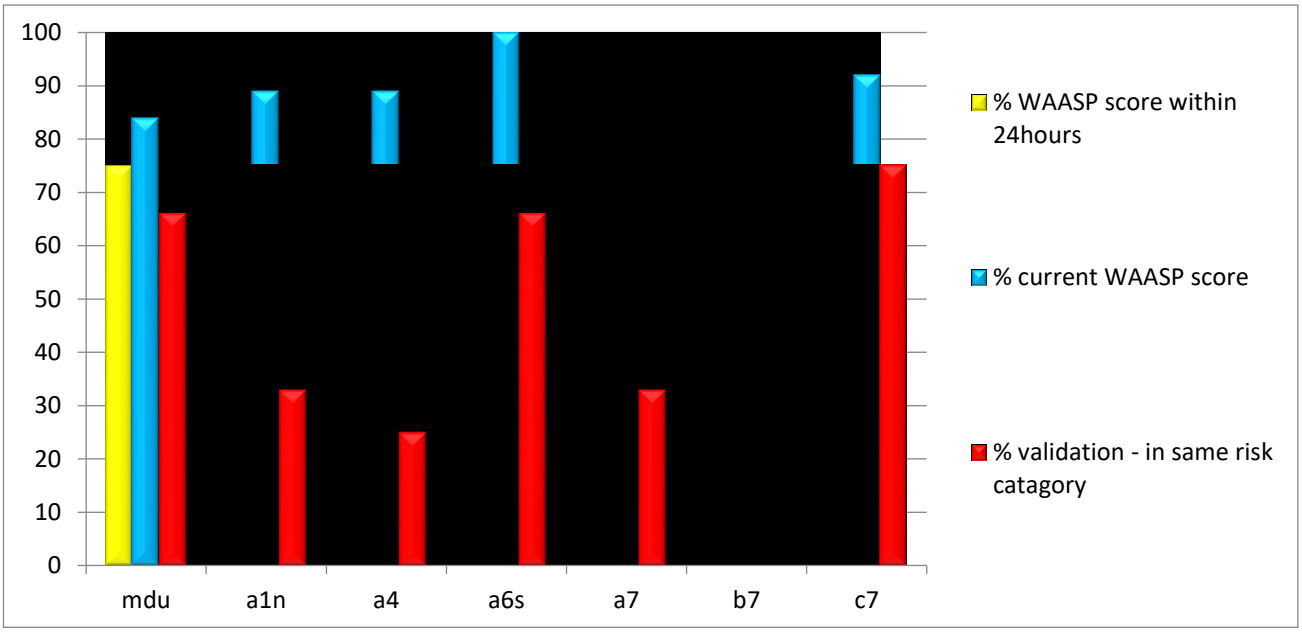


Chart 3: Medical wards WAASP audits outcomes

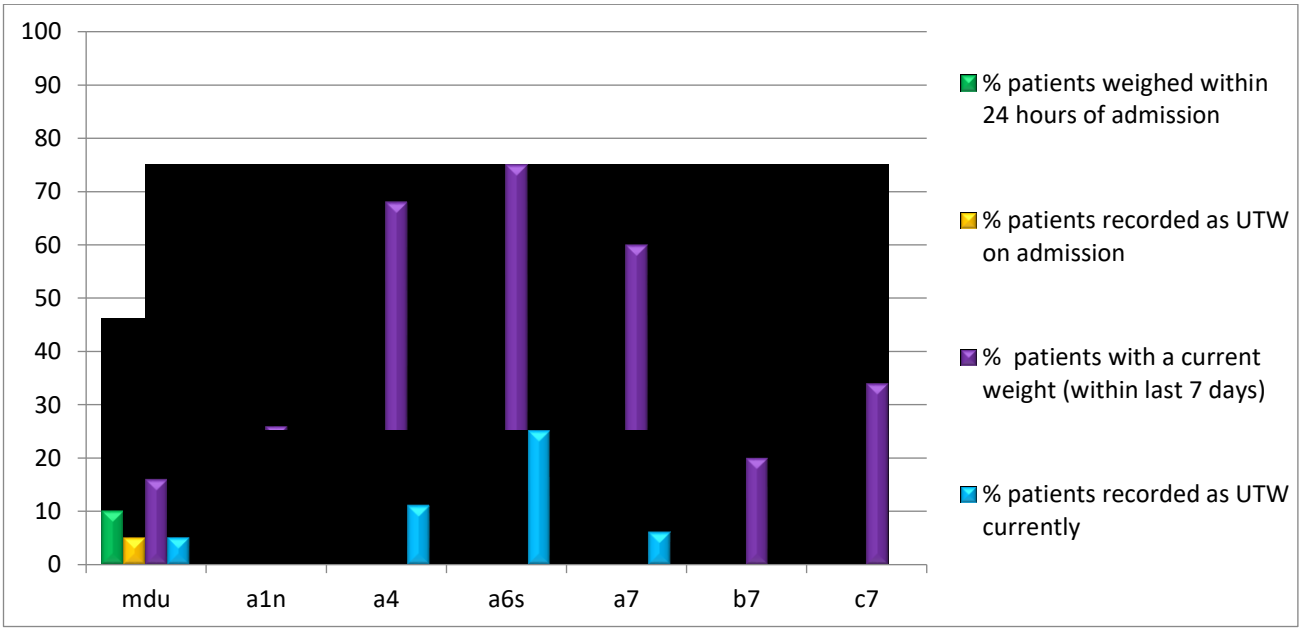


Chart 4: Medical wards weighing audits outcomes

Surgery

Across the surgical wards an average 84% of patients were WAASP screened within 24 hours of admission. Practise ranged from 68% (B2) to 100% (Heulwen)

76% of patients had a current WAASP score, range 50% (A5) to 100% (Heulwen).

49% of patients were weighed within 24 hours of admission, ranging from 8% (B6) to 100% (Heulwen). If including UTW patients results in an average of 59% with weight/UTW, ranging from 8% (B6) to 100% (Heulwen).

An average 55% of patients had a current weight; range 17% (A6N) to 91% (Heulwen). If including UTW patients results in an average of 62% with weight/UTW, ranging from 34% (A5) to 91% (Heulwen).

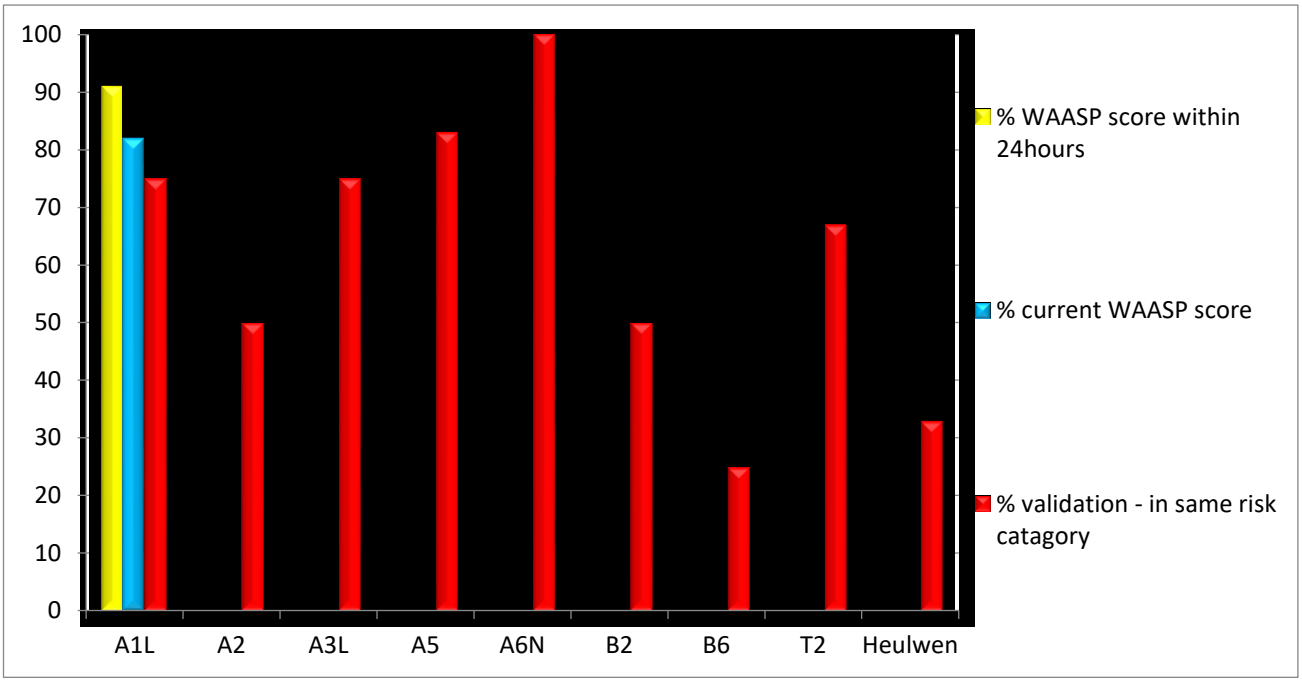


Chart 5: Surgical wards WAASP audit outcome

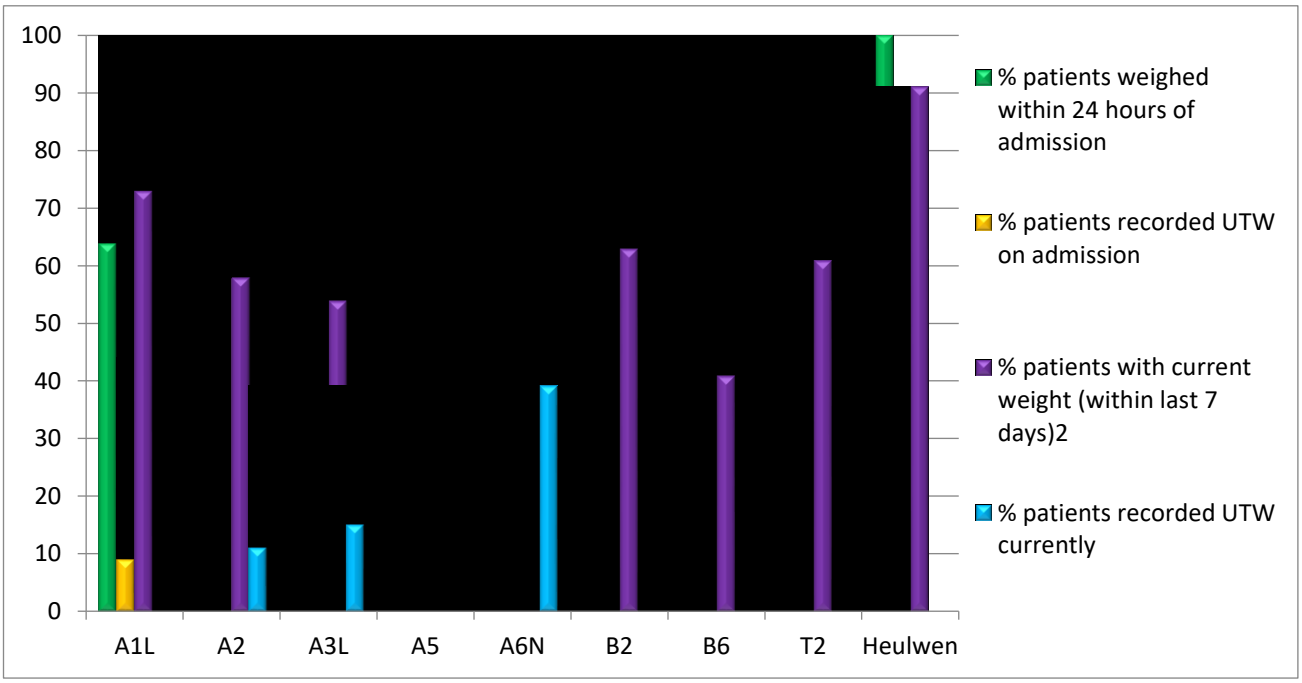


Chart 6: Surgical wards weighing audit outcome

Specialist services

Across the specialist wards an average 84% of patients were WAASP screened within 24 hours of admission. Practise ranged from 68% (B5) to 100% (C3/CCU, T4, BMTU).

88% of patients had a current WAASP score, range 54% (B5) to 100% (T4, TCTU, BMTU).

70% of patients were weighed within 24 hours of admission, ranging from 30% (C4N) to 100% (TCTU). If including UTW patients results in an average of 76% with weight/UTW, ranging from 42% (B%) to 100% (TCTU).

An average 75% of patients had a current weight; range 42% (B4N) to 100% (TCTU, BMTU). If including UTW patients results in an average of 82% with weight/UTW, ranging from 56% (T5) to 100% (TCTU, BMTU).

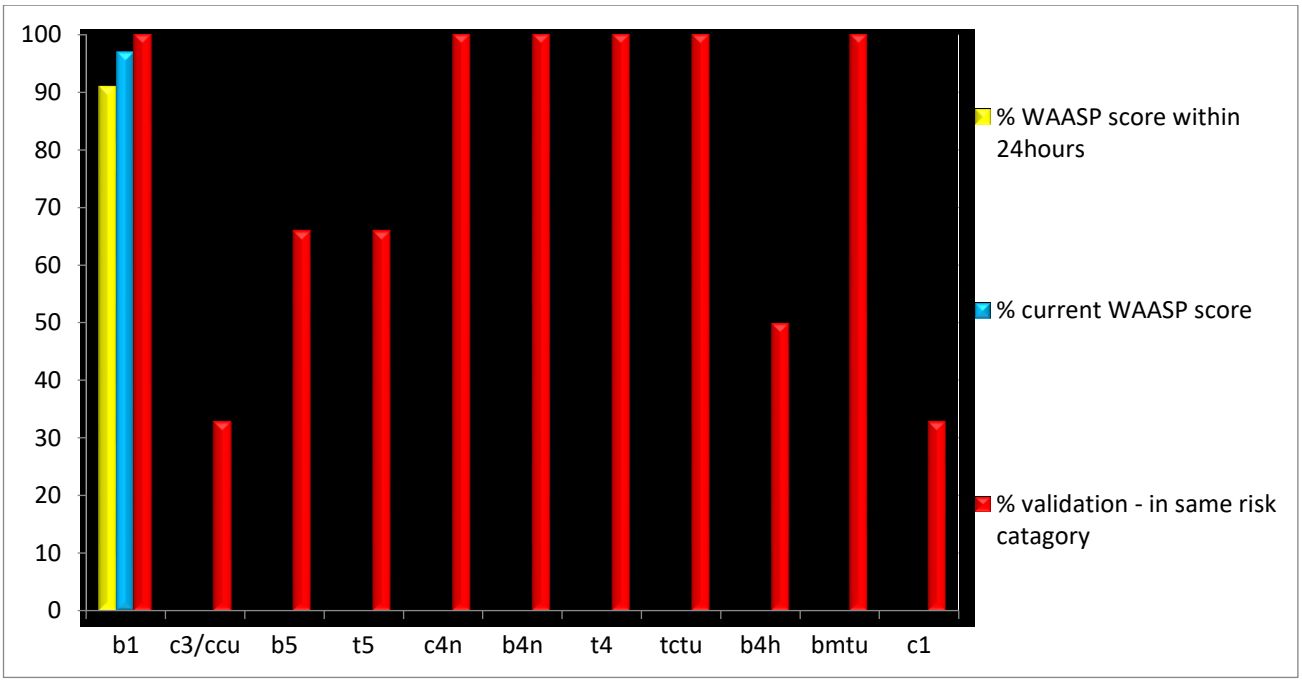


Chart 7: Specialist services wards WAASP audit outcomes

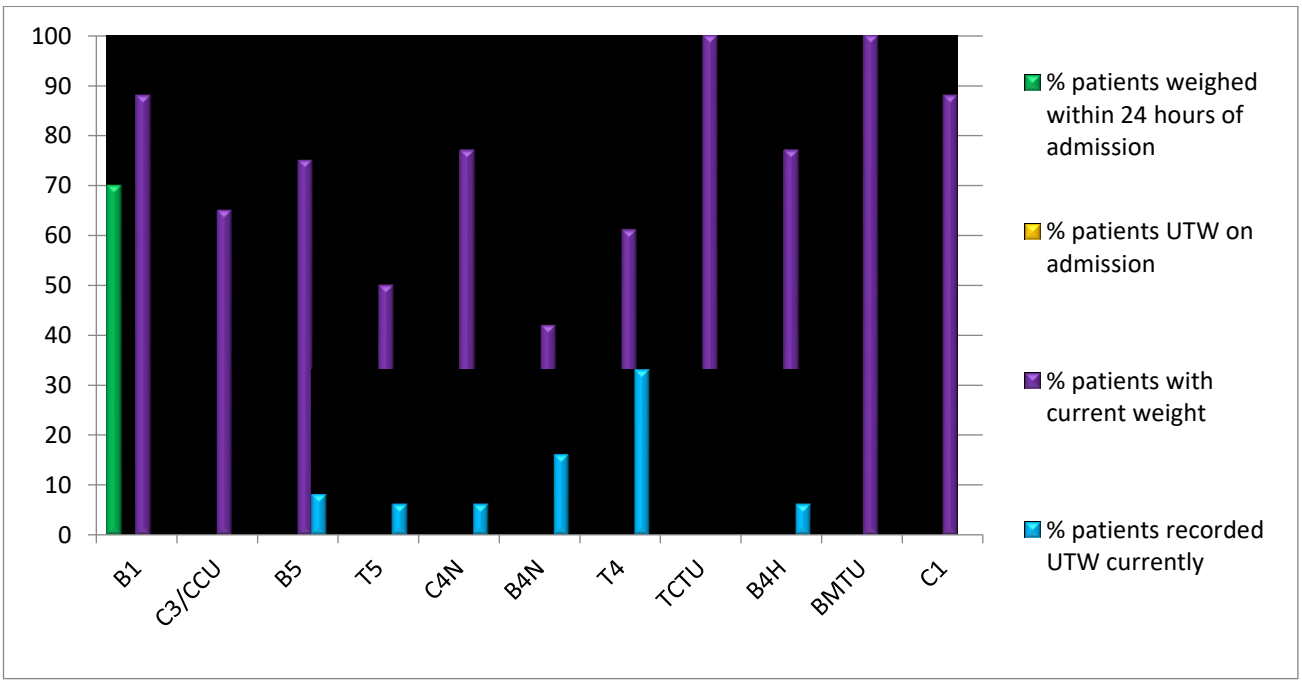


Chart 8: Specialist services wards weighing audit outcomes

Accuracy

We aimed to complete an accuracy check on a random 10% sample of patients. Ultimately the dietetic validation team nutritionally risk screened 97 patients, 15% of the total sample.

39% of patients screened by Dietetics were WAASP screened in a different risk category. Furthermore, dietetic screening revealed that 13 patients, 13% of the sample, should have been referred to the Dietitian based on their high WAASP score but had not been.

Wards with 100% of ward WAASP scores in the same risk category were A6N, B1, C4N, B4N, T4, TCTU, BMTU. Ward B7 had none of their WAASP scores reproduced in the same risk category. See Appendix 6 for ward-by-ward results.

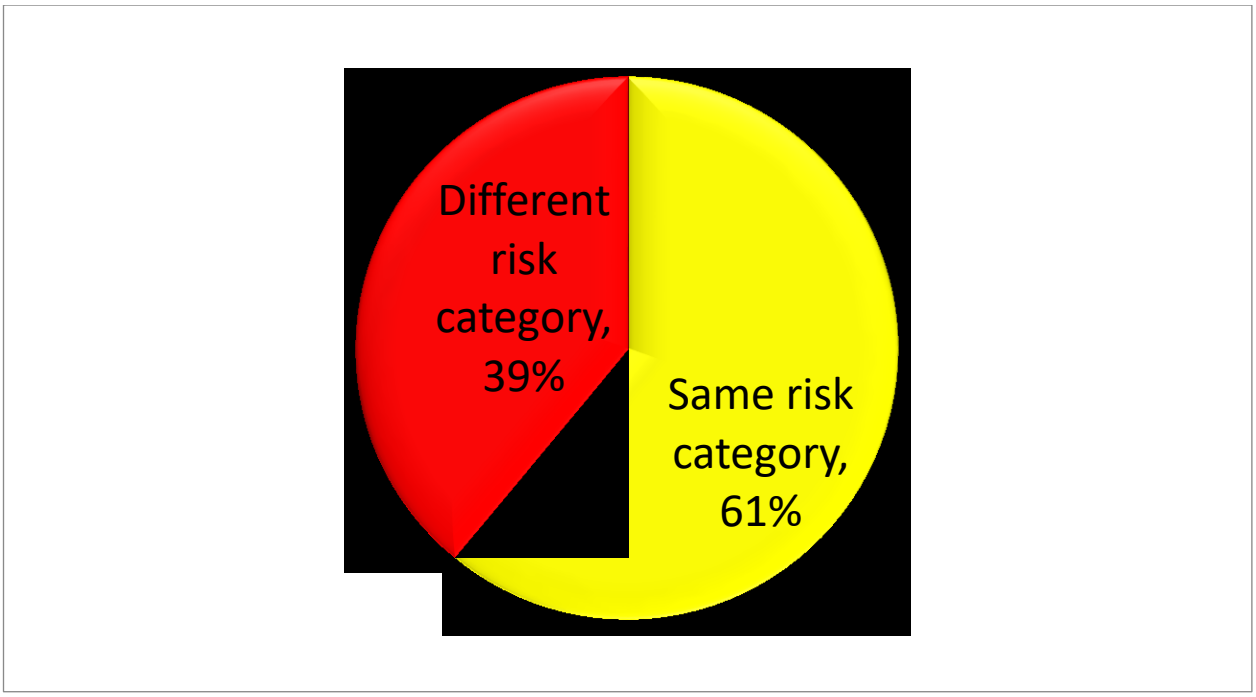


Chart 9: Nutritional risk score validation: dietetic versus ward WAASP

Discussion

Compliance with audit standards 1 and 2 has reduced slightly since last audited across the hospital in 2016. At this time 84% of patients had a WAASP on admission versus the 83% demonstrated in this audit. Accuracy of WAASP scoring also decreased which is a concern with an invalid WAASP score being as worthless as no WAASP score at all. The discovery of high nutritional risk patients that have been underscored and consequently not referred to Dietetics is concerning and hints at potential for a wider scale problem outside of the 13% sampled. If this percentage was extrapolated to reflect a UHW Adult inpatient population it would equate to a significant 254 patients being screened in the wrong risk category and 87 patients missing referral to the Dietitian.

Regular training for new staff in accurate completion of the WAASP tool is needed. The potential for education built into induction programmes or ward 'away' days should be explored in individual areas and agreed between ward management and their nominated Dietitians. There is still widespread use of agency / bank nursing staff in UHW and it is possible that unfamiliarity with the nutrition risk screening is contributing to the errors in scoring.

The largest numbers of discrepancies in scoring arose from the stress factor and appetite categories (see Appendix 6), highlighting that this is a particular area of focus that ward staff require more guidance on completing. The weight scoring section presented the next highest number of errors, reflecting the difficulties posed in interpreting weight, weight loss and BMI in the clinical setting, with only 60% of patients having an actual weight documented.

Interestingly in some clinical areas WAASP compliance improves when looking at 'current' vs on admission scores. Areas include B6, C7, A1L, TCTU, A4, A2, B4H, MDU, T5,C4N, B4N and A1N. It may be that in these areas it is difficult to complete the WAASP core within 24 hours of admission, perhaps given the nature of a sudden acute presentation and need for immediate medical / surgical intervention. Once more stable these patients are then accessible to be screened. Again, in some areas weighing performance improves from 'admission' to 'current' weight. This again is likely due to reasons cited above and additionally as patients are cleared as 'safe' by physiotherapy staff / surgeons for staff to weigh.

Compliance with weighing standards is generally poor across the UHW site. This may be attributable to numerous reasons: equipment availability / condition (e.g. hoist scales), importance afforded to weighing, immobility / unsafe to weigh, patient refusal / declining to be weighed. The majority of patients on B6 are unable to be weighed single handed due to hip fractures which may explain the small number of patients weighed in this area. Very few patients were marked as 'UTW'. This practice should be encouraged for clarity but a reason always cited why patient can't be weighed. This is a future development for the tool.

BMTU, T4, A6S and Heulwen displayed excellent compliance, with 100% completion of all audit standards. This may reflect nursing staff understanding of the importance of nutrition in this clinical area or the requirement for regular weights for accurate prescribing. Additionally it could be representative of higher nurse- patient ratios in these areas.

Maternity services do not WAASP their patients, and therefore were not included in the 2017 Nutrition Risk Screening audit.

Recommendations

- Individual ward results to be shared with ward managers, ward Dietitians and practise development nurses for action planning.
- Regular WAASP training for ward staff. Format to be agreed in clinical areas ward managers & Dietitians. Focus on stress factor, appetite and weight sections.
- Quality improvement projects lead by dietetic staff on certain areas to see which methods are most effective at bringing about improvemet.
- WAASP reliability check for random sample of patients in areas as identified as needing improvement.
- Explore reasons for poor appetitie performance. Does this correlate with poorly ompleted food record charts within these areas
- Also to look at reasons for incorrect stress factor being selected. Dose the tool need to be adapted ot include a great variety of stress factors, does it need to be clearer to only select one stress factor even if the patient has multiple co-morbidities or is greater training on how to use the screening tool required in certain areas.
- To look at the reasons for poor weighing performance. To consider setting of site wide targets for improving weighing compliance. Addition of a 'reasons for UTW' section on WAASP tool at next re-design / print run.
- Annual re-audit across UHW and UHL and paediatrics. Consider repeating in different seasons to assess seasonal variation. As it stands both of the last audits hav been completed over the winter months.
- Action plan to be disseminated via Nutrition and Catering Steering Group.

Appendix 1: WAASP tool

Cardiff and Vale University Health Board
NUTRITIONAL RISK ASSESSMENT (version 3 January 2013)

Addressograph

Guidelines for completion

- Complete assessment within 24 hours of admission to hospital
- Weigh patient (if unable, ask the patient or relative to estimate weight)
- Select the **highest** score that applies in **each** section
- **Add** the score of each section and record the **total** score in the box below
- Set the review date as appropriate depending on the total score
- Date and initial each entry

Date							
Weight (kg)							
Score							
Initial							

S CORE and ACTION

0-2 LOW RISK

- Repeat the WAASP assessment in one week

3-6 MODERATE RISK

- Assist with meal choice – items marked ★ indicate the building up choices
- Encourage to eat at mealtimes and assist to feed if required
- Encourage milky drinks and snacks between meals
- Commence patient on the All Wales Food record chart
- Repeat the WAASP assessment in one week

7+ HIGH RISK

- Commence patient on the All Wales Food record chart
- Refer to the Dietitian
- Repeat the WAASP assessment every 3 to 7 days (minimum every 7 days)

Referral to the Dietitian should be made irrespective of WAASP score if the patient:

- Requires or is receiving artificial nutrition i.e. NG, PEG, TPN feeding
- Reports the use of nutritional supplements on admission

Special diets e.g. gluten free, potassium restriction, milk free should be recorded on the Nutrition and Hydration plan within Clinical Workstation

Note: This nutrition risk assessment tool does not supersede clinical judgement – please refer to the Dietitian if you have any concerns regarding the patient's nutrition

Appendix 1: WAASP tool

Cardiff and Vale University Health Board
NUTRITIONAL RISK ASSESSMENT (version 3 January 2013)

NB: Where more than one score applies per section please select the highest

WEIGHT (consider fluid retention when assessing weight history)	Score
• Weight loss of 6 kg or more (1 stone) within last 6 months, extremely thin or cachexic, BMI < 18.5 kg/m^2	7
• Unintentional weight loss 3kg (7lb) within last 6 months	2
• No weight loss	0

APPETITE	
• Little or no appetite or refuses meals and drinks	4
• Poor – eating less than a quarter (1/4) of meals and drinks	3
• Reduced – eating half of meals	1
• Good – eats 3 meals/day or is fully established on tube feed	0

ABILITY TO EAT	
• NBM for more than 5 days	7
• Unable to tolerate food via gastrointestinal tract due to nausea/vomiting or difficulty chewing/swallowing	4
• Requires prompting, encouragement or assistance to eat and drink	1
• No difficulties - able to eat and drink normally and independently	0

STRESS FACTOR (if clinical condition is not listed, choose a similar condition)	
• Major surgery e.g. oesophagectomy, gastrectomy, bowel resection Head & neck surgery, kidney and pancreas transplant	7
• Moderate surgery e.g. cardiothoracic, kidney transplant, vascular Malignant disease, leukaemia, mucositis Recent multiple injuries/spinal injury/trauma, head injury Severe infection/sepsis, endocarditis, pneumonia, peritonitis Acute kidney injury, renal replacement therapy (HD/PD) Chronic liver disease, chronic pancreatitis, HIV	4
• MND, MS, Parkinson's, dementia, heart failure, COPD, CVA, Fractured neck of femur, inflammatory bowel disease	2
• Uncomplicated condition with no interruption in food intake e.g. MI	0

PRESSURE ULCER/WOUND	
• Grade 4 pressure ulcer or open abdomen	7
• Grade 3 pressure ulcer or dehisced/infected/moderate exudate wound	4
• Grade 1-2 pressure ulcer or non-healing/low level exudate wound	2
• Pressure areas intact, healing or healthy wound	0

Note: This nutrition risk assessment tool does not supersede clinical judgement – please refer to the Dietitian if you have any concerns regarding the patient's nutrition

Appendix 2: Data collection Proforma

UHW Nutrition Risk Screening (WAASP) Audit					**Ward:**					
Bed number										
Patient number										
Date of admission to a ward										
Is there a WAASP tool in the patient's notes?										
Is there a WAASP score within 24 hours of admission?										
Who performed the WAASP score?										
Admission WAASP: Total										
W										
A										
A										
S										
P										
Has the patient been referred to a Dietitian?										
Is there a current WAASP score (within last 7 days)?										
Who performed the WAASP score?										
Current WAASP: Total										
W										
A										
A										
S										
P										
Is there a weight within 24 hours of admission?										
Is there a current weight (within last 7 days)?										

Appendix 3: Validation Proforma

UHW Nutrition Risk Screening (WAASP)			**Ward:**	
Bed number				
Patient number				
Ward current WAASP: Total				
W				
A				
A				
S				
P				
Risk category				
RD / DSW current WAASP: Total				
W				
A				
A				
S				
P				
Risk category				

UHW Nutrition Risk Screening (WAASP)			**Ward:**	
Bed number				
Patient number				
Ward current WAASP: Total				
W				
A				
A				
S				
P				
Risk category				
RD / DSW current WAASP: Total				
W				
A				
A				
S				
P				
Risk category				

Appendix 4: Rank for WAASP within 24 Hours of Admission Compliance

Position	Ward	% compliance
1	A6s	100
=1	Heulwen	100
=1	C3/CCU	100
=1	T4	100
=1	BMTU	100
6	B6	97
7	C7	95
8	C1	94
9	A1L	91
=9	B1	91
10	A6N	89
11	TCTU	86
12	A4	83
=12	T2	83
13	A2	82
14	B7	80
15	B4H	77
16	A5	76
17	MDU	75
18	A3L	73
19	T5	72
=19	C4N	72
=19	B4N	72
20	B2	68
21	A1N	63
=21	B5	63

Appendix 5: Rank for Current WAASP Compliance

Position	Ward	% compliance
1	T4	100
=1	TCTU	100
=1	BMTU	100
=1	Heulwen	100
=1	A6S	100
6	B1	97
7	A2	95
=7	B6	95
8	C3/CCU	94
=8	C1	94
9	C7	92
10	A6N	89
=10	A1N	89
=10	A4	89
11	MDU	84
12	T5	83
=12	C4N	83
=12	B4N	83
=12	B4H	83
13	A1L	82
14	B7	71
15	A7	69
16	A3L	58
=16	B2	58
17	T2	56
18	B5	54
19	A5	50

Appendix 6: Difference in Scoring Categories

Ward	% Same risk category	% different risk category	Scoring difference in which category / categories?				
			W	A	A	S	P
MDU	66	34			*		
A1N	33	67	*			*	
A1L	75	25		*		*	
A2	50	50	*			*	
A3L	75	25	*	*			
A4	25	75	*	*			
A5N	66	34		*	*		
A5S	100	0					
A6N	100	0					
A6S	66	34	*	*			
A7	33	67	*			*	
B1	100	0					
B2	50	50		*	*	*	
B4N	33	67				*	
B4H	50	50		*		*	
BMTU	100	0					
B5	66	34		*		*	
B6	25	75	*	*	*		
B7	0	100	*		*	*	
C1	33	67	*				*
C3/CCU	33	67		*		*	
C4N	100	0					
C5	100	0					
C6	25	75		*	*	*	
C7	75	25	*		*		
TCTU	100	0					
T2	66	34				*	
T4	100	0					
T5	66	34	*	*		*	
HEULWEN	33	67		*			

Recorded differences:

W - 11

A - 13

A - 7

S - 13

P - 1

REPORT TITLE:	**HER MAJESTY'S CORONER REGULATION 28 PREVENTION OF FUTURE DEATHS REPORTS - UPDATE**								
MEETING:	Quality, Safety and Expereince Committee						**MEETING DATE:**	**16.04.19**	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Executive Nurse Director								
REPORT AUTHOR (TITLE):	Assistant Director Patient Safety and Quality								

PURPOSE OF REPORT:

SITUATION:

The purpose of this report is to provide an update on Regulation 28 reports issued by the Coroner to Cardiff and the Vale UHB during 2018-2019

REPORT:

BACKGROUND:

The Coroner has a legal duty to consider following an inquest if there is a risk of other deaths occurring in similar circumstances.

If the Coroner considers that future deaths could be prevented, s/he can write a report under Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The report is directed to people or organisations who the Coroner considers are in a position to take action to reduce the risk of future deaths. A reply must be sent to the Coroner outlining the action they plan to take. This must be sent to the Coroner within 56 days.
The Regulation 28 report is also usually sent to the family, Welsh Government and any other interested parties determined by the Coroner. Responses received by the Coroner are usually shared by the Coroner's office with the family. The Patient Safety Team copies the Health Board's response to Welsh Government as associated matters have usually also been reported as Serious Incidents. Other external parties may also receive a copy of the response, for example, Welsh Health Specialised Services Committee (WHSSC) where the matter has involved commissioned services.

The Regulation 28 reports are also published on the Chief Coroner's website so there is a public record of the matter. Any non-responses will also be noted.

ASSESSMENT:

During 2018-2019 the Coroner has issued 5 Regulation 28 reports and has written to the UHB on two further occasions to raise issues with the UHB following the conclusion of an inquest.

In July 2018 the Coroner returned a narrative conclusion following the inquest in to the death of a patient who had sustained a fall at home and fractured his left hip. His surgery was delayed and whilst under anesthetic he suffered a cardiac arrest and died three days later. The concern raised by the Coroner related to the pre-operative preparation of the patient for theatre. A member of staff who gave evidence felt that the patient was dehydrated and that this contributed to his cardiac arrest. The Coroner concluded that the UHB needed to take action to improve co-ordination between the multi-disciplinary team to reduce risk to patients in these circumstances**.**

An internal review of the patient's carerevealed that he was seen by a number of Doctors before his operation (including the Anaesthetist). They would have judged that his state of hydration at the time was suitable for Anaesthesia. It was felt, that unfortunately and with hindsight, he may have benefited from more fluid pre-operatively, but the clinical risk of over-hydration and cardiac failure was possible too, and therefore the clinical teams would have been making judgements on this while recognising that he required a necessary surgical intervention.

At the time, the University Health Board (UHB) did in fact employ a Trauma Nurse Practitioner whose role it is to co-ordinate the care of the patient from the time that they arrive in the organisation right through to safe transfer to theatre and post-operatively. There had been a shortfall in the service for 18 months which has now been addressed, and on the 9th July, the UHB employed a second trauma Nurse Practitioner who has now completed a full induction and the two practitioners work together to ensure that the whole of the patient pathway is co-ordinated. This in essence provides a robust back up to ensure that patients are optimised appropriately for theatre.

In July 2018 the Coroner returned a narrative conclusion following the inquest in to the death of a patient who had suffered a head injury at home following a fall. The investigation by the Coroner concluded that there were several omissions of care provided to the deceased prior to his transfer out of area to Southmead Hospital in Bristol. A Regulation 28 was issued in respect of delays in transferring the patient from the Royal Glamorgan Hospital (RGH) on 26th December and again on the 27th December from RGH to University Hospital of Wales.

At inquest the errors in assessing urgency and the delay in providing assistance were considered unlikely to have contributed to his death. However the main concerns raised by the Coroner were;

- The provision of rapid A&E review of patients with a reported head injury and reducing or fluctuating Glasgow Coma Scale even at times of public holidays
- Rapid transfer to hospital or specialist centre providing neuro-surgical diagnosis and treatment when such facilities are unavailable in the admitting hospital
- Failure by the Cardiff and Vale UHB to have any interventional radiologists in employment at the time thereby failing to provide tertiary support to the RGH and necessitating its patients to be sent to out of area to England for treatment with inevitable delay

- Failure by both Cwm Taf and Cardiff and the Vale UHBs to have computer software in place to enable electronic transfer of radiology to hospitals and specialist centres out of wales for review and Consultation.

In its response to the Coroner, Cardiff and Vale University Health Board confirmed that it uses computer software to enable electronic transfer of radiological images to centres outside of the UHB. It is called the Image Exchange Portal and is a system that has been in use for a prolonged period of time. The UHB advised the coroner that it had not been possible to identify a request at that time to transfer images relating to the patient. .

The UHB is acutely aware of the unfortunate challenges surrounding the provision of neuro - interventional radiology services. We currently have one consultant who undertakes both diagnostic and interventional work and a second consultant has been appointed and will commence in October 2019. The service has arrangements in place with Bristol to arrange cover for times such as annual leave and this has generally worked well. Transfer of patients when required is currently managed through the Neurosciences directorate.

The UHB continues to seek opportunities for recruitment. However, this is recognised to be a profession where there is a national shortage and the potential to recruit generally occurs once per year.

In July 2018 the Coroner issued a joint Regulation 28 report to Welsh Ambulance Service Trust, the Minister for Health and Cardiff and Vale University Health Board. He returned a narrative conclusion following an investigation in to the death of a patient who died as a consequence of the combined toxic effect of both prescribed and over the counter medication together with alcohol. There was a delay of 4 hours in sending any emergency response.

The issue of concern raised in respect of the UHB related to turnaround delays at major hospitals. The UHB responded jointly with WAST confirming a range of measures that were being put in place to minimize delays in hospital handover.

Over recent years the UHB has made significant changes in its unscheduled care system, including substantial investment. These have included: an increase in the Emergency Unit (EU) medical and nursing workforce, the establishment of an Ambulatory Emergency Care (AEC) unit, the commissioning of three additional resuscitation bays, an increase in emergency theatre capacity, an expansion of the Frail Older Person Assessment and Liaison (FOPAL) service, a redesign of the Emergency General Surgery and Urology services to provide a dedicated consultant daily, and an increase in critical care capacity.

In addition the UHB has worked with its regional partners, including WAST, to redesign the unscheduled care system seeking to reduce the need for emergency conveyance, attendance and admission and implementing alternative pathways of care. These have included preventative initiatives with the local authorities, support for care homes, a frequent attenders programme, investment and skill mix changes in GP out-of-hours, the establishment of a community assessment unit, the expansion of the community resource team (CRT) to seven days/week, and the development of WAST pathways aimed at reducing the number of ambulance conveyances to the emergency unit (including the use of taxis where appropriate). During the winter months it is recognised that the demands on the unscheduled care system can be significantly higher and more variable than at other periods. The UHB leads on the

development of a regional integrated winter preparedness plan for Cardiff and Vale jointly produced by the partnership organisations: the UHB, WAST, Cardiff Council, Vale of Glamorgan Council, Cardiff Third Sector Council and Glamorgan Voluntary Services. This plan seeks to coordinate the preparations for winter to anticipate and mitigate the impacts of winter pressures as best this can be achieved within the constraints of the system.
Throughout the year the staff within the Emergency Unit work closely with WAST colleagues to respond dynamically to the operational demands and maintain safe levels of care. Senior managers from both organisations meet on a monthly basis to address any operational issues raised and identify opportunities for improvement.

In recent months the UHB has established two-hourly safety and performance huddles in EU to closely monitor the status of the unit (including any ambulances waiting outside) and proactively respond to any build-up of pressures.

In November 2018 the Coroner returned a narrative conclusion following the death of an elderly patient who died after taking a deliberate overdose on an in-patient ward. The main areas of concern related to:

- In the Emergency Department and whilst patients were awaiting admission to a ward, their Patients' Own Drugs (PODs) remained with them unsecured in a bay (or similar), exposing the medication to potential further use/mis-use by the patient, another patient or relative, or theft and mis-use
- On the ward, the policies in place at the time in relation to PODS were not followed, allowing his medication to remain unsecured on the ward, exposing the medication as in (1) above.
- A lack of clarity in relation to timeframes for review of the Patient Property Policy and Medicines Code
- The current arrangements/policies in place for the receiving, utilising and storing of PODS at UHW,
- The arrangements in place to ensure that all relevant staff are aware of the revised Policy/Code and clear on its interpretation/requirements

The management of patient's own medication is one which presents a particular challenge in the healthcare environment. Following the incident the UHB has carried out a benchmarking exercise across the UK and it does not appear that there is any one centre that has managed to put an effective solution in place. While patients are always encouraged to hand over all medication or to send it home with family, there are many practical issues that make this difficult to implement and monitor robustly. Medication is the patient's own property and they can refuse to hand it over should they wish. Staff would of course always have a discussion with the patient and the family with regards to the risk. It is not possible for staff to monitor patients' property on a continuous basis and there are occasions when family members bring in additional property for patients while they are in hospital and this may include medication. The content of many patients' lockers can change on a daily basis.

It is currently policy that whilst patients are awaiting assessment/admission they must retain responsibility for the security of their medicines (and other property). There is no easy solution to address this in terms of making secure boxes etc available in this (or any other) public area. Signage in the area would help to raise awareness about the importance of secure handling of medicines (and other valuables) and this is an action that will be taken forward. The UHB is currently developing an 'Admission Information' booklet that is intended to provide the patients

with key, relevant pieces of information on admission and we are exploring this as a further opportunity to communicate with patients and relatives the importance of ensuring that medication is either taken home or handed in for secure storage in the ward areas. It is anticipated that this piece of work will be completed by June 2019.

Staff have been made aware of the importance of following UHB policies/procedures in relation to the safe storage and security of medication. Tragically in this case, the gentleman was an adult with mental capacity regarding decision making, who retained a supply of medication. Staff had no indication of his intention to take his own life by taking an overdose. This is a highly unusual set of circumstances which the UHB has not seen reported before.

The Medicines Code has already been updated to make this process even more explicit and cross referenced with the Patient Property Policy. The current Patient Property Policy has been reviewed to ensure that this issue is explicit within it.

The UHB believes that the updated procedures for receiving, utilising and storing PODS are as robust as possible to ensure patient safety. This was supported by the benchmarking exercise carried out across the UK as explained earlier. At present the UHB does not feel there is anything further that can realistically be put in place that would not impede the appropriate clinical care. However pharmacy colleagues will continue to benchmark with colleagues across the UK to see whether there is a practical solution that can be implemented effectively.

There is a process in place within the organisation to raise awareness of updated procedures and policies i.e. dissemination via induction for new staff and for existing staff via weekly “CAV You Heard” bulletin and inclusion within the Medication Safety Executive newsletter. Wards and departments have induction checklists in place for bank and Agency staff and these would include medicines related practices.

In December 2018 the Coroner returned a narrative conclusion following the inquest of an in-patient who died as result of a traumatic brain injury following a fall in September 2015. The delay in hearing the inquest was in the main due to a criminal prosecution involving two members of staff involved in his care. These staff were acquitted at the trial and are subject to disciplinary processes within the UHB. Both have been referred to the NMC.
The main issues of concern related to:

- a clear lack of understanding and basic knowledge of falls management in both trained and support workers in circumstances in which it should have been obvious that the patient had sustained a head injury.
- a clear lack of knowledge amongst all staff, both registered nurses and support workers as to how to conduct neurological observations
- no forward planning for the continued observations of the patient throughout the day on 9th September 2015 and as a result he was simply put to bed and not closely monitored as the circumstances required.
- evidence given at the inquest showed that the health board had considered the introduction of the NEWS scoring system (National Early Warning System) for the Mental Health Directorate but felt unable to introduce it as the mental health unit did not sit within/alongside a district general hospital.

Mental Health Clinical Board run a bespoke falls training programme which has been developed by the Practice Nurse Educators within the Mental Health Services for Older People (MHSOP) Directorate. The sessions specifically include training on falls risk management (to identify measures to reduce the risk of a patient falling), post falls management, responding to an unwitnessed or witnessed fall and performing neuro observations. This training is delivered on a rolling programme and so far, approximately 75% of nurses (both qualified and unqualified) within MHSOP and Adult Mental Health have attended this training. 37 out of 42 nurses working on St Barrac's ward have completed this training and arrangements are in place for the outstanding 5 nurses to attend training soon.

The UHB has recently opened a falls simulation training suite in the University Hospital of Wales (UHW) and there are plans for a further suite to be sited in University Hospital Llandough. All qualified and support staff are encouraged to attend simulation workshops on falls prevention management and post fall care. The training covers the management of an unwitnessed fall including how to respond to a head injury.

One of the Nurse Advisors for Standards and Professional Practice is currently working a day a week with nursing staff in MHSOP reviewing patients who have been assessed to be at high risk of falling. The purpose of this work is to try and identify other preventative measures to further reduce the risk of falling.

Training on neuro observations is included in the bespoke Mental Health training programme and also in the UHB wide falls simulation training. A new neuro observation chart was introduced in August 2018 and it is now UHB policy that only registered nurses perform this task.

In 2015 undergraduate nurse training did not cover how to perform neuro observations but this task has now been added to the curriculum and as mentioned above, training on how to perform neuro observations is now included in falls training within the UHB.

The ward is part of Barry Hospital which is not attached to one of the UHB's district hospitals and is a community hospital with in-patient wards and other community out-patient services.

MHSOP Directorate are not able to guarantee the level of medical cover at Barry Hospital (there is no 24 hour medical cover) hence it has not been possible for the NEWS monitoring system to be implemented there in the same way as it has been implemented in the district general hospitals where medical staff are available on-site at all times. . MHSOP have therefore introduced an escalation policy specifically for this ward covering in and out of hours. This policy gives nursing staff guidance on who to contact for medical advice and who to escalate any concerns to.

NEWS is used across MHSOP wards based in University Hospital Llandough to assist nurses and medical staff in determining the degree of illness of a patient and again there are clear escalation policies in place, if nurses identify a patient whose NEWS score is deteriorating or if they have general concerns.

In December 2018 the Coroner retuned a conclusion of suicide following the death of a patient who hung herself at home. She had been admitted to UHW the week before having taken an overdose of medication. She had seen her GP for an assessment and had also been followed up by the REACT team. The UHB was requested to consider the following points:

- The identification of patients who need immediate psychiatric assessment and review by specialist teams
- The care and attention to detail taken when noting histories and information from mental health patients
- The frequency of medication reviews with mental health patients.

The findings of our internal reviewconcluded that the care and treatment given to the patient from the point of the mental health assessment conducted by the REACT team the following day, was comprehensive and demonstrated full awareness of her history, her level of risk, the true nature of her overdose the previous day and balanced this against the capability of her family to provide a safe and supportive context.

The UHB would absolutely concur that some families may not have been in a position to provide ongoing support, but the judgement that she might remain at home with regular and frequent input from the REACT team was made with the conscious participation and agreement of all, including the team, the patient and the family.

It is clear from the accounts given by all professionals involved that consideration was given almost on a daily basis to whether she should be admitted to a hospital bed. It is equally clear that this was consciously balanced against the possibility that hospital admission may have been detrimental and she herself was not amenable to hospital admission. It is normal and good practice to provide treatment and support at home wherever possible, and it was concluded that the decision to do this was appropriate in this case, based on the information that was available to clinicians at the time.

The patient had not had any involvement with mental health services for many years, and there was therefore no information available to the assessing doctor from either paper notes or the electronic PARIS mental health record system. The Doctor was therefore restricted to the information that she (and those accompanying her) gave him at the time. Had there been involvement with the mental health within the last several years, then a PARIS history would have been available.

Our review has identified that, although there was a typographical error in the documentation stating that only two tablets of Sertraline had been taken when in fact the true figure was twenty, this error was rectified on the night in question. When the Doctor had his discussion with the night site coordinator for mental health services, both individuals knew that twenty tablets had been taken and made their clinical decision on that basis. This is borne out by the notes taken by the Doctor at the time. Personal notes from the night site coordinator in mental health services also record the fact that she took twenty tablets, not two. The typographical error was therefore *not* a factor in the decision making process on that night.

The UHB uses the Bristol Matrix, a decision making tool which is used to support the identification of patients who require psychiatric assessments. This decision making can also be

conducted jointly with senior mental health staff. Training in the use of the Bristol Matrix is well established, that all junior doctors learn about it during their induction to the department and are familiar with its use which is standard practice in this kind of situation.

The doctor that conducted the initial assessment has many years' experience in emergency medicine and works regularly in the department. She has had training in the assessment of the patient with mental health problems and would have felt confident in entrusting a decision that the patient was low risk and safe for out- patient review.

Although the internal review has identified a typographical error as described above the general standard of documentation was found to be satisfactory. All staff have, however, been reminded of the importance of full and diligent information taking, using all information that is available at the time and this will be achieved through the Clinical Board's Quality, Safety and Experience structures.

The patient was not known to secondary care mental health services at the time of her death. Her care was being provided by her General Practitioner. The management of patients with Depression is carried out in line with NICE Guidance 'CG90 – Depression in adults: recognition and management' and there is a standard for the regular review of patients depending on the nature and severity of their depression. This matter has been raised with the Primary Community and Intermediate Care Clinical Board as a practice issue for them to consider.

RECOMMENDATION:

The Quality, Safety and Experience Committee is asked to:

- **RECEIVE** the overview of the recommendations made by Her Majesty's Coroner.
- **NOTE** the actions undertaken in response to the internal investigations and Coroner's recommendations.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	Prevention		Long term		Integration		Collaboration		Involvement		

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Kind and caring / Caredig a gofalgar | Respectful / Dangos parch | Trust and integrity / Ymddiriedaeth ac uniondeb | Personal responsibility / Cyfrifoldeb personol

REPORT TITLE:	**ENDOSCOPY DECONTAMINATION – PATIENT NOTIFICATION EXCERCISE**								
MEETING:	Quality, Safety and Experience Committee						**MEETING DATE:**	**16.04.19**	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**	**x**	
LEAD EXECUTIVE:	Executive Nurse Director								
REPORT AUTHOR (TITLE):	Assistant Director Patient Safety and Quality								

PURPOSE OF REPORT:

SITUATION:

The purpose of this report is to provide the Committee with an overview of the management of a decontamination incident which was identifed in September 2018.

The incident resulted in a Patient Notification Exercise (PNE) which was undertaken during March/April 2019

REPORT:

BACKGROUND:

During a decontamination process in August 2018, Cardiff and the Vale University Health Board (the UHB), identified that a gastroscope and a video colonoscope had not been adequately decontaminated in line with the manufacturer's decontamination re-processing instructions. This happened because each endoscope contained a 6th internal channel that staff were unaware of.

The UHB has made contact with both the MHRA and the manufacturer

ASSESSMENT:

On identification of this decontamination incident, a multi-disciplinary Serious Incident Management Team (SIMT) was established immediately and the UHB has worked closely with colleagues from Public Health Wales to investigate the matter. The Community health Council also provided support in planning the PNE.

A total of 111 patients underwent procedures involving the endoscopes. The endoscopes had been used on 132 occasions as some patients had undergone more than one endoscopy procedure.

Based on all available evidence, none of the patients are known to have a blood borne virus (BBV).

A UHB-wide exercise was undertaken immediately to establish whether there were any other 6-channelled scopes in use anywhere across the organisation and also to confirm that all endoscopes in use were being decontaminated in line with manufacturer's instructions. This was concluded and it was apparent that there were no other 6 channelled endoscopes in use and that all endoscopes in use, were being decontaminated in line with manufacturer's instructions.

The SIMT, in line with advice from clinical experts in Public Health Wales, undertook a clinical analysis of the potential risk to patients. This identified that patients who received procedures with the two endoscopes may have been placed at a very low risk of infection from blood borne viruses (hepatitis B, hepatitis C and HIV). Based on this clinical advice, Public Health Wales did not recommend screening for all patients as the risk is very low. However, the UHB recognised that some patients may have other lifestyle factors which may present a greater risk of transmission and if these patients were to contact the telephone line provided in support of this PNE, it was agreed that they would be referred back to the UHB to make the necessary arrangements for a simple blood test screening for BBV, if the patient wished.

It was agreed that it was reasonable to wait 6 months post the last exposure to the endoscopes. Hepatitis C antibodies generally take around three months to develop in the blood, but can take up to six months to develop, meaning that if a patient is tested before six months after any possible exposure they may receive a false negative result. At this point if patients wished to be tested, one simple screening test would provide a clear answer reducing the likelihood of false negative results.

INFORMING PATIENTS

The UHB, with the support of Public Health Wales and the Community Health Council, carried out a PNE in the weeks commencing 25th March 2019 and 1st April 2019. All patients who were investigated with the endoscopes were contacted with letters (and supporting FAQs) to make them aware of the circumstances and to reassure them that they were at a low risk of transmission of blood borne viruses. A helpline was provided by Public Health Wales and this was made available from 26th March 2019 – 29th March 2019 and from April 1st to April 5th form the hours of 09.00 to 17.00hrs.

A number of patients had sadly died as a natural progression of their underlying condition and these families were not contacted. Other patients were identified as having learning disabilities and mental health problems and bespoke communication methods, involving their next of kin, carers and care agencies were put in place, based on their specific needs.

In the week before the PNE, the UHB contacted the General Practitioners of all affected patients.

Some of the cohort of patients were 'out of area' patients whose routine care is normally provided by other healthcare providers in Wales and England. :

Health Board	Number of patients affected
Cardiff and the Vale	81
Aneurin Bevan	18
Abertawe BroMorgannwg	1
Cwm Taf	4
Hywel Dda	1
England	2

The UHB liaised with the BBV teams in these UHBs and a stakeholder briefing was provided to each UHB on Thursday 21st March 2019. The details of affected patients was provided on request.

A press statement was prepared in case the PNE attracted any media attention.

CONTACTS WITH THE HELPLINE

14 patients contacted the helpline and the following table summarizes the actions that were taken:

Action	Numbers
Caller reassured after healthcare professional discussion on general decontamination issue and/or BBV issue.	3
Caller wishes to discuss treatment / management further with HB	0
Caller wishes to be tested for BBV	8 (one caller approached GP for a BBV test)
Caller provided with Redress / complaints details	2

At time of writing, 2 patients have been tested for a BBV and both were negative. A verbal update will be provided to the Committee on 16th April 2019, confirming the outcomes of any further BBV testing.

RECOMMENDATION:

The Quality, Safety and Experience Committee is asked to:

NOTE the actions taken in response to the decontamination incident
NOTE the outcome of the Patient Notification exercise
AGREE that all the necessary steps have been taken to avoid a re-occurrence of this incident and that all reasonable steps have been taken in respect of the affected patients

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	Prevention		Long term		Integration		Collaboration		Involvement		

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Report Title:	**Cancer Peer Review Thyroid 2018**						
Meeting:	Quality, Safety and Experience				**Meeting Date:**	April 2019	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	Dr Graham Shortland, Medical Director						
Report Author (Title):	Alicia Williams, Cancer Services Lead Manager						

SITUATION

The purpose of this report is to present the committee with an analysis of the findings and actions required following the Cancer Peer Review process. Following peer review of each cancer tumour site, a report is forwarded to the UHB and an action plan agreed by the multidisciplinary team and relevant Clinical Board. The action plan is reported back to the Wales Cancer Network and Welsh Government.

This report outlines the findings of the initial review of the Thyroid cancer services in Cardiff and Vale University Health Board which took place on 3rd December 2018.

REPORT

BACKGROUND

Peer review is a collaborative, quality improvement process which allows for the evaluation of scientific, academic or professional work by others working in the same field and constitutes a form of self-regulation by qualified members of a profession. It is designed to allow peers to share information, learn where their strengths and weaknesses lie and agree plans for improvements to patient care.

Peer review methods are employed to maintain standards of quality, improve performance and provide credibility.

In 2011 Welsh Government recommended that the peer review process for cancer services be led by Health Inspectorate Wales (HIW), working in partnership with the Cancer Networks. Peer review was then launched in Wales in 2012.

In 2017, through Welsh Health Circular WHC/2017037 the NHS Wales Peer Review Framework was published and tasked the NHS Wales Health Collaborative to oversee an all-Wales programme for peer review.

A three yearly re-review process has been developed by the cancer network. Following the peer review meeting, a report is sent to the UHB. An action plan is then developed and implemented to address the concerns raised at each peer review and re-review.

ASSESSMENT

Summary of Thyroid Peer Review Report

Good Practice/Significant Achievements:

- The review panel believes that this MDT is one of the biggest in the UK.

- MDT members showed good team working across boundaries.
- Good relationship between clinicians and management within the Health Board.
- Excellent support towards trials and research by the MDT and oncology provider.

There were no immediate risks highlighted.

Serious Concerns noted were:

- **Rare, advanced and complex cancer cases:** Cases of this nature were said to be treated within cancer units (e.g. anaplastic and medullary cancers). As the number of cases are small the panel suggest the MDT should agree the criteria for rare and complex cancer cases to be referred to a nominated specialist centre/s for treatment and management. In addition, a designated centre/s is required for patients requiring lateral neck dissection and advanced thyroid cancer surgery requiring tracheal resection where cardio-thoracic is required to be present.

Concerns noted were:

- **Frequency of the MDT:** The South Wales MDT functions mainly outside of the MDT meeting where all aspects of patient care may not be discussed, certainly prospectively. More regular meetings would ensure all aspects of care are considered in a multidisciplinary approach. The South Wales MDT should be adequately supported by administrative provision.
- **Annual Service Review / Business Meeting:** An annual service review or business meeting would aid the South Wales MDT in service development, education and sharing of audit/improvement project findings.
- **Clinical Nurse Specialist:** There is one clinical nurse specialist providing support for all thyroid cancer patients in the region who is based in Velindre Cancer Centre. The CNS will see patients attending Velindre Cancer Centre but can only try to make contact by telephone with other patients. This does not extend at all to patients in south west Wales routinely who may/may not have some support from the H&N CNSs. An essential part of this role is to support a patient at diagnosis, which needs to be looked at by stakeholders and the South Wales MDT to develop a way of improving the support for patients especially for south west Wales patients.
- **Multi-Disciplinary Team Membership:** An MDT of this size should have core membership that includes surgeons, endocrinologists, oncologists, pathologists, radiologists, clinical nurse specialists and an MDT co-ordinator. Core members must have a second clinician to cover absence. The current challenges to provide cover arrangements relate to the positions of:
    - Oncologist
    - Endocrinologist
    - Clinical Nurse Specialist
    - MDT Co-ordinator
- **Pathway Performance:** USC cancer waiting time performance is at 73%, where the target is 95%. The Health Board should work towards achieving the national target.
- **Outpatient Service, Survivorship and follow up:** There are no guidelines to support the requirements of what supportive services are provided locally or regionally. In addition, there was no follow up process or policy in place that may aid patients who

may have a requirement to access such services as lymphoedema, physiotherapy, speech and language therapy (SaLT), welfare and benefit advice, and psychological support.

See attached Action Plan

ASSURANCE is provided by:

- The level of scrutiny applied internally and externally to the Peer Review assessment and Peer Review reporting process. Any concerns identified are addressed via an action plan and are regularly reported within the required process; at the Clinical Board performance reviews and by WG and the South Wales Cancer Network

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **Note** the report
- **AGREE** that appropriate assurance has been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	√
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	√
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	√
4. Offer services that deliver the population health our citizens are entitled to expect	√	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term	√	Integration	√	Collaboration	√	Involvement	√

Equality and Health Impact Assessment Completed:	Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Thyroid and Endocrine Peer Review Action Plan 2019

Cardiff and Vale University Health Board

	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
1	Rare, advanced and complex cancer cases were said to be treated within cancer units (e.g. anaplastic and medullary cancers). As the number of cases are small the panel suggest the MDT should agree the criteria for rare and complex cancer cases to be referred to a nominated specialist centre/s for treatment and management.	The Peer review panel recommended that these patients should be treated in centres where cardiothoracic services are available – this is Morriston and UHW. The health boards need to agree to refer such patients to these two Units and a referral process needs to be implemented	High	MDT Lead / Surgical clinical board and Cancer lead	End 2019	
2	The South Wales MDT functions mainly outside of the MDT meeting where all aspects of patient care may not be discussed, certainly prospectively. More regular meetings would ensure all aspects of care are considered in a multidisciplinary approach. The South Wales MDT should be adequately supported by administrative provision.	Having an MDT more frequently than 1 x month is desirable but will place a challenge on current job plans, especially for support services such as radiology and pathology. A plan should be developed to have a more frequent (2 x month) meeting and need to have 1) An MDT room 2) Agreement from members of the MDT with backing from Health boards for a change to job plans	Medium	MDT Lead / DOO CD&T / Cancer Services / surgical clinical board	End 2019	

3	An annual service review or business meeting would aid the South Wales MDT in service development, education and sharing of audit/improvement project findings.	The establishment of the Thyroid Cancer Site Group under the umbrella of the All Wales Cancer Network will provide the forum for educational meetings. A core group is being established to develop this programme	Medium	MDT Lead	End 2019	MDT Lead has invited expressions of interest to join the Core Group
4	There is one clinical nurse specialist providing support for all thyroid cancer patients in the region who is based in Velindre Cancer Centre. The CNS will see patients attending Velindre Cancer Centre but can only try to make contact by telephone with other patients. This does not extend at all to patients in south west Wales routinely who may/may not have some support from the H&N CNSs. An essential part of this role is to support a patient at diagnosis, which needs to be looked at by stakeholders and the South Wales MDT to develop a way of improving the support for patients, especially those within South West Wales.	This is a matter for South West Wales to make an investment. Regional discussions required with development of a business case.	Medium	Lead Cancer Nurse / MDT lead	End 2019	
5	An MDT of this size should have core membership that includes surgeons, endocrinologists, oncologists, pathologists, radiologists, clinical nurse specialists and an MDT co-	There is currently no capacity to cover oncologist Need to recruit an endocrinologist – this could be done at the same time as increasing the frequency	Medium		Summer 2019	

	ordinator. Core members must have a second clinician to cover absence. The current challenges to provide cover arrangements relate to the positions of: • Oncologist • Endocrinologist • Clinical Nurse Specialist • MDT Co-ordinator	of MDT meetings		Velindre / Medicine Clinical Board / Cancer Services		
6	USC cancer waiting time performance is at 73%, where the target is 95%. The Health Board should work towards achieving the national target.	An all Wales discussion about the SCP is being developed through the cancer network	Medium	MDT Lead	End 2019	MDT Lead is convening a Core group within the thyroid WCSG
7	There are no guidelines to support the requirements of what supportive services are provided locally or regionally. In addition, there was no follow up process or policy in place that may aid patients who may have a requirement to access such services as Lymphoedema, physiotherapy, speech and language therapy (SaLT), welfare and benefit advice, and psychological support.	SALT has already been engaged and a discussion is being held in Cardiff. The remainder is not relevant to patients with thyroid cancer	Medium	MDT Lead	Spring 2019	SALT team engaged

Report Title:	**National Hip Fracture Database (NHFD)**								
Meeting:	Quality Safety and Experience Committee					**Meeting Date:**	16th April		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	Medical Director								
Report Author (Title):	Alun Tomkinson Clinical Board Director Surgery Clinical Board								

Implications of the 2018 NHFD Annual Report for patient care in Cardiff and the Vale

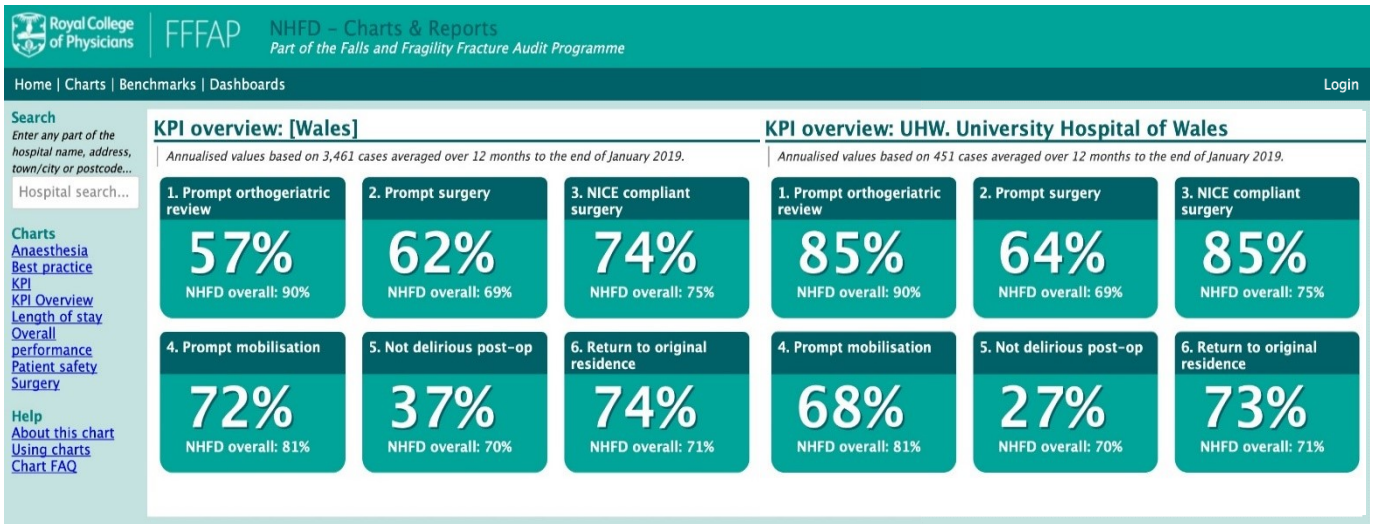
Situation

The NHFD reports on around 40 measures of case mix, performance, care quality and outcome but the 2018 Annual Report focused on case mix adjusted 30 day mortality and six new Key Performance Indicators (KPIs**).**

Background

In 2017 the UHW trauma unit reported a case mix-adjusted 30 day mortality of 8.5%. This is comparable for the figure of 8.6% for Wales, but 25% higher than the 6.9% benchmark figure for the NHFD as a whole.

The C&V response to this and other NHFD findings therefore needs to take into consideration a pattern of poorer performance across Wales. This has been recognized by WG, and underpins a new system of Performance Management; a requirement that UHBs report quarterly on their progress against the six KPIs.



This report seeks to address C&V performance for these six KPIs. However, the NHFD infographic above, and the discussion which follows, are focused on current performance as opposed to the 'historical' data for 2017 that was the focus of the NHFD Annual Report.

Assessment

Highlights and Good practice

This infographic draws attention to excellence in terms of orthopaedic surgeons' use of the most cost- effective and the most effective surgical approaches – as defined by NICE in its 2011 and 2016 guidance.

Surgeons and emergency unit staff should also be commended on their provision of local anaesthetic nerve blocks as pain relief for patients awaiting theatre: 86% of C&V patients received these last year (*cf.* 71% of patients in Wales and an NHFD benchmark figure of just 56%).

Areas of concern and proposed responses

NHFD finding: Case ascertainment – C&V submitted data on all 479 people who presented in 2017

A band 3 NHFD Data Clerk works 2 days a week supporting the input of relevant data. However this post is single handed

Action

- The clinical board is looking at ways to invest in appropriate administrative support to sustain good data collection.

NHFD finding: Case-mix – 8% of people who presented with a hip fracture had sustained their injury following an inpatient fall within our UHB (cf. NHFD benchmark figure of 4%)

This leads to an additional burden on the orthopaedic services and poor outcomes for patients. From 2019 this information will be reported in the National Audit of Inpatient falls and the Health Board is continuing to work on plans to reduce the number of inpatients falls in line with the national target.

Action

- The Surgery Clinical Board have implemented the "get up, get dressed and get moving" project across all wards
- The Surgery Board ensure that all inpatient injurious falls (which are reported as Serious incidents to Welsh Government) have Root Cause Analysis investigations carried out and the learning is shared appropriately via professional forums
- The trauma and frailty team are an integral part of the Falls Strategy Group lead

look at ways of further reducing the number of falls

NHFD finding: Admissions –9% of trauma patients reach an appropriate T&O bed within 4 hours of presenting with hip fracture (cf. NHFD benchmark figure of 40%)

It is important to dedicate a number of beds to the trauma stream thereby ensuring patients can be admitted to appropriate beds.

Actions

- The Surgery Clinical Board would like to ring-fence beds a number of trauma beds (2-4) for the frail and older patient with have sustained trauma – this will be part of upcoming Lightfoot frailty pathway work
- Review current pathway with wider hospital team as part of the clinical board trauma pathway workshop. The first session has been undertaken in conjunction with Lightfoot on Monday 1st April with further dates in the diary for future sessions

NHFD finding: Assessment – assessment, prevention and management of delirium is poor with just 27% of C&V patients recorded as free of delirium in the week after surgery (cf. 37% in Wales and an NHFD benchmark figure of 70%)

Delirium is the most common complication of hip fracture surgery and anaesthesia. The NHFD reported that people who developed delirium were twice as likely to die as inpatients and four times more likely to end up needing to move to live in a nursing home.

This finding reflects an inconsistent approach to the initial clerking of patients – 81% are screened for cognitive impairment on admission (*cf*. NHFD benchmark of 95%) – and we are trying to improve compliance with pre- and post-operative care bundles by orthopaedic juniors and middle grades.

Work is in hand to unify the approaches to pre-op. and post-op. care bundles for hip fracture and general trauma patients. However, compliance with these remains poor and requires a formal process of QI and governance to be established – just as it has been in hospitals across England.

Actions

- Establishment of formal monthly meetings of Clinical Governance and Quality Improvement for patients in the trauma stream
- Work is in hand to unify the approaches to pre-op and post-op care bundles for hip fracture and general trauma patient and requires a formal process of QI and governance to be established.

NHFD finding: Peri-operative care – time to operation has improved and 64% of C&V patients now receive the 'by the next day' operation recommended by NICE (cf. NHFD benchmark of 69%)

Improvement in prompt surgery has been achieved by surgeons' attention to the clinical need of patients with hip fracture – who usually now receive appropriate priority when operation lists are being planned.

It would not be clinically appropriate to try and improve this NHFD figure by placing additional priority on these patients, as this would be at the expense of other patients.

Action

- Review anaesthetic input into the frailty pathway
- The Clinical board has invested in two trauma nurse practitioners who support patient flow from the Emergency Unit to the perioperative phase
- Improvement in the NHFD's 'prompt surgery' KPI requires attention to the whole of the trauma patient stream, and to the efficient use of UHW and UHL theatre capacity

NHFD finding: Peri-operative care – C&V have still not appointed consultant NHFD Clinical Leads from anaesthesia and orthopaedics

Action

- The Clinical Board will be appointing to these posts over the next few months

NHFD finding: Peri-operative care – just 16% of patients received consultant surgical-anaesthetic care in UHW (cf. 61% in NHFD benchmarks)

This 16% figure slightly undercounts our performance since we have an associate specialist hip surgeon who has more hip fracture operating experience than any Consultant in Wales This requires that we ensure that future consultant appointments in orthopaedics and anaesthesia carry a commitment to the trauma stream.

Action

- The Clinical Board are to appoint dedicated orthopaedic trauma surgeons which will improve this performance indicator

NHFD finding: Post-operative care –66% of people 'got out of bed by the day after their operation' (cf. 70% in NHFD benchmarks)

In addition to improving our approach to these frail and complex patients we should be providing a far more dynamic model of rehabilitation to younger and fitter individuals who fail to receive the rapid restoration of independence they need.

Action

- Introduce “Red to Green” tool to support patient focused care within Trauma with clear predicted data of discharge and focus on onward referrals into community care.
- Develop dedicated therapeutic input as part of multi-disciplinary team

NHFD finding: Post-operative care – nurse staffing in UHW trauma unit was <75% of that reported in NHFD benchmarks

Nursing establishments on all out trauma wards are set in line with “All Wales safer staffing act” legislation and are reviewed by the Clinical Board on a six monthly basis. However the level of staffing vacancies have contributed to a shortage of registered nursing staff on our wards. This is compounded with ageing workforce. The Clinical Board have developed a number of work streams to address these issues

- Local adaptation of oversea nurses
- Regular local recruitment events which have successful (the next one being held on the 10 April 2019)
- Student streamlining events
- Return to practice nursing
- Establish MDT working to review constraints

NHFD finding: Adjusted mortality for UHW was 8.5% in 2017 (cf. NHFD benchmark of 6.9%)

The C&V Trauma Unit RCT of nutritional support after hip fracture (Duncan *et al*. doi:10.1093/ageing/afj011) showed that this could halve mortality.

This work has been widely adopted elsewhere – indeed the halving of mortality we had shown was recently replicated across four English hospitals in Health Foundation funded 'HipQIP' project (*The Times*, Jan 2019).

- Work is ongoing to address WAST and Emergency Unit policies in respect of ‘nil by mouth’ policies. Each of the trauma wards adopts the principle of “protected mealtimes” as it is recognises that support of patients at meal times is crucial to their recovery
- Review current pathway with wider hospital team as part of the clinical board trauma pathway workshops. The first session has been undertaken in conjunction with Lightfoot

NHFD finding: 33.9 day LOS (cf. benchmarks of 33.7days in Wales and 20.6 days in NHFD)

The LOS reduction and bed closures achieved in 2014 were in part achieved through C&V funding for a ward- based social worker working as part of the MDT; not to bypass normal social work processes or delays in allocation, but to support patients and their families in goal planning and in dealing with the stresses and uncertainties associated with nursing care placement.

The post was very popular, but Cardiff Social Services withdrew the appointment. A similar model continues on Ward West 4, in collaboration with Vale Social Services.

The fortnight's difference in LOS between England and Wales is in part an artefact resulting from better capture of 'super-spell' in Wales, but serves as an indication of the possible resource implications of our current model and the potential benefits of improved working.

- Introduce "Red to Green" tool to support patient focused care with clear predicted data of discharge and focus on onward referrals into community care.
- Introduce monthly MDT to discuss key performance indicators and review trends around length of stay
- This including value ward based social worker (± AHP) will be explored through the Lightfoot workstreams

This report is timely given the work being undertaken in the Clinical Board which is looking to transform the frailty pathway improving both patient outcome and experience. The Clinical Board would be happy to update the committee on the progress of the Lightfoot work later this year.

Recommendation

The Committee is asked to AGREE the Surgical Board action plan

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x
Equality and Health Impact Assessment Completed:	**Not Applicable** *If "yes" please provide copy of the assessment. This will be linked to the report when published.*								

REPORT TITLE:	**HEALTHCARE INSPECTORATE WALES ACTIVITY**							
MEETING:	Quality, Safety and Experience Committee					**MEETING DATE:**	**16.04.19**	
STATUS:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	
LEAD EXECUTIVE:	Executive Nurse Director							
REPORT AUTHOR (TITLE):	Assistant Director Patient Safety and Quality							

PURPOSE OF REPORT:

SITUATION:

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview of the reviews/inspections carried out by Healthcare Inspectorate Wales (HIW) since the last over-arching report to the Committee on June 12th 2018. The paper seeks to assure the Committee that action is already being implemented in response to the findings of inspections and that appropriate monitoring of progress against the actions is being undertaken.

A report outlining HIW activity in Primary care was presented to the Committee in December 2018.

The Committee should be advised that the frequency of reporting was reduced during 2018 - 2019, due to the reduction in the number of inspections and reviews being undertaken in Cardiff and the Vale UHB, when compared with the previous year.

REPORT:

BACKGROUND:

HIW is the independent inspectorate and regulator for health care in Wales. The core role of HIW is to review and inspect the NHS and Independent Healthcare organisations in Wales so that assurance can be given to patients, public, Welsh Government (WG) and healthcare providers that services are safe and of good quality.

Hospital Inspections are a means of providing assurance that a patient's dignity is being maintained whilst in receipt of care. It is a structured inspection and supports the view of Francis (2013) who emphasised the importance of undertaking direct observations of care. The unannounced inspections undertaken by HIW focus on the following themes:

- Quality of the patient experience
- Delivery of safe and effective care
- Quality of management and leadership

- Delivery of a safe and effective service

ASSESSMENT:

Thematic reviews

Since the last report to the committee the UHB has participated in a number of Thematic Reviews:

- **Patient discharge from Hospital to General Practice**

The final report was issued in August 2018 and can be seen at the following link:

http://hiw.org.uk/docs/hiw/reports/180808dischargeen.pdf

An action plan is currently under development and will be reported to the June 2019 Committee.

- **Joint Thematic review of Community Health teams**

The All Wales report on Community Mental Health Teams was published in February 2019. The UHB participated fully in the report which can be viewed here: http://hiw.org.uk/docs/hiw/reports/190207joint-thematic-review-community-mental-health-en.pdf.

The UHB has developed an improvement plan to address the findings. This is attached at Appendix 1

- **How are Healthcare services meeting the needs of young people?**

The UHB participated in phase 1 of this thematic review which involved a self-assessment of current services. Although a phase 2 was anticipated this was not undertaken and HIW have published their final report on 22nd March 2019 based on evidence from the self-assessments. This will be reported in full to the June 2019 Committee

Special reviews

ABMU

In March 2018, HIW commissioned an Independent Review of how Abertawe Bro Morgannwg University Health Board (ABMUHB) handled abuse allegations made against (KW). KW was an employee of the ABMUHB at the time, working at Rowan House in Cardiff.

The Review related solely to the actions of and processes within ABMUHB. However, one of the patients who made an allegation against KW was a patient of Cardiff and Vale UHB and, as the UHB remains a commissioner of learning disability services from ABMUHB, it was recognised as a stakeholder in this process.

A stakeholder meeting was held on 19th April which was attended by the UHB who have fully engaged in the process as required.

The final report was published in January 2019 and can be viewed here http://hiw.org.uk/news/SpecialreviewKrisWade?lang=en

Wider learning for the NHS in Wales was identified and this includes:

- Up-to-date DBS checks for staff (both retrospective and renewal of checks)
- Updated Wales Safeguarding Procedures (through all safeguarding boards) to ensure consistency practice and reporting, and benchmarking, throughout the NHS in Wales
- Robust mechanism for sharing safeguarding learning across Wales
- Improved systems for triangulation of information from concerns, incidents and claims
- Robust governance and board oversight in relation to quality and safety.

It was also noted that formal service agreements between commissioners and providers would assist in ensuring that the services were meeting the needs of patients in the respective health boards and in performance monitoring.

Announced visits

Vale Locality Mental Health Team

This visit was undertaken on 4th December 2018. Feedback was largely positive. There were no immediate assurance issues; the main findings related to:

- Information for patients and access to advocacy services
- Improving timely access to assessment services
- Availability of psychology support
- Environment
- Ligature point risk assessments
- Workload of psychiatrists

The UHB has responded to the report and submitted an improvement plan and is currently awaiting confirmation that HIW is satisfied with the steps being taken to address the findings. The findings will be reported in more detail in the next report to Committee in June 2019.

Unannounced inspections

There has been a significant reduction in the number of unannounced visits that have been carried out since the last report to the Committee. However at the time of writing, two unannounced visits have been carried out in the last week and these include a visit to:

Mental Health Services at Hafan Y Coed during week commencing 18th March 2019 – feedback was very positive. There were no immediate assurance issues and the UHB awaits the draft report. This will be reported in more detail at the June 2019 Committee meeting

The Emergency and Assessment Units (EU/AU) at University Hospital of Wales during week commencing 25th March 2019. The reviewers could not speak highly enough of the staff that they met over the three day visit, stating that they were all observed to be working incredibly hard and were extremely knowledgeable and demonstrated a high level of clinical skills. All interactions that staff had with patients was dignified and caring. All patients, without exception,

who were approached over the three days, were very positive about their care and their experience in the departments.

This visit has however, resulted in immediate assurance issues in relation to the suitability of the Lounge area in the AU as an area for unwell patients who want to sleep and/or lie down, staffing levels in the Medical Assessment care Unit (MACU), checks in relation to the resuscitation trolley, fridge temperatures. There was also an unlocked medication cupboard containing eye medication.

Immediate action has been taken to increase staffing levels as an interim measure and to put in place more senior oversight and review of patients in the Lounge on a 2 hourly basis. All staff have been reminded of the need for regular checks of resuscitation equipment and fridge temperatures and new thermometers have been ordered for domestic fridges which are used to store food. The unlocked medicine cupboard has been de-commissioned and the eye medication that was contained in it has been re-located to another suitable, secure cupboard in the department.

Primary Care Contractors

An update report on HIW activity in primary care was presented to the December 2018 Committee.

Since that report, an announced visit to a Dental Practice in Cardiff and the Vale resulted in an immediate assurance issue in relation to the recording and monitoring of fridge temperatures. This has been addressed by the practice and HIW have confirmed that they are satisfied with the action that has been taken.

The Primary, Community and Intermediate Care Clinical Board has been asked to remind all GP and Dental practices of their responsibilities in relation to maintenance of the cold chain.

A further full update on primary care inspections will be presented to the June 2019 Committee.

RECOMMENDATION:

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the level of HIW activity across a broad range of services.
- **AGREE** that the appropriate processes are in place to address and monitor the recommendations

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	

3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	Long term	Integration	Collaboration	Involvement

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Appendix C – Improvement plan

Service: **Joint Thematic Review of Community Health teams**

Date of inspection: **2017/2018**

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Health Boards should ensure there is clarity over the criteria for accessing CMHTs and the various community support teams that exist. In particular GPs and primary care practitioners need to have the information and support to enable them to provide the best possible advice for service users.		The C&V model is evolving from CMHTs to Community Mental Health services that are responsive to the individual's needs. There will be a single point of access to ensure that individuals are supported to access the most appropriate services for their needs. There will be a Mental Health practitioner working in each GP practice to support GPs with referral choices and a tiered range of mental health services available from a locality community resource, including primary care and crisis support. The model is being established in the Vale locality and due	Head of Operations and Delivery	2019/20

Improvement needed	Standard	Service action	Responsible officer	Timescale
		for roll out to the remaining two localities over the next 18 months.		
CMHTs need to ensure that service users are clear on how to access or contact services out of hours, or in the event of crisis or serious concern.		Care co-ordinators develop a crisis plan for each individual who is under the care of the Community Mental Health services, which will include a management plan and points of contact. Compliance and quality of crisis plans will be monitored on an ongoing basis.	Director of Nursing	Quarterly review of a selection of crisis plans)
Health Boards need to ensure that information relating to the 'Putting Things Right' process is available at all CMHT locations. CMHTs need to improve the way that they oversee the handling, monitoring, and lessons learned aspects of concerns/complaints within their care.		Putting Things Right posters are displayed at reception in each of the Community Mental Health centres. All complaints are managed through the PTR process and 30 day compliance is monitored through Clinical Board Quality, Safety and Experience (QSE) structures and also through Executive Performance reviews. December 2018 compliance 84%. No outstanding actions.	Director of Nursing	The UHB will continue to monitor compliance with PTR regulations monthly
Health Boards and Local Authorities need to look at ways to improve awareness of advocacy provision amongst their staff and develop local		Local advocacy services are regularly invited to staff training forums within the	Director of Nursing	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
monitoring of CMHT engagement with advocacy services, to ensure service users have access to the support they require on assessment at significant points.		Community Mental Health teams including the Community Health Council, IMHAs via a contract with South Wales Mental Health Advocacy and the Cardiff and Vale Action for Mental Health (Cavamh) network. Posters are displayed at reception informing patients of the role and access to advocacy services. The Clinical Board has an SLA in place with South Wales advocacy services and there is 100% compliance with a response to a request for advocacy services.		
Significant work is required from health boards to improve the provision and maintenance of safe and clinically appropriate facilities for CMHT service users and staff.		There are significant issues with Community Mental Health accommodation in Cardiff, with the associated health and safety concerns. This view is also held by the Local Authority within Cardiff. There has been a recent resolution to accommodation issues within the Vale Community Services. The Health Board has been very supportive to the Mental Health accommodation improvements with	Director of Operations	Up until 20121

Improvement needed	Standard	Service action	Responsible officer	Timescale
		outline plans to resolve accommodation problems in the South and East Locality in Cardiff during 2019 and the North and West Locality in Cardiff during 2020/21 the Vale CMHTs into a Locality community service.		
CMHTs need to improve the recording of risk assessments within CTPs to ensure risks and management plans are more comprehensively recorded, more detailed and relevant to individual circumstances and particular situations.		Six individuals have been trained to undertake the role of WARRN trainers. They will offer monthly training for all staff. Action Plan prepared in response to the Delivery Unit National Review of Care and Treatment plans and the associated quality of risk assessments completed in 2018, which has been presented to the local mental health legislation committee for acceptance and performance monitoring.	Director of Operations	Ongoing Monitoring
CMHTs need to ensure that CTPs are of sufficient quality, with evidence that service users have been involved in their development, and that the resulting CTPs are relevant to the outcomes the service user wishes to achieve.		Action Plan prepared in response to the Delivery Unit National Review of Care and Treatment plans and the associated quality of risk assessments completed in 2018, which has been presented to the local Mental Health Legislation	Director of Operations	Ongoing Monitoring

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Committee for acceptance and performance monitoring.		
CMHTs must ensure copies of CTPs are given to service users and their relatives, where consent has been provided for this to happen.		Action plan prepared in response to the Delivery Unit National Review of Care and Treatment plans and the associated quality of risk assessments completed in 2018, which has been presented to the local Mental Health Legislation Committee for acceptance and performance monitoring.	Director of Operations	Ongoing Monitoring
Health boards ensure regular audits are performed to ensure that service users are not detained under section 4 of the MHA for longer than 72 hours.		Compliance with Mental Health Act is monitored and reported bi-monthly to the Mental Health Sub Committee. There have been no breaches within the UHB for one year. Patients are very rarely detained under section 4 of the Mental Health Act for more than 24 hours.	Director of Operations	The UHB will continue to Monitor bi-monthly
Health boards and Local Authorities need to ensure there is joint access to relevant CMHT records. This has a clear potential adverse impact upon the standard of care being provided and needs to be addressed as a matter of priority.		Systems are in place to ensure that Local Authority and health staff have equitable access to the patient record. No outstanding actions.	Director of Operations	Complete and embedded as part of routine practice

Improvement needed	Standard	Service action	Responsible officer	Timescale
Health Boards need to ensure that there are clear lines of accountability, staff training and robust auditing processes to oversee and implement medicines management within community services, especially within CMHTs.		Local guidelines and protocols have been developed to support a system where a named individual takes responsibility for the prescribing, ordering of Depo injections and mentoring of physical health of patients receiving this treatment. This process will be embedded and monitored. Temperatures of all medication fridges are monitored daily. Compliance is reviewed as part of the internal observations of care inspections.	Lead Pharmacist CMHT Leads	April 2019 Each Team will continue to monitor medication fridge temperatures daily.
CMHTs need to ensure that all staff complete mandatory adult and child safeguarding training.		Adult and Children safeguarding training is mandated for all staff and is monitored monthly and reported to the Executive Performance Reviews. December 2018 Compliance, Adult level 1 -75.54% , Children level 1- 72.87%	Director of Nursing	The Clinical Board will continue to monitor compliance monthly.

Improvement needed	Standard	Service action	Responsible officer	Timescale
CMHTs need to ensure that carers' assessment of needs are routinely offered.		A dedicated third sector link worker jointly funded by the Local Authority and Health oversees the co-ordination and implementation of carer's assessments and associated outcomes. Care and Treatment Plans record whether carers have been offered a carers assessment. Compliance with the recording and monitoring of carers assessment will be included within supervision compliance.	Clinical Lead for Quality and Safety	April 2019
CMHTs need to undertake an audit of discharges to measure the quality and timeliness of discharge planning in order to help improve services and outcomes for service users. CMHTs need to review the role of the care co-ordinator and establish whether the service users are receiving the correct input from the most appropriate professional. CMHTs and care co-ordinators in particular, need to ensure discharge planning is robust and meets with legislative requirements.		A holistic approach to recording patient health and social needs is incorporated within the CTP, including accommodation needs etc. Complaints and concerns relating to discharge will be monitored and discussed in Quality Safety and Experience Committee. A programme of work reviewing the timeliness of discharge is currently underway.	Director of Nursing and Clinical Director	Review 6 monthly JT to confirm timescale

Improvement needed	Standard	Service action	Responsible officer	Timescale
CMHTs need to develop processes to evaluate the effectiveness of information, advice and assistance that is provided for service users.		All Community Health teams have a generic collection of patient literature and information resources that are used as well as information pertaining to local third sector services which will vary in each area. Stepiau is an online resource used in all teams and available in five different languages and DEWIS is a standardised information platform for health and social care service information across Cardiff and Vale. In February 2019 the Director of Operations and other leads will attend a Service User Engagement Form representing all service users across Cardiff and Vale and explore feedback on the quality of information available locally and respond with a plan within 2 months.	Director of Operations	February to April 2019
Health Boards need to explore and utilise the support that may be offered by third sector services across Wales, with a need to take advantage of the range of community groups and mental health support services available to patients in their local communities.		Third sector teams are co-located with community mental health teams during clinic times to encourage utilisation. There is a third sector chair of the Together for Mental Health strategy	Director of Operations	Complete and embedded as part of routine practice

Improvement needed	Standard	Service action	Responsible officer	Timescale
		meetings implementing the national strategy. Over £2m has been spent of third sector resources and a further £0.5m is being made available to implement the primary care initiative.		
Much more work is needed to increase the availability and timely access to psychological therapies across Wales. Health boards need to improve resources in this area and look at different ways of making sure sufficient psychological services were being provided.		There has been funding in place for the past two years to expand access to psychological therapies including condition specific psychological therapies. The UHB is currently achieving 70-80% compliance with the 26 week RTT target. Further work is required to address waiting times for PTSD services for which there is now funding available. 3000 people at any one time in Cardiff and Vale are waiting to receive a formal psychological Intervention with over 70% of those being received within 26 weeks.	Head of Operations and Delivery	The UHB will continue to monitor RTT compliance on an ongoing basis

Improvement needed	Standard	Service action	Responsible officer	Timescale
Health Boards and Local Authorities need to work together to improve joint processes for driving the improvement of services. This includes the need for greater alignment of processes within CMHTs including integrated records and data collection.		An integrated structure and records allow the UHB and Local Authority to work in partnership.	Director of Operations	Complete and embedded as part of routine practice
All CMHT staff should receive training in the following; □ Mental Health Act □ Social Services and Well Being Act □ First Aid and the use of defibrillators		MHA-Targeted training is undertaken as required. SSWBA- training was made available when the SSWBA was enacted but there has been no subsequent training. However all Local Authority staff will have received training and therefore are available to support teams with decision making. First Aid and Defibrillation training- Defibrillators are not routinely made available in community clinics. Nursing staff, however, have received training in their use to allow them to confidently use a defibrillator opportunistically. The protocol in the case of a collapse in any UHB community clinic is to ring 999.	Director of Operations	Complete

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print):	Ian Wile
Job role:	Director of Operations
Date:	19th December 2018

CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD
QUALITY SAFETY AND EXPERIENCE SUB-COMMITTEE

MINUTES OF THE MEETING HELD ON 9TH JANUARY 2019

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Sarah Jones	Quality Lead, Pharmacy
Bolette Jones	Head of Media Resources
Robert Bracchi	Consultant, AWTTC
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Suzie Cheesman	Patient Safety Facilitator
Emma Cooke	Head of Physiotherapy
Judyth Jenkins	Head of Dietetics

Apologies:

Mike Bourne	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Alun Morgan	Assistant Director of Therapies and Health Sciences
Rachael Daniel	Health and Safety Adviser
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 19/001 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting and introductions were made.

CDTQSE 19/002 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 19/003 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 12th December 2018 were **APPROVED.**

CDTQSE 19/004 Matters Arising/Action log

The action log was **RECEIVED** and it was noted that a number of actions had been completed. The outstanding actions were updated as follows:

CDTQSE 18/164 Schedule of Patient Stories/Annual Reports

Sue Bailey to issue directorates with dates of when they are required to present a patient story and an annual report to this Group.

Action: Sue Bailey

CDTQSE 18/291 Academic Building

Rachael Daniel will discuss the health and safety risk assessment undertaken on the Academic Building with the Estates team as she has a number of concerns.

Action: Rachael Daniel

It was noted that no further incidents have been reported.

CDTQSE 18/427 PSN046

Rebecca Vaughan-Roberts has discussed the Patient Safety Notice with an Interventionalist and the issue is identified as low risk. She needs to request further information from the Patient Safety Team to substantiate that this is low risk and will contact Matthew McCarthy.

Action: Rebecca Vaughan-Roberts

CDTQSE 18/429 Disposal of Medical Equipment

Sue Bailey will raise at the next Clinical Board Formal Board meeting the concerns of other Clinical Boards auctioning off or disposing of medical equipment themselves and not via Clinical Engineering which is UHB Policy.

Action: Sue Bailey

CDTQSE 18/443 Bariatric Patient Pathway Meeting

Rebecca Vaughan-Roberts will provide feedback from the Bariatric Patient Pathway Meeting to a forthcoming meeting of this Group.

Action: Rebecca Vaughan-Roberts

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 19/005 Patient Story – Sensory Loss

Sion O'Keefe presented on the sensory loss initiatives undertaken within Health Records and Outpatients.

The directorate was directly involved in a public meeting for deaf patients and those with hearing loss in January 2018 and attended again in September 2018. It was tasked to enable all patients with sight loss to receive letters in a larger font. Feedback from individuals with sensory loss mainly raised issues based on their communication needs from the Health Board. This was noted and the following action has been taken:

For hearing loss patients, a form has been created for them to indicate their preferred choice of interpreter. A dedicated generic email address has been set up for patients with hearing loss only to email their forms to this email address. The aim is for a response to be sent straight away with confirmation that the interpreter has been booked within 2 days. This is currently being piloted but uptake has not been significant.

The directorate has also considered how it can engage better with patients with sight loss. Patients who provide their mobile phone telephone number can now view their appointment letters on-line. The patient is sent a code to their mobile phone which they can input into a web link. They then input some personal details and their letter can then be viewed on-line. This allows them to expand the font size and colours etc. that fits their requirements. There are 99 languages available including Welsh. Uptake is around 33% although 80% of patients have provided their mobile number. Development support is now needed to look at placing flags and alerts on the PMS system. In the first instance this will focus on deaf patients. This functionality can eventually be rolled out to services that use other systems.

CDTQSE 19/006 Feedback from UHB QSE Committee 16th October 2018

The minutes from the Annual Special Meeting held on 16th October were **RECEIVED.**

An analysis was presented on trends and themes of Serious Incidents and a presentation was provided on Human Factors and initiatives to support staff and improve safety and quality.

CDTQSE 19/007 Health and Care Standards

A report providing an overview on the UHB's approach to assessment of compliance the Health and Care Standards was **RECEIVED.**

For this year's programme, Clinical Boards need only self-assess against 7 of the 22 standards. The remaining standards will be managed by UHB Committees. The deadline for self-assessments is 27th April.

At the next meeting, a discussion will be held on the Clinical Board's position against the standards.

Action: All

CDTQSE 19/008 Risk Register

No updates to report.

CDTQSE 19/009 Exception Reports

Vanessa Golding, Highly Specialist Podiatrist was in attendance to escalate the Podiatry department's concerns on the significant increase in the number of heel pressure damage referrals received during the last year which has placed considerable pressure on the team.

The Podiatry department currently assesses all foot wounds including heel pressure damage referred to the service from the hospital setting in the respective wards they present. There has been a significant increase in the number of referrals received particularly from October and November 2018. The reasons have not been identified but the following issues are being considered:

- Is there a link to the change in mattresses in September and October 2018?
- The new fitted bed sheets may not be fitting the mattresses.
- Is there a change in care?
- Is this the new norm?

An audit has been undertaken and data indicates that there were 83 additional referrals received in 2018 compared to 2017. This increase equates to an additional 14 clinical days required to assess these patients. The data also indicates a sharp rise in referrals during October and November 2018. Further analysis has found that 64 of these referrals are for new heel pressure ulcers with 40% of these falling in the most severe damage category 3, 4 or unstageable.

2 cases studies were presented highlighting the consequences of most severe heel pressure ulcers.

A 61 year old patient, wheelchair bound, peripheral neuropathy and blind, on admission to hospital developed grade 2 heel pressure ulcer on the right heel which deteriorated to grade 4. 7 months later on further admission to hospital he developed grade 2 heel pressure ulcer on the left heel which deteriorated to grade 4. This resulted in a right below knee amputation and the left heel deteriorated further requiring a left below knee amputation. The patient deceased prior to the second surgery.

An 86 year old patient admitted to a mental health ward was at high risk of heel pressure ulcers because of peripheral arterial disease and peripheral neuropathy. The patient was acutely unwell with reduced mobility, spending more and more time in bed. Actions were not taken to offload or protect the heels. He developed bilateral heel pressure ulcer which became infected. Further deterioration resulted in a bone infection requiring amputation.

It is well documented that peripheral arterial disease and peripheral neuropathy are risk factors for heel pressure ulcer development. In terms of making an impact the Podiatry service has been requesting for the implementation of the Foot Risk

Assessment to be part of the core assessment on admission and would recommend that this is reviewed.
It has developed and are implementing posters on mattress selection and heel offloading products.

The service is upskilling staff to enable junior staff to manage simple wounds and heel pressure ulcers.

The service also recommends an increase in Band 7 funding to be provided to podiatry to meet the current demand on the service to ensure patients receive timely and appropriate care.

Sue Bailey will escalate this issue to the Clinical Board Formal Board. The UHB Pressure Damage Group are aware of the increase in referrals for heel pressure ulcers and Sue Bailey will also discuss the issues with the Chair of the Group. She will gather further information from the Head of Podiatry, Radiology and Medical Photography and consider escalation to the UHB QSE Committee.

Action: Sue Bailey

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 19/010 Initiatives to promote Health and Wellbeing

The Clinical Board is reporting 66.6% uptake of the flu vaccination for frontline staff and has met the UHB target. Flu outbreaks are now being reported and staff who have not yet received the vaccination are encouraged to be vaccinated.

CDTQSE 19/011 Falls Prevention

Nothing to report.

SAFE CARE

CDT QSE 19/012 Concerns and Compliments Report

From 1st April 2018 to 31st December 2018 the Clinical Board reported 43 formal concerns. This compares to 49 in the same period as last year.

In December 2018, 1 formal concern was received. This compares to 5 received in December 2017.

Since 1st April 2018, the Clinical Board is reporting 16 breaches in response times. There were 0 breaches in December 2018.

The Clinical Board received 0 AM concerns in December 2018. Since 1st April 2018 the Clinical Board has received 6 AM concerns.

From 1st April 2018 to 31st December 2018, the Clinical Board has received 70 compliments. This compares to 72 received in the same period last year. 5 compliments were received in December 2018.

The key theme for formal concerns received is communication between staff and patients. 19 of the 43 concerns received fall within this category. The breakdown by sub-category is as follows:

- 6 (32%) related to attitude of staff.
- 6 (32%) related to difficulties in arranging/cancelling appointments.
- 7 (36%) related to lack of communication/communication issues.

CDTQSE 19/013 Ombudsman Reports

Nothing to report.

CDTQSE 19/014 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 19/015 Patient Safety Incidents

SI Report

Closure forms for In72302 and In69239 have been submitted to Welsh Government.

An RCA for In79310 related to the mortuary is in progress.

CDTQSE 19/016 New SI's

There are no new SIs to report.

CDTQSE 19/017 RCA/Improvement Plans

Incident In57334 related to Surgery Clinical Board will be presented to the next meeting.

CDTQSE 19/018 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 19/019 Regulation 28 Reports

Nothing to report.

CDTQSE 19/020 Patient Safety Alerts

There were no Patient Safety Alerts received.

CDTQSE 19/021 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 19/022 Medical Device Risks/Equipment and Diagnostic Systems

Nothing to report.

CDTQSE 19/023 IP&C/Decontamination Issues

A letter has been received from Welsh Government to request that Health Boards communicate to frontline staff that bare below the elbow and good basic hand hygiene practices must be adhered to.

CDTQSE 19/024 Key Patient Safety Risks

Safeguarding

Kevin Hogan of the UHB Safeguarding Team was in attendance to provide an update from the service. The service is available Monday to Friday 9-5 with an out of hours emergency service linked to police and social services.

The team has ongoing commitments to MASH in Cardiff, nothing that this service not available for the Vale. The team also work closely with the Vale Children and Adults Services.

An organisation called RISE has been set up in Cardiff area, primarily aimed at women but can be accessed by males who are experiencing domestic abuse.

There is training available for staff at level 2 and level 3. For this Clinical Board, clinical staff and managers and service leads should complete level 2 training. Level 3 study days are available that focus on particular topics e.g. FGM, legal aspects of safeguarding.

Over the last year county lines training has been made available. This relates to gang/drug related crimes. South Wales police keen to raise awareness on this. Any requests for county lines training can be fed back. The Safeguarding team are also looking at developing training related to Counter Terrorism.

The team are being supported to raise awareness of Adverse Childhood Events as they become adults. A number of events will be held on this subject.

Safeguarding supervision is on offer to staff if they have to deal with a challenging case.

It was noted that safeguarding notes are held on the PARIS system. The functionality is available for managers with access to PARIS to search for safeguarding events if they have concerns. The Safeguarding team can do this for managers that do not have access.

The UHB Safeguarding Steering Group is held bi-monthly and the leads from Clinical Boards are members of this Group.

MCA Act

Nothing to report.

CDTQSE 19/025 Health and Safety Issues

Nothing to report.

CDTQSE 19/026 Regulatory Compliance and Accreditation

There were no issues escalated from the Clinical Board Regulatory Compliance Group.

CDTQSE 19/027 Policies, Procedures and Guidance

Nothing to report.

EFFECTIVE CARE

CDTQSE 19/028 Clinical Audit

Nothing to report.

CDTQSE 19/029 Research and Development

The next meeting of the Clinical Board Research and Development Group will be held next week.

CDTQSE 19/030 Service Improvement Initiatives

Nothing to report.

CDTQSE 19/031 NICE Guidance

Nothing to report.

CDTQSE 19/032 Information Governance

Nothing to report.

CDTQSE 19/033 Data Quality

Nothing to report.

DIGNIFIED CARE

CDTQSE 19/034 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 19/035 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Item discussed under patient story.

CDTQSE 19/036 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 19/037 Equality and Diversity

Nothing to report.

TIMELY CARE

CDTQSE 19/038 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 19/039 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Nothing to report.

INDIVIDUAL CARE

CDTQSE 19/040 National User Experience Framework

The December report is not yet available.

STAFF AND RESOURCES

CDTQSE 19/041 Staff Awards and Recognition

Information on how to nominate in the National Patient Safety Awards has been circulated today.

CDTQSE 19/042 Monitoring of Mandatory Training and PADRs

Dates of future fire training sessions have been circulated.

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

The following minutes were **RECEIVED:**

Clinical Board Health and Safety Group Minutes 5th December 2018

ANY OTHER BUSINESS

Monies are available to departments from the Health Board Charity. It was noted that some departments have been successful in their applications to improve their staff working environment.

DATE AND TIME OF NEXT MEETING

13th February 2019 at 2pm in Room 4.4. 4th Floor Ty Dewi Sant Building UHW

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD
QUALITY SAFETY AND EXPERIENCE SUB-COMMITTEE

MINUTES OF THE MEETING HELD ON 13TH FEBRUARY 2019

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Alun Morgan	Assistant Director of Therapies and Health Sciences
Matthew Temby	Clinical Board Director of Operations
Rachael Daniel	Health and Safety Adviser
Bolette Jones	Head of Media Resources
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Emma Cooke	Head of Physiotherapy
Judyth Jenkins	Head of Dietetics
Maria Jones	Senior Nurse, Outpatients
Kathy Ikin	Directorate Manager, Radiology and Medical Physics/Clinical Engineering
Andrew	Graduate Trainee

Apologies:

Mike Bourne	Clinical Board Director
Robert Bracchi	Consultant, AWTTC
Paul Williams	Clinical Scientist Medical Physics
Lisa Griffiths	Quality Manager, Laboratory Medicine
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering
Suzie Cheesman	Patient Safety Facilitator

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 19/043 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting and introductions were made.

CDTQSE 19/044 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 19/045 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 9th January 2019 were **APPROVED.**

CDTQSE 19/046 Matters Arising/Action log

The action log was **RECEIVED** and it was noted that a number of actions had been completed. The outstanding actions were updated as follows:

CDTQSE 18/164 Patient Stories and Annual Reports

Sue Bailey has emailed the running order for directorates to present their annual reports and patient stories. She has also produced an annual report template for directorates to complete.

CDTQSE 18/429 Disposal of Medical Equipment Policy

The Executive Director for Therapies and Healthcare Sciences has written to every Clinical Board to remind them of the policy. Matt Temby has also raised the issues at the Directors of Operations Forum.

CDTQSE 19/006 Health and Care Standards

The Health and Care Standards will be discussed at the next meeting.

CDTQSE 19/008 Heel Pressure Ulcers

Following the issues raised by Podiatry at the last meeting in relation to heel pressure ulcers, Sue Bailey has escalated the issues to the Chair of UHB Pressure Ulcers Group. The Clinical Board will also continue to ensure the issues are escalated.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 19/047 Patient Story

Apologies were received from Oli Williams who was due to present on Falls Transformation.

Rebecca Vaughan-Roberts presented feedback from the course she attended on the management of bariatric patients. The main challenges around caring for bariatric patients were identified as:

- Treating the person as an individual and not just a bariatric patient. There are prejudices amongst healthcare staff.
- Knowing what to do and how to reduce the risk of injury.
- Understanding what equipment is available.

A systems approach involving multidisciplinary and multi-agencies should be taken. This involves:
- Shared risk assessments
- Clear documented protocols and pathways

- Organisational and setting specific protocols should consider all potential outcomes.
- A defined contact person to initiate protocol.
- Where possible, a pre-arranged equipment package sourced with an agreed timescale.
- Specialist training for care givers.
- Discharge planning should start when a patient is admitted.

A bariatric patient is likely to have adapted movement patterns and this can be used to facilitate movement. It is imperative that healthcare staff do not ignore other health factors and that risks are reduced to the lowest level. The dignity and respect of the patient must be maintained at all times.

Key learning:
- Planning is key.
- Understanding the challenges of both mobile and immobile patients within this group.
- Understanding the psychological issues affecting bariatric patients.

It has been agreed that the UHB will reconvene the Bariatric Pathway Group. Rebecca Vaughan-Roberts will meet with the Manual Handling Unit to identify what equipment or modifications to equipment is required in order to safely transport and image bariatric patients. She will also identify what bariatric moving and handling equipment is available on-site.

Alun Morgan stated that a key driver for setting up the Bariatric Pathway Group was that assumptions were being made on bariatric patients for example that they are unable to mobilise and strategies were needed to address this as many bariatric patients are able to mobilise.

CDTQSE 19/048 Feedback from UHB QSE Committee 18th December 2018

The minutes from the meeting held on 18th December are not yet available.

CDTQSE 19/049 Health and Care Standards

The UHB is currently in the assessment phase for this year's submission and this will be reviewed at the next meeting.

CDTQSE 19/050 Risk Register

There is no update from the UHB on the new risk register template.

CDTQSE 19/051 Exception Reports

Phlebotomy at Barry is reporting a marked increase in demand on its services and there has been an increase in complaints from patients. There has also been an increase in patients' behaviour becoming aggressive. Information has been sent out to GP Practice Managers to pass on to patients on the constraints on the service. An extra phlebotomist has also been sent to Barry Hospital to provide additional resource.

There is an estates issue relating to maintenance required on the hydropool. Alun Morgan will follow this up.

Action: Alun Morgan

Concerns were raised that CT3 scanner has had significant maintenance issues. Demand is being managed within Radiology.

A meeting is being held this week to discuss Acute Parental Nutrition following Pharmacy's decision to withdraw from this service. This has not been received well by the Surgery Clinical Board. Matt Temby noted his disappointment on Pharmacy's decision but it is hoped that a resolution will be reached at the meeting.

Matt Temby was concerned that no apologies were received from Pharmacy and Laboratory Medicine with the exception of Lisa Griffiths. He will write to both services.

Action: Matt Temby

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 19/052 Initiatives to promote Health and Wellbeing

The Clinical Board is not achieving the same levels of uptake of the flu vaccination compared to last year. Staff still have the opportunity to receive the vaccination. It was noted that at risk groups of catching the flu this year is the 18-40 year olds.

The UHB recently held a CAV a Coffee event which supports colleagues with mental health issues. The UHB is also holding mindful sessions for the start of the day and details are available on the intranet news page.

Matt Temby reported that this Clinical Board is undertaking a project to resource individuals from across professions to promote mindfulness and physical and dietetic wellbeing for staff in a bid to break through sedentary lifestyles. Matt Tenby is keen for as many leaders as possible within the Clinical Board to become involved when this is launched.

CDTQSE 19/053 Falls Prevention

Alun Morgan reported that the UHB Falls Group met last week and is in the process of finalising the falls framework. A transformation bid is also being produced to enhance the Community Resource Teams.

SAFE CARE

CDT QSE 19/054 Concerns and Compliments Report

From 1st April 2018 to 31st January 2019 the Clinical Board reported 49 formal concerns. This compares to 54 in the same period as last year.

In January 2019 6 formal concerns were received. This compares to 5 received in January 2018.

Since 1st April 2018, the Clinical Board is reporting 16 breaches in response times. There were 0 breaches in January 2019.

The Clinical Board received 3 AM concerns in January 2019. Since 1st April 2018 the Clinical Board has received 9 AM concerns.

From 1st April 2018 to 31st January 2019, the Clinical Board has received 83 compliments. This compares to 79 received in the same period last year. 13 compliments were received in January 2019.

The key theme for formal concerns received is communication between staff and patients. 20 of the 49 concerns received fall within this category. The breakdown by sub-category is as follows:

- 7 (35%) related to attitude of staff.
- 6 (30%) related to difficulties in arranging/cancelling appointments.
- 7 (35%) related to lack of communication/communication issues.

Matt Temby raised 3 points:

- He is concerned that attitude of staff is a key theme for formal concerns.
- He is pleased with the number of compliments being received.
- He noted that there has been a marked improvement in the number of breaches in turnaround times being reported.

CDTQSE 19/055 Ombudsman Reports

Nothing to report.

CDTQSE 19/056 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 19/057 Patient Safety Incidents

SI Report

The Clinical Board has 2 SIs outstanding. Closure forms are with Welsh Government.

CDTQSE 19/058 New SI's

There are no new SIs to report.

There have been 4 IRMER incidents reported with 3 reportable to HIW. There were no themes or communalities identified.

CDTQSE 19/059 RCA/Improvement Plans

Incident In57334 was shared by Surgery Clinical Board for learning purposes.

A patient attended Assessment Unit North of the Emergency Unit on 30th June at 21:17 hours with acute right upper quadrant pain. The patient was an 80 year old with acute onset right upper quadrant non radiating abdominal pain. Bowels open normally that morning, the patient had a good appetite and no other relevant history.

On examination the patient had a bilateral basal lung crackles and wheeze, abdomen soft and generally tender and distended, with bowel sounds present. A rectal examination noted hard stools in rectum but no blood or malaena present. Abdominal and chest x-rays were requested. A Surgical Specialist Registrar review followed. It was noted that the abdominal x-ray showed some small bowel dilation and the concern was possible small bowel obstruction. A CT scan was requested. Transfusion of blood to address anaemia and the patient was kept nil by mouth. On 01.7.17 a consultant ward round occurred at 08:50 hours with documentation of awaiting CT scan.

The CT scan was undertaken at 14:07hrs. The recorded conclusion given by the Radiologist stated “Findings in keeping with acute cholecystitis, no evidence of small bowel obstruction”. There was a note following the recorded conclusion that that “this is a provisional report. The images were reviewed by a consultant radiologist and an addendum issued.” At that stage no addendum had been added. The surgical doctors access the report at 16:36hrs and printed this off and proceed to act upon the acute cholecystitus finding reported. This was the CT report results the team discussed on the consultant ward round on the morning of 2nd July 2017. The patient’s observations were stable and pain improved and he was planned for discharge with antibiotics and Outpatient OGD.

The patient underwent a follow up ultrasound scan as an outpatient on 1st August 2017 which showed only gall stones. The patient was then admitted to UHL on 26th October 2017 at 14:35 with shortness of breath and anaemia. As a result attempts were made to expedite the colonoscopy. This was undertaken on 7th November 2017. During the colonoscopy a tumour was found the ascending colon. Biopsies were taken but the consultant undertaking the colonoscopy noted that the patient was not fit for surgical resection of the tumour. The patient was added to the colorectal MDT for further discussion on care plan. The patient was fully informed of the findings and discharged on 8th November 2017. He was then seen in Outpatient clinic on 15th November 2017 and a palliative plan was agreed due to severe COPD, cough, frailty and anaemia.

The investigation considered the events that occurred when failure to note the addendum finding was noted. It was unclear what action was undertaken after the addendum radiology report was issued and documentation relating to who was informed. The CT report showing likely T3 cancer was not acted upon leading to delayed management and MDT discussion and further acute hospitalisation with symptomatic anaemia.

A root cause analysis of the incident identified that there is no robust system of flagging unexpected/urgent/significant radiological findings in place within the Health Board.

Initial CT reported issued stated “this is a provision report. The images were reviewed by a Consultant Radiologist and an addendum issued”. At that stage no addendum had been added.

Surgical doctors printing the results off and not questioning the lack of addendum with Radiology.

Completion of the discharge summary document communication to GP was completed without checking the radiology report.

The improvement plan recommends that medical staff are reminded of the importance of checking addendum reports.

A standard approach to be devised within the Health Board for unexpected results reporting escalation by a Radiologist.

A standardised approach to be devised within the General Surgery directorate to review emergency patient radiology results reporting.

Review approach of handing over outstanding tests and additional information between teams within the Emergency General Surgery stream.

CDTQSE 19/060 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 19/061 Regulation 28 Reports

The Chief Executive has responded to a Regulation 28 Report relating to a patient who brought in prescription medicines from home and who took his own life by taking an overdose. The Coroner raised a Regulation 28 Report and the UHB was asked to respond whether it could have undertaken action to prevent this from happening. The Chief Executive in his response recognised the difficulties of encouraging patients with capacity to lock away their medicines. The UHB will be taking action to produce signage to raise awareness of the importance of secure handling of medicines and valuables. It is also revising its Patient Property Policy and Medicines Code which is due to be presented for ratification in March.

CDTQSE 19/062 Patient Safety Alerts

PSN046 Resources to support safer bowel care for patients at risk of autonomic dysreflexia

The safety notice has been circulated to the Clinical Board and across Physiotherapy in particular, to raise awareness.

PSN048 Risk of harm from inappropriate placement of pulse oximeter probes.

Circulated across Clinical Board as a reminder to ensure the correct probe is used for fingers and ears.

Internal notice re never event involving wrong route administration of an oral solution subcutaneously.

This was disseminated across the Clinical Board on 11th February as outlined in the notice.

CDTQSE 19/063 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 19/064 Medical Device Risks/Equipment and Diagnostic Systems

MDA/2019/002 Nellix Endovascular Aneurysm Sealing EVAS System – device recall and enhanced patient surveillance

Notice circulated for information.

MDA/2019/003 Freestyle Libre flash glucose sensor – use of barrier methods to reduce skin reactions to the sensor adhesive.

Notice circulated for information.

MDA/2019/004 Arjo Minstrel passive floor lift – risk of spreader bar detachment from lifts without a scale

Clinical Engineering has identified that these hoists are not in use in the UHB.

A letter has been circulated from Welsh Government reporting changes to medical device regulations. The Health Board has been asked to provide a response to their questionnaire. Radiology has responded re MRI and Saul Harris in Clinical Engineering is formulating a response back to Welsh Government.

CDTQSE 19/065 IP&C/Decontamination Issues

Alun Morgan reported that legionella is present in UHL. Awareness of importance of flushing regimes has been raised. Any showers or taps not in use are to be capped off.

The Medical Director has circulated a letter advising clinicians that legionella is present in the community. Rachel Daniel advised that legionella is a RIDDOR reportable event and the HSE will investigate any cases.

A baseline review of ANTT training by directorate will be undertaken.

The Interventional Radiology rooms and cleaning standards are now set to theatre standard.

Cleaning audits are being undertaken by housekeeping without professional oversight. They should be accompanied by a ward sister or appropriate professional and this is not happening.

Alun Morgan commented on the need to be mindful that a number of areas in this Clinical Board could be vectors for bacteraemia and good handwashing regimes must be in place.

CDTQSE 19/066 Key Patient Safety Risks

Safeguarding

Maria Jones provided feedback from the UHB Safeguarding Group.

17 year olds are considered as adults and cases are being missed.

Quality Assurance work is being undertaken on the Safeguarding Maturity Matrix.

A process is being piloted in PCIC Clinical Board in relation to thresholds for reporting Grade 3 Pressure Ulcers.

A presentation on FGM was delivered, highlighting that Education is better at reporting cases compared to Health.

It was noted that a good response for ambassadors for the White Ribbon Campaign has been received from the Executive Team.

MCA Act

Nothing to report.

CDTQSE 19/067 Health and Safety Issues

Rachael Daniel reported that it was agreed at the Local Partnership Forum last week that stress in the workplace will be added to the LPF work programme. A lot of work is being undertaken in isolation within the Health Board and there needs to be an organisational approach. It is not yet clear what this work will involve. Stress in the workplace was highlighted as a major issue in the staff survey.

As of January there is a new Executive Lead for Health and Safety and Martin Driscoll has taken on this role. He will chair the Operational Health and Safety Group and Clinical Boards are asked to ensure they are represented at the meeting.

CDTQSE 19/068 Regulatory Compliance and Accreditation

It was pleasing to note that the HTA has closed the CAPA from the inspection in Cellular Pathology in 2017.

A UKAS Inspection was successfully completed in Biochemistry.

The MHRA action plan for Blood Transfusion Laboratory is on target for closing out in February.

Alun Morgan raised concerns that operational management attendance at the Regulatory Compliance was poor. It is important this is not seen solely as a quality forum and requires attendance from operational managers

Regulatory Heat Map

The Clinical Board has had a challenging 2 years in terms of regulatory inspections. Consideration has been given as to how it can better map out its performance and Matt Temby has produced a dashboard for areas that are subject to regulatory inspection which provides a graphic that shows the risk of an inspection that could occur at any time.

The dashboard also sets out metrics and compliance against these in each of the areas to provide an overall score on current compliance. This is then translated into a simple graphic using a RAG rating dial.

Following the incidents that have occurred in Radiology UHL as reported earlier, the likelihood of an IRMER inspection has increased and Matt Temby and Rebecca Vaughan-Roberts will review the regulatory dashboard.

Action: Matt Temby/Rebecca Vaughan-Roberts

CDTQSE 19/069 Policies, Procedures and Guidance

The following policies have been approved by the UHB Health and Safety Committee:
Latex Policy
CCTV Policy
Environmental Policy

EFFECTIVE CARE

CDTQSE 19/070 Clinical Audit

Nothing to report.

CDTQSE 19/071 Research and Development

Sion O'Keefe reported that discussions were held at the Clinical Board R&D Group in relation to changes to the allocations of R&D funding and the process for directorates.

Therapies have undertaken a scoping exercise of R&D activities being undertaken within the directorate.

A new R&D Lead is required for the Laboratory Medicine directorate.

CDTQSE 19/072 Service Improvement Initiatives

Sion O'Keefe reported that the Programme Management Office is instigating 'We Love Project Management' events. Documentation has been produced on their intranet page relating to successful project management. The team are also expanding a mentoring programme for individuals needing support.

Sue Bailey reported that nominations are being sought for LIPS Cohort 11 which is starting in April.

CDTQSE 19/073 NICE Guidance

Nothing to report.

CDTQSE 19/074 Information Governance

Information Governance issues are now being raised at the Clinical Board Regulatory Compliance Group. There are no issues to escalate.

CDTQSE 19/075 Data Quality

Nothing to report.

DIGNIFIED CARE

CDTQSE 19/076 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

The CHC visited the Radiology department on Octopus Ward, Children's Hospital.

Matt Temby attended the CHC Liaison Meeting this week and the CHC requested to be informed if there are any significant service changes to the Clinical Board.

They also noted that they would like to be invited to Radiology to understand the IR service. They would also like to see the rollout plan for the First Contact service.

They noted that 8 patients have identified issues with Community Physiotherapy but were unclear on the detail so it is not yet identified whether this relates to this Clinical Board.

The CHC have also undertaken visits to all Podiatry centres following patient concerns relating to the service in the communities. An aggregated report will be submitted to the Chief Executive with a request to reinstate the social nail cutting service.

CDTQSE 19/077 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Nothing to report.

CDTQSE 19/078 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 19/079 Equality and Diversity

Alun Morgan reported that the UHB is promoting the LGBT history month in February.

Trans Awareness sessions are also being held and Alun Morgan will circulate the dates.

Action: Alun Morgan

TIMELY CARE

CDTQSE 19/080 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 19/081 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Therapies has no new risks in terms of breaches.

Paediatric MRI issues are being resolved however there will be significant challenges in the next few weeks.

Work associated with the GI pathway is delivering results that are exceeding expectations.

INDIVIDUAL CARE

CDTQSE 19/082 National User Experience Framework

The overall Clinical Board report was received for January 2019. 97% of patients rated their experience as 7 out of 10 or higher.

The Podiatry Report for January 2019 was also received. 100% of patients rated their experience 7 out of 10 or higher and 85% 10 out 10.

STAFF AND RESOURCES

CDTQSE 19/083 Staff Awards and Recognition

Physiotherapy have staff shortlisted in the UHB Staff Recognition Awards in March.

CDTQSE 19/084 Monitoring of Mandatory Training and PADRs

The Clinical Board compliance for fire training has improved. It is a statutory requirement that all staff must complete fire training.

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

The following minutes were **RECEIVED:**

Biochemistry Quality Group Meeting Minutes 7th January 2019.

ANY OTHER BUSINESS

The Clinical Board has 2 successful bids from the Health Board Charity. Emma Cooke asked if a successful bid could be shared as a good example. Helen Jenkins to ask Rhodri John to circulate the Cellular Pathology bid.

Action: Helen Jenkins

Alun Morgan reported that a biochemistry result reported high potassium levels due to a sample that had not been stored at the right temperature. A task and finish group to look at pre-analytical storage and transport of blood samples is being taken forward by Carol Evans, Laboratory Director, and will involve PCIC Clinical Board and Haematology.

DATE AND TIME OF NEXT MEETING

13th March 2019 at 2pm in Room 4.4. 4th Floor, Ty Dewi Sant UHW

MENTAL HEALTH CLINICAL BOARD QUALITY & SAFETY CLOSURE AND LESSONS LEARNED MEETING

17th January 2019

Seminar Room, Hafan y Coed, Llandough Hospital

Present:
Jayne Tottle, Director of Nursing Mental Health (Chair)
Will Adams, Professional Practice Development Nurse
Jayne Bell, Lead Nurse Adult MH
Debbie Brown, Ward Manager St Barrucs
Des Collins, Ward Manager Pine Ward
Natalie Coombs, Deputy Senior Nurse Manager CMHTs
Lisa Crump, ANP Adult In-patient
Jodie Deaves, HCSW REACT
Mark Doherty, Lead Nurse MHSOP/Neuro
Ibrahim Elbadrmany, Consultant REACT
Victoria Gimson, MHCB Pharmacist
Heather Hancock, Deputy Directorate Manager Adult MH
Steve Herkes, CPN REACT
Natalie Hulbert, Deputy Senior Nurse Manager MHSOP
Mathew Hoskins, Consultant MHSOP
Cristie Howells, Head CMHN, REACT
Robert Kidd, Consultant Psychologist
Tracey Lewis, CMHN, Vale Vale Locality CMHT
Kelly Panniers, ANP Adult In-patient
Tara Robinson, Senior Nurse Manager Rehab & Recovery
Darren Shore, Interim Senior Nurse Manager Adult Mental Health
Alexandra Skinner, Deputy Ward Manager St Barrucs
Jayne Strong, ANP Rehab & Recovery
Alice Thomas, Team Manager REACT
Sarah Trench, Lead CPN, Hamadryad CMHT
Dragana Turic, Consultant Younger Onset Dementia
Mark Warren, Senior Nurse Manager Criminal Justice & Forensic
Natalie Williams, Lead CPN Gabalfa CMHT

Apologies:
Simon Amphlett, Senior Nurse Manager Crisis & Liaison
Owen Baglow, Clinical Lead for Quality, Safety & Governance
Philip Ball, Senior Nurse Manager Vale Locality CMHTs
Alison Edmunds, Concerns Co-ordinator
Carol Evans, Assistant Director Patient Safety & Quality
Catherine Evans, Patient Safety Facilitator
Ruth Evans, Lead CPN Links CMHT
John Hyde, Mental Health Lecturer, Cardiff University
Noel Martinez-Walsh, Integrated Manager Pentwyn CMHT
Annie Procter, Director Mental Health
Andrea Sullivan, Concerns Co-ordinator
Tayyeb Tahir, Consultant Liaison Psychiatrist
Joanne Wilson, Directorate Manager MHSOP
Lowri Wyn, Ward Manager Cedar Ward

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

Chair welcomed all to the meeting and introductions were made.

Chair informed the group that the new NMC CEO, Andrea Sutcliffe, was visiting Hafan y Coed, Llandough Hospital on 1st February 2019 to listen to the views of mental health nurses. Andrea will meet nurses in the Seminar Room, Hafan y Coed at 10.00am and will then meet senior leaders from across Wales at 11.00am. Jayne invited all present to attend.

1.2 Apologies for Absence

Apologies for absence were noted as above.

PART 2 : ACTIONS

No Actions.

PART 3 : CLOSURES

3.1 JP

At the age of just 57 years, JP was diagnosed with early onset dementia. JP was cared for at home until his condition deteriorated and he was admitted to ward East 10, University Hospital Llandough then St Barruc's, Barry Hospital. JP was looked after well in St Barrucs until this incident.

JP had several seizures over 18 months, most were witnessed. JP would collapse on the floor then sleep afterwards, to sleep off the effect of the seizure. This particular incident, JP was witnessed falling backwards onto the floor hitting his head and shoulder, during or after a seizure. Basic neurological observations were taken and JP was placed in his bed. No neurological observations were carried out afterwards as the staff thought he was sleeping off his seizure and also they did not know how to complete neurological observations.

Jayne Tottle, Director on Nursing Mental Health, confirmed that at that time neurological observations were not part of Mental Health training. There is now a new training programme that covers the recognition of head injuries, neurological observations and procedures following a fall.

A Regulation 28 will be received from the Coroner regarding falls management; however the Coroner recognised the sizeable work already completed regarding falls training.

There had been a concern that JP had not been transferred to A&E earlier for attention. The Consultant Neurosurgeon at UHW said JP had a secondary bleed and would have died as the only treatment option would have been surgery but JP was not a candidate for surgery due to his co-morbidites and in particular JP's dementia.

Inquest conclusion was a subdural haemorrhage as a result of a traumatic brain injury following a fall.

Jayne Tottle said that the Healthcare Support Workers were outstanding when giving their evidence at the inquest, they knew what they were talking about and they are a credit to St Barrucs.

Lessons Learned:

1) Falls/Neurological Observations training.

   Action:
   275+ nurses had undertaken the new Falls Management training that covers recognition of head injuries, neurological observation and procedures following a fall, and this training was on-going.

2) Do Not Transfer.

The 'not for transfer plan' appears to be a misinterpretation of the DNAR for cardiac or respiratory arrest. A traumatic injury following a fall would necessitate transfer for emergency assessment in case of head injury.

Action:
Directorate has advised all registered staff to escalate all medical emergencies and that there is no policy for 'not for transfer' in such cases.

3) NEWS (National Early Warning System) standardised recording tool was not in use on St Barrucs ward.

Action:
Introduced NEWS with the appropriate training programme to support the implementation.

Miscellaneous:

Training requirement for staff was discussed. Suggestion that staff should be asked at their PADR if they feel there is anything they are not sure of and if they require any additional training.

Two staff members involved in this incident have been referred to the NMC.

TO CLOSE.

3.2 BD

BD was first referred by his GP to Mental Health Services in 2015. He had been diagnosed with ADHD as a child and was being prescribed Concerta XL (methylphenidate) however the emphasis of the referral was for help managing his long-standing depression. BD attended the ADHD clinic and had regular appointments at the Community Mental Health Team (CMHT) following the referral.

During 2017 BD had several additional referrals that include: –

- Taith Drug and Alcohol Service
- Therapies Hub
- Primary Mental Health Support Service - did not engage with telephone assessments.
- Mindfulness & Behavioural Activation – did not attend workshop
- Adult Liaison Psychiatry for overdose of heroin

Very sadly, in 2018, BD was found deceased from an overdose of heroin.
The cause of death: Drug overdose (heroin). The conclusion of the inquest was Open.

Issues identified:

- Taith keep their own notes (CRIIS) and these are not on PARIS, therefore unable to review Taith's notes so details of these contacts would not have been visible to CMHT workers.

Action:
Jayne Tottle will ask the Senior Nurse Manager of Addiction Services to look into this.

- At no point is it documented that BD was given overdose training or that he received a Naloxone kit.

Lessons Learned:

In retrospect there was probably inadequate consideration of substance misuse at first. Although initially there was little to raise suspicion of substance misuse it does not appear that this was explored at every opportunity nor was there use of urine testing to confirm the patient's denial of substance misuse, apart from one isolated occasion.

Notable practice:

Following the heroin overdose a comprehensive plan was put in place by the CMHT with support to refer to EDAS/Taith, addressing BD's housing situation and also an Out Patient Appointment was arranged.

Many of the routine medical reviews are documented to a high standard and evidence good consideration of the wider context of the patient's difficulties and attempts to encourage the patient to engage with non-medication approaches to managing their difficulties rather than just focussing on ADHD prescribing.

The Doctor was proactive on more than one occasion and contacted the patient by telephone to follow up non attendances.

Recommendations:

Wider discussions as to whether Naloxone Training and kits should be rolled out to CMHTs to enable provision of kits to those patients reluctant to engage with substance misuse services.

Action:
Jayne Bell, Lead Nurse said she would discuss this with the Adult Directorate. Expiry date of Naloxone kits may present a problem.

TO CLOSE.

3.3 NW

NW was open to Pendine CMHT from 2008. The precipitating factor at that time was the death of her grandmother who had been her main care giver during her childhood. Concern at time of referral was about the risk of overdose.

Deliberate self harm dating back to 2008 - biting herself, picking skin, burning self with iron or lighter. and superficially cutting stomach.

Multiple overdoses documented from 2008, all except one appear impulsive and sought own rescue (from partner, friends or services). One Overdose in 2013 demonstrated planning writing cards to children and giving them money.

Medical reviews in CMHT between 2008-2012 gave the diagnosis of Bipolar Affective Disorder, treating with mood stabilisers and antidepressants.

Medical reviews from 2012 identified difficulties with poor emotional regulation and the diagnosis changed to Emotionally Unstable Personality Disorder.

Engagement with community staff was sporadic with frequently cancelled or missed appointments. Anger management was recommended on a couple of occasions but NW does not appear to have attended this. NW attended the Ymlaen Therapeutic Group for 18 months and gained some coping

skills for emotional distress. NW was referred twice to the Emotional Regulation Group but did not attend. Referred to Cynnwys in 2018 for DBT.

NW had significant physical health problems. Very sadly in 2018 NW was found unresponsive in her bed, an ambulance was called and NW was taken to UHW but she sadly died. Cause of death: Pneumonia

Issues:

Wider discussion and learning would be beneficial regarding documentation of assessment/care and treatment plans. In particular copying and pasting of information without updating, inclusion of relevant information in clinical information and updating assessments at point of discharge from inpatient/CRHTT.

There was discussion regarding risk assessments. Noted that there was a module on PARIS for physical health but it is problematic and not user friendly.

Action:

WARRN training being rolled out.

Jayne Tottle to set up a group to look at PARIS input. Volunteers/Nominations:

Natalie Williams, Robert Kidd, Justin Williams, Paul Williams,
Mark Warren, Natalie Coombs, Natalie Hulbert, Mike Lewis.

TO CLOSE.

3.4 LC

LC had a long history of involvement with mental health services for multiple overdoses, and self harm. LC had a traumatic childhood marred by physical abuse. LC also had a history of rape and was diagnosed with post traumatic stress disorder. LC's symptoms then and throughout her life were consistent with an Emotionally Unstable Personality Disorder, and she also appeared to have a long history of alcohol misuse.

LC's daughter was born with profound problems including severe autism and learning disability. LC's daughter was in care and the stress of the distance of travel to visit her, along with limited and restricted access, would have been a stressor.

Very sadly, when the police undertook a welfare check due to LC not replying to calls they found LC dead at home. The Inquest outcome was: 1a Hanging Conclusion: suicide.

Jayne Tottle said that she can arrange support from a solicitor for staff who attend Coroner's Court. The solicitor will go through the process.

Lessons Learned:

There was a discussion regarding the support for patients with children in care. Support could have also been gained from Claire Humphries, Safeguarding Nurse Advisor Child Protection. However, it was noted that LC did not want to engage with staff; she would only engage with staff regarding her medication

The document "Serious Incident Review" stated "LC had a Psychiatry Liaison Assessment at A&E following an overdose" and queried whether the Psychiatry Liaison team or Emergency Unit made a referral to Substance Misuse Liaison, or signposted to EDAS (Entry into Drug and Alcohol Services). The Q&S Lessons Learned meeting determined that this section should be updated. **TO CLOSE**.

3.5 NA

NA has a history of deliberate self harm and risk taking behaviours. NA has a long standing diagnosis of Emotionally Unstable Personality Disorder (Borderline Subtype) and co-morbid history of harmful use of substances and alcohol. She has an extensive history of utilising self harm and overdoses of substances to manage her emotional distress, and also has a long history of overdependence on medication (mainly Procyclidine, Benzodiazepines and sleeping tablets). NA has had numerous admissions to hospital both formally and informally.

NA has undertaken a full programme of Dialectical Behaviour Therapy, involving Skills Group sessions, and individual therapy sessions while in specialist placements. NA has attended specialist inpatient detox and personality disorder settings. NA has previously received weekly support from the Cynnwys Service however she stopped this independently.

NA has a history of reporting suicidal urges and intent at times of intense emotional dysregulation. This is usually after an argument or following substance or alcohol misuse.

NA consistently secures rescue through alerting others to her situation, some examples of this include: informing emergency services/attending the GP surgery/attending the CMHT/informing family or CMHT by telephone.

NA took an overdose of one week's supply of medication and was admitted to Gwenwyn ward at Llandough Hospital where NA was assessed and admitted to Hafan y Coed, Llandough Hospital on an informal basis. During the admission NA frequently self harmed which included ligaturing, lacerations to arms and abdomen, overdosing and swallowing objects.

In February 2018, staff on the ward received a phone call from NA. NA sounded distressed and stated that she was on a bridge. NA stated that she just 'wanted to end it all' but she didn't believe that the bridge she was 'high enough so if she jumped it may just paralyse her, which would then mean that she wouldn't be able to end it at all. Staff gave NA constant reassurance and asked her to come back to the hospital or staff would get a taxi to go and get her. NA refused so staff continued to give NA reassurance, however NA hung up the phone. Staff alerted the police via the emergency line. The Police later contacted the ward stating that NA had jumped off the bridge. The ambulance service and police took NA to A&E in UHW. NA had a serious break to her ankle requiring surgery and a broken back, which may require surgery.

NA was discharged from UHW a few months later.

Findings:

Plans were put in place in an attempt to manage NA's risk and to support and manage her through crisis periods.

Whilst an inpatient it is clear from the case notes that the nursing staff provided her with almost daily 1:1 time, in order for her thoughts and feelings to be validated and offer the support and coping mechanisms that she may require.

Recommendations:

Jayne Tottle wondered what support the nursing staff had received regarding NA's continuous self harming whilst on the ward. The support of another discipline such as Psychology would be helpful to staff.

A referral to the Complex Case Forum should be considered.

The risk management plan to be checked to see if it requires updating.

3.6 GOOD PRACTICE:

RE

RE's mental health has resulted in attempted suicides in the past, these are recorded as:-

in 1976:
Overdose

in 1983:
Admitted to Whitchurch Hospital for Post Natal Depression (PND) with Obsessive Compulsive Disorder (OCD).

Jumped from a bridge resulting in serious injuries and was admitted to UHW following this for many months.

Took a Paracetamol overdose.

Following the birth of her second child RE again suffered with PND, she overdosed on Paracetamol and tried to drown herself in the bath.

There was no further contact until 2018 when RE was referred to the Mental Health Services for Older People (MHSOP) by her GP, this was due to an overdose of 20x50mg Setraline Tablets taken the previous day which was treated via ambulance and taken to Emergency Department at University Hospital of Wales. The MSHOP React Team accepted the referral and RE was seen as a priority. The case note clearly includes a detailed risk management plan. The trigger for this episode appears to be a recent car accident.

The REACT team visited RE at home daily and RE was agreeable to look at options such as psychology and individual work. Suicidal ideation was explored during the visits and RE consistently denied having thoughts to end her life. The team discussed the option of admission to hospital with RE but this was declined. The visits also discussed ways of managing her thoughts when she felt low in mood. Sleep pattern was noted to have improved but RE's appetite remained poor. RE was encouraged to speak to her family or to ring the REACT Team if needed.

Very sadly, during a visit by REACT staff they arrived to find RE's husband engaged in performing CPR on his wife. The ambulance arrived but unfortunately RE was declared dead.

Staff contacted the son and informed him of the news. Both members of the REACT team remained with RE's husband until the son arrived.

The Inquest outcome was: Hanging Conclusion: suicide.

Notable Practice:

RE was seen extremely promptly by a senior clinician for assessment of mental health needs. The notes are a detailed assessment of RE's mental state and it is also clear that this was a lengthy visit of between 1 to 2 hours. Case notes were extemporary.

The documentation was of a high standard. The discussions around suicide were documented discussions with good evidence to support home treatment.

On the day of the incident, REACT staff arrived as the husband was performing CPR. They remained throughout the incident and showed real compassion in a very difficult situation.

Conclusion:

Surprisingly, an unexpected Regulation 28 has been received from the Assistant Coroner. The Assistant Coroner has asked us to consider:

A – the identification of patients who require immediate psychiatric assessment and review by specialist teams

B – the care and attention to detail taken by doctors and other healthcare professionals when noting histories and information from mental health partners

C – the frequency of medication reviews with mental health patients

Following the disclosure of the Regulation 28, there was a discussion regarding the confusion over the quantity of tablets taken. Documentation originally stated 2 tablets when in fact it was clarified later as 20 tablets. Darren Shore to scrutinize and add to the Incident Review if necessary. Jayne Bell suggested asking the Assistant Coroner to visit REACT to see how they work.

In relation to a different case, Jayne Tottle spoke about the Coroner considering the use of plastic bags in an in-patient setting - the All Wales Group may meet with the Coroner as highlighting the issue may well increase the prevalence of use.

4.0 DATE OF NEXT MEETING

21st March 2019 at 9.30am in the Seminar Room, Hafan y Coed.

Item 4

MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE COMMITTEE held at 1.30 pm, 22nd January, 2019 in PCIC Meeting Room 1, CRI

Present

Gareth Hayes (GH) (**Chair**)	Clinical Director, Clinical Governance
Anna Mogie (AM)	Lead Nurse, North and West Cardiff
Ceinwen Frost (CF)	Lead Nurse, Vale Locality
Denise Shanahan (DS)	Nurse Consultant
Helen Earland (HE)	Senior Nurse PC
Helen O'Sullivan (HO'S)	Quality and Safety Manager
Karen May (KM)	Head of Medicines Management
Matthew McCarthy (MM)	Patient Safety Facilitator
Mel Lewis (ML)	Lead Nurse, Palliative Care
Nicky Hughes (NH)	Lead Nurse, S&E Locality
Nicola Marvelley (NM)	Assistant Head Of Workforce (representing Nicola Evans)
Rachel Thomas (RT)	Locality Manager, S&E Locality
Sarah Griffiths (SG)	Head of Primary Care
Rachel Armitage (RA) (Minutes)	PCIC Quality and Safety Officer

By invitation

Theresa Blackwell (TB)	Assistant Business Manager
Alexandra James (AJ)	Macmillan Advance Care Planning Facilitator
Karen Davis (KD)	Associate Clinical Nurse Specialist, Palliative Care

Apologies

Kay Jeynes (KJ) (Vice Chair)	Director of Nursing PCIC
Anna Kuczynska (AK)	Acting Clinical Board Director
Lisa Dunsford (LD)	Director of Operations
Lynne Topham (LT)	Locality Manager N&W Locality
Stuart Egan (SE)	Trades Union representative

Preliminaries		**Action**
01/19/001	**WELCOME AND INTRODUCTIONS** All present introduced themselves and were welcomed by the Chair.	
01/19/002	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
01/19/003	**DECLARATIONS OF INTEREST** GH asked for any declarations of interest – none noted.	
01/19/004	**MINUTES OF THE PREVIOUS MEETING HELD ON 13TH NOVEMBER, 2018**	

	The minutes of the previous meeting were recorded as an accurate record. **Matters Arising** There were no matters arising.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		**Action**
01/19/005	**PCIC CLINICAL BOARD QUALITY AND SAFETY GROUP ACTION LOG** The Clinical Board (CB) Quality and Safety Group action log was reviewed. Members noted the content. The following points were discussed: **Update on service model and staffing for CHAP**: Agreement has been reached for CHAP to over-establish for 2-3 months to stabilise the service following the recent increase in patient attendance. **05/18/008 Risk Register – GP OOH IT issues:** It was noted that new servers for OOH were expected during week commencing 29th January, 2019. **11/18/009 Risk Register – QS&E 160714 Patient Flow Updated risk assessment required regarding District Nursing (DN) Service** – it was noted that negotiations are ongoing to rebuild the Roath DN service with a revised team, aiming to return to fully operational status by the end of January 2019. **11/18/009 Risk Register – PCIC 28.01.15 GMS Services/Primary Care Capacity and Sustainability Evaluate "MyGP"** – it was noted that the LMC has also requested evaluation of "MyGP" with a particular view to identifying what has been achieved for the amount of investment. A report will be submitted to the QSE Group in March 2019. Lee Virgo and/or Dawn Baker-Lari to be invited to the meeting to discuss the outcomes. **11/18/010 Audit – Add community Pharmacy audits to the audit plan:** Action completed. 11**/18/023 Tracheostomy Guidelines Updates:** North and West team continue to audit and will evaluate on completion. South and East has only one patient with a tracheostomy; the audit has identified issues with staff competence because the care of the tracheostomy is carried out by a care agency. CF summarised the findings of the Vale audit which had been found to be very favourable regarding all four appertaining patients, although it had been highlighted that one patient did not have an emergency pack. It was intended that there would be a further audit with particular emphasis on emergency packs.	**SG**
01/19/006	**PATIENT STORY** Alex James and Karen Davis were welcomed to the meeting to provide an update on the Advanced Care Planning project	

	which aims to enable discussion with patients on their wishes for future care. It was noted that the All Wales documentation that had been provided was currently under review, noting the necessity for it to comply with the Mental Capacity Act (MCA) before the project is implemented. ML confirmed that the forms have been risk assessed in line with the MCA and feedback has been provided to the All Wales group which will review the documentation as a matter of urgency. DS highlighted that any documentation that is not absolutely compliant and lawful will create a risk for all. It was noted that the associated risk related to legal issues rather than patient care. AJ highlighted that the project will initially be implemented in GP and care home settings in the Central Vale, which will inform any further changes required. It was noted that it will be necessary to educate both GPs and the public about this work. It was confirmed that existing advance care plans would remain in place while in future it will be necessary to use consent forms to ensure support from the MCA. It was confirmed that this will be a 3-year pilot project which will include education of healthcare professionals. It was noted that patients will take responsibility for their own care plans and use the existing "message in a bottle" scheme to ensure its accessibility in time of need. In addition a computer system to support the scheme is under development, while an intranet page will emphasise that anyone can state their preferences at any stage even if they are not on the palliative care pathway. It was confirmed that work is under way with the UHB MCA Manager to ensure that all healthcare professionals understand the Best Interests function. The QSE Group n**oted** the update and **agreed** to receive a report on the outcomes of the pilot project in due course.	
01/19/007	**QUALITY DASHBOARD** GH reviewed the dashboard. The following points were highlighted. **Current SIs:** It was noted that all except one of the open SIs are pressure ulcers; the remaining SI relates to a case of tuberculosis identified in an inmate of HMP Cardiff. **Sickness rate**: NM reported that the sickness rates for October to December were 5.68%, 5.8% and 5.86% respectively. It was noted that the ongoing issues in Roath DN team accounted for some of the sickness rates. There was discussion on medium and long term sickness rates, noting that there are around 40 cases of medium to long term sickness from a total cohort of around 800. It was highlighted that remedial work will be focused on people who have been off sick for between 3 and 4 months, of which the majority are for musculoskeletal and stress reasons.	

	Mandatory training: it was noted that improvement is required on statutory and mandatory training compliance; in addition fire training will need to be refreshed in light of the transfer of the PCIC team to the new setting at Woodland House. **Cold Chain breaches:** It was noted that the figures relating to the recent power cut will be reported to the next QSE meeting; learning is under way and processes will be revised. **Out of Hours Statistics**: it was noted that these statistics are under review on an All Wales basis and are expected to be amended. The QSE Group **noted** the Quality Dashboard and the agreed indicators.	
01/19/008	**RISK REGISTER (RR)** **QS&E 000214 OOH** There were low fill rates throughout the Christmas period; it was recommended that incentivisation arrangements should be altered in advance of Christmas 2019. It was noted that there were also low fill rates within the nursing staff cohort. It was confirmed that two business cases have been submitted to the Chief Operating Officer with the expectation that these challenges will be resolved by February 2019. **QS&E 000113 Independent Sector** Continues to be tolerated. **QS&E 020714 CHAP** Action plan has been submitted and adopted; to be reviewed monthly. **QS&E 160714 Patient Flow** Review of Cardiff Community Resource Teams has been completed and recommendations are being reviewed by LT and Local Authority colleagues. There continues to be a lack of capacity within domiciliary care. A number of projects funded by the integrated care fund are under way to support patient flow. There are early indications of success in a pilot project involving Vale Community Resource Service and the Medical Emergency Admissions Unit at University Hospital, Llandough. **PCIC 110914 Complex Packages of Care** Risk remains the same with continuing lack of capacity to support patients with complex care needs in their own homes. **PCIC 160614 Primary Care Estates Development and PCIC 0814 Local Development Plan** A member of staff with an Estates remit will join the Primary Care team on 29th January. It was confirmed that there are a number of estates developments ongoing which have time limitations but which are being hampered by the lack of effective and timely Procurement support. It was confirmed that this would need to be added to the local risk register and escalated as necessary.	

	PCIC 28.01.15 GMS Services/Primary Care Capacity and Sustainability A second GP Practice has returned its contract to the UHB; work is under way to secure alternative GMS provision for the area affected. A provider has been found to replace one contractor and will be established by April 2019. The musculoskeletal and Mental Health Project Managers have commenced in post. **PCIC 10.03.16 Pressure Ulcer (PU) Prevalence** A 3-month pilot project has resulted in fewer safeguarding reports relating to pressure ulcers. **PCIC18.05.16 Domiciliary Care Provision** A provider in the Vale of Glamorgan took over a provider previously reported as unstable. The domiciliary care workforce has been adversely affected by UHB recruitment of additional Healthcare Support Workers. **S&E 05.12.16 HMP Cardiff – Prescribing, Staff Stress, Environment** Staffing levels remain challenging; work is under way to improve recruitment and retention. **S&E 06.01.17 HMP Mental Health Provision** An external review has been undertaken; results will be shared in due course. It was discussed that the risk is reported on the PCIC risk register but would be more appropriately placed on the Mental Health clinical board risk register, noting the complexity of relationships between clinical boards and HMP Cardiff. **S&E 10.07.18 HMP Spice Incidents** Continuing high incidence of code reds and blues. Risk tolerated. **N&E 10.01.17 Cardiff CRT Medication Administration Procedure** No further progress. **CHC 11.08.17 CHC Commissioning group** No further progress. **PC101218 NESA Accreditation** 800 pharmacists have been accredited out of approximately 1800 across Wales. Those not accredited will not be permitted to provide services. <u>Risks escalations to note</u> *Ventilated patients in the community*. CF and AM summarised the cases relevant to their Localities. It was agreed that these risks should be escalated to Executive level. The QSE Group **noted** the Risk Register.	
01/19/009	**AUDIT**	

	PCIC Clinical Board District Nursing Rotas AM confirmed that an Internal Audit had provided reasonable assurance on how nurses are rostered. An action plan will be developed to manage the recommendations made in the audit report. The QSE Group **noted** the report.	**AM**
01/19/010	**DATIX** MM summarised a report on incident reporting in 2018. It was noted that the reporting rate was stable with a small backlog to manage. It was highlighted that the majority of incidents that remained open for some time were pressure ulcers; work is under way to improve the quality of the flow of information on pressure ulcers, noting the complex movement of incidents between primary and secondary care. The QSE Group **noted** the updates.	
01/19/011	**PHARMACY UPDATES** KM noted the expected impact of Brexit on the availability of medicines noting that shortages have already been identified. It was highlighted that legislation is under development to support pharmacies through Brexit. Data will be collected and reviewed every 6 months. The QSE Group **noted** the report.	
01/19/012	**FRAMEWORK FOR THE MANAGEMENT OF PERFORMANCE CONCERNS IN GENERAL MEDICAL PRACTITIONERS (GPS) ON THE MEDICAL PERFORMERS LIST WALES** This item was withdrawn.	
01/19/013	**OPTOMETRY UPDATE** The QSE Group **noted** the update.	
01/19/014	**BUSINESS CONTINUITY PLANS** This item was deferred to the next meeting.	**RA**
01/19/015	**CONCERNS** Concerns themes performance summary by Business Unit It was confirmed that KJ and RA will meet with the Patient Safety Team to develop a report that is more meaningful for PCIC. The QSE Group **noted** the report. Claim JW vs OOH The QSE Group **noted** that there has been a new claim made against the Health Board.	

01/19/016	**OUT OF HOURS PEER REVIEW – ACTION PLAN** Colleagues were invited to forward issues to LD and KJ. <u>GP OOH Briefing – Christmas transfer of calls</u> It was highlighted that the escalation process had been successful although the Senior Manager on Call and the Executive had been reluctant to agree to the transfer of calls believing that there would be a significant adverse effect on the EU. HE agreed to work with Loretta Reilly to develop a method to assess the actual impact on the EU. The QSE Group **noted** the report.	**HE**
01/19/017	**BUSINESS UNIT QSE MINUTES** It was confirmed that the Business Unit minutes had been reviewed with feedback provided where appropriate.	
01/19/018	**INFORMATION GOVERNANCE** <u>Standard Operating Procedure (SOP) – Document retention: Performance Management of Doctors and Dentists</u> GH summarised the SOP and highlighted the agreed period of retention for documents relating to performance management of doctors and dentists. The QSE Group **agreed** the SOP. SOP to be submitted to Corporate Information Governance Committee for ratification.	**RA**
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		**Action**
01/19/019	**RESEARCH AND DEVELOPMENT (R&D)** <u>Email from Robyn Davies</u> The QSE Group **noted** the update.	
01/09/020	**SEASONAL FLU GUIDANCE FOR 2018 TO 2019 FOR HEALTHCARE AND CUSTODIAL STAFF IN PRISONS, IMMIGRATION REMOVAL CENTRES AND OTHER PRESCRIBED PLACES OF DETENTION FOR ADULTS** NH highlighted that a patient with flu had been discharged from hospital to a care provider who had refused to attend the patient. It was confirmed that Kayren Jeffers-Murphy, Nurse Assessor, would discuss this with the care provider. The QSE Group **noted** the report.	
SAFE CARE		**Action**
01/19/021	**SPECIMEN COLLECTION – BEST PRACTICE IN THE PRE-ANALYTICAL STAGE** It was highlighted that the means by which specimens are transported may affect the result of the subsequent tests.	

	The QSE Group **noted** the report.	
01/19/022	**NEW "START SMART THEN FOCUS" (SSTF) AUDIT TOOL** KM confirmed that the tool provides advice on the prescribing of antibiotics by Junior Doctors, to be noted by District Nurses. The QSE Group **noted** the report.	
01/19/023	**POINT OF CARE TESTING** <u>Urgent message from Executive Team for all staff who undertake POCT</u> DS highlighted that a ward inspection undertaken within the last 2 weeks had identified POCT equipment that was not working, noting that this fails to comply with guidance and that staff need to have appropriate training before using the equipment**.** The QSE Group **noted** the update.	
01/19/024	**MEDICAL EQUIPMENT ISSUES** TB confirmed that the UHB has been charged with reviewing how medical equipment is managed, such as by developing asset registers and maintenance logs for all medical equipment. TB agreed to circulate the guidance materials and lodge the minutes of the medical equipment group meetings in the shared folder, including links to all the relevant supporting documents. It was agreed that Medical Equipment will be a standing item on the QSE agenda.	**TB**
EFFECTIVE CARE		**Action**
01/19/025	**INFECTION CONTROL** • <u>HCAI monthly update and reduction expectation dashboards</u> • <u>HCAI monthly update and reduction expectation summaries</u> • <u>HCAI monthly update dashboards (Public)</u> The QSE Group **noted** the updates, which had been provided for information.	
DIGNIFIED CARE		**Actions**
01/19/026	**DEMENTIA** <u>Dementia Action Plan Update</u> DS confirmed that the plan has been circulated to Cluster and Locality leads, while optometry and dental colleagues have been requested to identify appropriate indicators for measurement. <u>Madeline's Project Stage 2 and Workshop Report</u> DS highlighted that the Project has been successful in achieving funds from Welsh Government and will be working as a test bed for improving dementia friendly communities.	

	The QSE Group **noted** the update.	
TIMELY CARE		**Action**
01/19/027	**SAFEGUARDING** • Cardiff Public Service Board Addressing Exploitation Workstream • Working Together to Safeguard Children • Interim Report of the Independent Inquiry into Child Sexual Abuse and • Interim Report: A Summary Independent Inquiry into Child Sexual Abuse • Truth Project • WG Anti-slavery guidance • South Wales Police Operation Signature – protecting vulnerable victims of fraud These items were presented for information. The QSE Group **noted** the contents. Pressure ulcer incidents MM summarised the report, noting that South and East Cardiff Locality reports fewer pressure ulcer incidents than North & West Cardiff or the Vale, which may be explained by differences in demographics between the localities. There has been a significant increase in SI reporting following clarification of Welsh Government's (WG) requirement for community acquired pressure ulcers to be submitted as SIs, but it is expected that the number of pressure ulcer SIs will drop again in 2019 once the anticipated updated WG guidance is received to only SI report avoidable pressure ulcers. The two main themes evident from the pressure damage incidents reported to WG during 2018 were patients at or approaching end of life and patients who have capacity, but decline pressure relieving advice/equipment. The QSE Group **noted** the report.	
01/19/028	**ACUTE RESPONSE TEAM PATIENT EXPERIENCE SURVEY** CF confirmed that the survey had been carried out by means of using iPads and highlighted the positive feedback that had been received. The QSE Group **noted** the report.	
INDIVIDUAL CARE		**Action**
01/19/029	**TRACHEOSTOMY AUDITS** This item was discussed during item 5, action log.	
01/19/030	**PATIENT EXPERIENCE GROUP MINUTES DECEMBER 2018 – NORTH AND WEST LOCALITY** The QSE Group **noted** the minutes.	

01/19/031	**TRANSITION PATHWAY FOR YOUNG PEOPLE WITH COMPLEX NEEDS** CF highlighted that PCIC and Child Health have jointly developed a pathway for transition to community care; this has been ratified at the Child Health QSE meeting. Following ratification at the PCIC QSE meeting a 6-month pilot project will commence. The QSE Group **ratified** the pathway.	
01/19/032	**WELSH LANGUAGE UPDATE** TB highlighted that the UHB has received a compliance notice from the Welsh Language Commissioner, consequent on which a working group is developing a compliance plan. It was noted that community settings are also expected to comply with the Welsh Language Act 1993. The compliance order sets out the standards against which the UHB will be measured by the Commissioner from May 2019 onwards; it is expected that measurement is likely to be by means of "mystery shoppers". SG requested further direction on UHB responsibilities regarding independent contractors and liabilities relating to any failure of the contractors to comply. TB confirmed that services provided by the UHB are expected to be bilingual. SG noted that substantial criticism had been received from Practices regarding the fact that the OOH service telephone message is provided first in Welsh, noting that for many Practices Welsh is not a priority for their patient groups. In addition, while the Practice appraisal asks whether the Practice can provide services in Welsh, if the Practice is unable to do so the UHB is unable to enforce it. It was highlighted that the Practices have access to LanguageLine. DS emphasised that, for safety reasons, the language of the medical record must be English. The QSE Group **noted** the update.	
STAFF AND RESOURCES		**Action**
01/19/033	**WORKFORCE UPDATE** The QSE Committee **noted** the updates which had been discussed under item 7, PCIC Quality Dashboard.	
SUB-GROUP REPORTS		**Action**
01/19/034	<u>34.1 GP OOH Business Unit</u> HE confirmed that work was ongoing on updating the policy for verification of death. Training is under development and will in the long term be linked with the ESR system. This will lead to the training of OOH nurses and DNs to enable them to make the certification. <u>34.2 Vale Locality</u> CF highlighted the ongoing issues of Netbook coverage in the western Vale. In addition the PARIS team has indicated that it would be inappropriate to purchase new devices because they	

	are not compatible with the new module which will be introduced. CF to raise with Mark Cahalane, MHCS Programme Manager. 34.3 Cardiff South and East Locality No additional issues to report. 34.4 Cardiff North and West Locality AM highlighted that an escalation report has been submitted regarding Park View, noting that the solution that had been identified has proved to be unsuitable. The DNs have been relocated to St David's Hospital so are therefore not operating in their own area and are consequently spending more time travelling to calls. Additionally, patients are unwilling to go to St David's Hospital to be seen in the treatment room or by sexual health services; there is therefore a risk of unplanned pregnancies. 34.5 Pharmacy and Medicines Management No additional issues to report. 34.6 Palliative care ML highlighted that a provider who had applied to provide palliative care services could not be accepted as it does not meet regulatory standards; HIW has failed to identify this. The palliative care team is working on a solution but expects that it will take some time to resolve. There is a plan in place to carry out a peer review in the short term to ensure the correct level of patient safety. 34.7 Primary Care No additional issues to report. 34.8 Clinical Governance Group No additional issues to report.	**CF**
PART 2:	**ITEMS RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE**	
01/19/035	**CMO UPDATES** CEM/CPhA/2019/1 — Actavis Group Ptc Ehf, Irbesartan/Hydrochlorothiazide300/12.5 mg film-coated tablets: Irbesartan/Hydrochlorothiazide 150/12.5 mg film-coated tablets CEM/CPhA/2018/16 — Update: supply disruption adrenaline auto-injector – Interim Dispensing Protocol CEM/CPhA/17a — Update on Protocol on Dispensing of adrenaline auto-injectors, 150 microgram applying from 29th November, 2018 CMO Update 94: December 2018 CMO letter — MenACWY Immunisation for all those 18 up to 25 years old CEM/CMO/2019/1 — Influenza Season 2018-19 : use of antivirals now recommended in line with NICE guidance **MHRA MEDICAL DEVICE AND MEDICINES ALERTS**	

MDA/2018/034(Wales)	Suction catheters, gastro-enteral tubes, intermittent urology catheters and sterile urine drainage bags – potential breach in sterile barrier packaging
MDA/2018/036(Wales)	Batteries for the HeartStart MRx monitor/defibrillator may fail to charge or to provide power

WELSH HEALTH CIRCULARS

WHC (2018) 041	Awareness of Carbon Monoxide Poisoning
WHC (2018) 048	National Enhanced Service Specification for Non-routine Immunisations

WELSH GOVERNMENT ADVISORY *None received since last meeting.*

NICE GUIDANCE *None received since last meeting.*

PATIENT SAFETY NOTICES/INTERNAL SAFETY NOTICE AND GUIDANCE

ISN: 2018/008	Disruption in supply of Sodium Chloride 0.9% Solution for Infusion 1000 mL
PSN046	Management of life threatening bleeds from arteriovenous fistulae and grafts
ISN 2019/001	Clexane (enoxaparin) 40 mg injection

SI CLOSURE FORMS

NHS ALERTS

- ADVOCATE Questionnaires for Dentists
- WG EFA 2019 001 Portable fans in health and social care facilities: risk of cross-infection

PUBLIC HEALTH WALES

- Public Health Wales Briefing: Increase in acute flaccid paralysis/myelitis in the UK – reporting for investigation and surveillance
- Public Health Wales Briefing: European bat lyssavirus found in serotine bat, England

UPDATES FROM OTHER GROUPS

- NHS Wales Safeguarding Network Minutes, 6th December, 2018.
- Minutes from the UHB Nutrition and Catering Steering Group December 2018
- Safeguarding Team Newsletter Autumn/Winter 2018
- Agenda for the Nursing Productivity Group Meeting.

DATE OF NEXT MEETING

Tuesday, 12th March, 2019, 1.30 pm – 3.30 pm
Meeting Room 2, PCIC Offices, Woodland House, Maes-y-Coed Road, CF14 4TT
FOCUS: AUDIT

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 23rd November, 2018
Venue: Critical Care Resource Room

MINUTES

In Attendance:
Carys Fox (CF), Chair, Director of Nursing, Specialist Services Clinical Board
Steve Gage (SG), Pharmacist, Pharmacy
Sarah Matthews (SM), Senior Nurse, Nephrology and Transplant
Mary Harness (MH), Senior Nurse, Haematology
Fiona Kear (FK), Assistant Service Manager, Haematology
Orla Morgan (OM), Lead Nurse, Critical Care
Craig Spencer (CS), Consultant, Critical Care
Lorraine Donovan (LD), Senior Nurse, Neurosciences
Sian Williams (SW), Senior Nurse, Cardiothoracic
Suzie Cheeseman (SC), Patient Safety Facilitator
Holly Williams (HW) Patient Quality and Safety Facilitator
Gail Clayton (GC), MS Lead Specialist Nurse, Neurosciences
Nav Masani (NM), Consultant Cardiologist, Clinical Board Director

Not present but referenced:
Vince Saunders (VS), IP&C Lead for Specialist Services Clinical Board
Dr Vinod Ravindran (VR), Consultant Nephrologist, Nephrology and Transplant

PART 1: PRELIMINARIES		**Lead**
1.1	Welcome & Introductions	
1.2	Apologies for absence Claire Main, Gareth Jenkins, Rachel Barry, Jennifer Proctor, Ceri Phillips, Hywel Roberts, Colin Gibson, Vince Saunders.	
1.3	To review the Minutes of the previous meeting 1st November, 2018 The minutes were agreed as an accurate record. Matters Arising Lanyards • Each Directorate to send orders to Ian Sidney, Critical Care Stock Controller M&M Meetings ✓ Please can the remaining Directorates confirm their criteria for selection for discussion at M&M by the close of November 2018 (received from Critical Care, Neurosurgery and Haematology) B5 MRSA report	

	✓ CF confirmed that this would not be attributed to the Specialist Services Clinical Board PVC Insertion Packs/ChloraPrep usage in Theatres ✓ HR to speak with Surgery counterpart to discuss this further. o Remove/Replace when the patient is received from Theatre with a PVC? o VIP scoring o Clarify protocol • NM explained that the correspondence to be circulated needed amending to remove the Executive involvement. This could then be issued to Q&S Leads and Lead/Senior Nurses. • HW advised that Intentional Rounding will be piloted within selected Wards in the Cardiothoracic Directorate. The findings from this will be shared within the Clinical Board. A further meeting will take place in December 2018 to progress these plans further. Llantrisant Dialysis Unit ✓ Dr Vinod Ravindran has concluded that there has been no increased incidents – to send report to CF – MH to support this	**HR** **NM/HW** **CPHW** **VR**
1.4	Patient Story: MS Focus - Presented by Gail Clayton, MS Lead Specialist Nurse, Neurosciences	
PART 2: SAFE CARE		
2.1	Antibiotic Audit: "START SMART THEN FOCUS"(SSTF) AUDIT TOOL This audit applies to all ward areas with the aim to increase engagement and awareness amongst prescribers. Nephrology and Transplant and Critical Care provided a verbal update during the meeting. Can all Directorates provide Holly Williams with an e-mail containing their arrangements to engage with this audit. This information can then be shared with CF and NM.	**All**
2.2	Open Serious Incidents (SIs) & Closure Forms • These were reviewed with 25 presently open. The Clinical Board is progressing with the closure of incidents, with a number planned for November's performance figures. • The majority of the incidents are attributed to pressure damage. • LD will circulate information regarding the procedure for fitting the new sheets for the mattresses. HW to provide a Datix report detailing the number of pressure damage incidents associated with the mattresses/sheets to determine any contributory factors. Complication in Pacing Theatre – CF provided an update regarding this incident following the dedicated meeting on 16th November, 2018. Open Inquests These were briefly reviewed.	**LD/HW**
2.3	Patient Safety Alerts Carbon Monoxide – Welsh Health Circular – *referenced by not discussed* Sodium Chloride Supply – *referenced but not discussed* *(Confirmation received from N&T, CC and CCOT, Neurosurgery and Haematology)*	

2.4	Safeguarding Newsletter CF advised that all colleagues should review this. The website link to the newsletter can be located in the e-mail attachment embedded in the agenda.	**All**
2.5	Healthcare Associated Infections • **HCAI Report – no IP&C representation** ✓ MRSA HCAI has been confirmed within Critical Care. Further details will follow. ✓ The HCAI report provided by VS was reviewed and the HCAI levels of incidences was discussed. • **STOP Campaign** ✓ This is an ongoing campaign to support the safe and suitable use of Intravenous Lines and urinary catheters, with the ultimate aim of preventing infection for patients. • **HCAI Extraordinary Meeting: 13/11/18** o RCA themes ✓ OM provided an overview of the discussions from the HCAI Extraordinary Meeting. She confirmed that medical attendance was poor, with only one Consultant in attendance – TCT. NM will follow-upon this attendance issue. ✓ OM confirmed that 75% of HCAI bacteraemia reports are PVC related, emphasising the importance of safe and suitable use and maintenance. • **Flu Update** ✓ MH provided an update confirming just over 50% of frontline staff within the Clinical Board had received a vaccination. Vaccines are currently being withheld due to the number being ordered against consent forms returned being a cause for concern by the UHB Flu Lead. An e-mail circulation is in place to support the sharing of resources. • **IP&C Newsletter** – Winter Edition – Previously circulated, *referenced for information*	**NM**
2.6	Zero Tolerance Report ✓ Previously circulated for Directorates to review. Please note, when submitting a blood sample, ensuring that the compulsory address details for the patient are included on the NHS number/Address line of the sample bottle. The NHS number is not compulsory.	**ALL**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee None received	
3.2	Exception reports and escalation of key QSE issues from Directorate QSE groups None raised	
3.3	Q&SE Clinical Board Terms of Reference Review Any changes are to be e-mailed to Carys by the close of November.	**ALL**
3.4	Clinical Board RCA Improvement Meeting *(Next Meeting Tuesday 8th January 2019)*	

	HW/SC provided a brief overview of the previous meeting. Minutes will shortly follow.	
3.5	Mandatory Training Current compliance was discussed, with an acknowledgement that medical compliance was key to increasing performance across all training areas. CPD attendance can be affected by low/non-compliance but is not applicable to medical staff. HW has circulated mandatory training reports to a number of the Clinical Board Directorates, but advised that the figures may not be wholly accurate/up-to-date. This information will be made available monthly.	**ALL**
PART 4: ANY URGENT BUSINESS		
4.1	Any Urgent Business ✓ Health and Care Standards. HW to circulate the associated spreadsheet and a working group will be established to progress the standards. Please send any updates to HW for her to update the main spreadsheet.	**ALL**
PART 5: ITEMS TO BE RECORDED AS RECEVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	Received and noted for information: ✓ Minutes from SpS Health & Safety Group for approval. Please send any comments by 30th November, 2018 to HW.	**ALL**
	✓ Medicines Safety Briefing – Epipen and Epipen Junior	**SG**
	✓ Capacity on Critical Care – Ruth Walker will be part of a walk around the Directorate on 29th November 2018.	**OM**
	✓ Antibiotic Awareness Week – 12th – 18th November 2018	**SG**
	• **VTE Performance** September 2018 – 73% (Is VTE risk assessment documented on drug chart) The discussion consider whether education was required to improve compliance. Furthermore: ➢ Pharmacy to check this has been actioned ➢ Sticker entry on the drug chart to follow-up – SG to follow-up on this	**SG**
	➢ Dr Vinod Ravindran is undertaking a review/audit within the Nephrology and Transplant Directorate – to provide an update. He is currently advising that this documentation needs to be completed otherwise prescribing cannot be progressed.	**VR**
	• **Neurosciences Risk Register Update - SBAR - Sodium Valproate** LD advised that this is being attended to and the risk register will be updated to reflect this.	**LD**
	• **Catastrophic Brain Injury incident** Clarity was sought on this issue. SC advised that the incident identified that the protocol could not be followed due to Critical Care capacity and there was not capacity for the patient to donate. The Organ Donor Intensivist/Clinical Donation are aware of this patient/incident. CS advised there were no concerns in relation to this.	**CS/SC**

PART 6: DATE OF NEXT MEETING		
6.1	Friday 13th December, 2018, 8am, in the Critical Care Resource Room, UHW. *Please send you apologies in advance.*	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Thursday 13th December, 2018
Venue: Critical Care Resource Room

MINUTES

In Attendance:
Hywel Roberts (HR), Chair,
Vince Saunders (VS), IP&C Lead for Specialist Services Clinical Board
Ceri Phillips (CP), Lead Nurse, Cardiothoracic
Maggie Hill (MH), Sister, Cath Labs
Julia Barrell (JB), Mental Capacity Act Manager
Sarah Matthews (SM), Senior Nurse, Nephrology and Transplant
Mary Harness (MH), Senior Nurse, Haematology
Gareth Jenkins (GJ), Service Manager, Haematology
Craig Spencer (CS), Consultant, Critical Care
Colin Gibson, Clinical Engineer, Rehabilitation Engineering, REU/ALAS
Lorraine Donovan (LD), Senior Nurse, Neurosciences
Suzie Cheesman (SC), Patient Safety Facilitator
Kevin Nicholls, Service Manager, Cardiothoracic
Holly Williams (HW) Patient Quality and Safety Facilitator

Not present but referenced:
Carys Fox (CF), Director of Nursing, Specialist Services Clinical Board

	PART 1: PRELIMINARIES	**Lead**
1.1	Welcome & Introductions	
1.2	Apologies for absence Jennifer Proctor, Maria Roberts, Carys Fox, Rachel Barry & Ravindra Nannapaneni Additional colleagues on AL	
1.3	To review the Minutes of the previous meeting 23rd November, 2018 – not all colleagues had received these – recirculated following the meeting on 13.12.18 The minutes were agreed as an accurate record. Matters Arising Lanyards • A link has been circulated from Dr Read for a lanyard design that does not allow "rotation" of the security badge and hence remains visible at all times. Each Directorate to order for their staff if they feel appropriate. M&M Meetings ✓ Please can the remaining Directorates confirm their criteria for selection for discussion at M&M (received from Critical Care, Neurosurgery and Haematology). HW to send CC information to HR for review (actioned 13.12.18).	

	<u>PVC Insertion Packs/ChloraPrep usage in Theatres</u> ✓ HR to speak with Surgery counterpart to discuss this further. (actioned 13.12.18) o Remove/Replace when the patient is received from Theatre with a PVC? o VIP scoring o Clarify protocol ✓ HW advised that a meeting with CF and VS to discuss this issue had been summarised in an e-mail to Lead and Senior Nurses with improvements to take forward.	**HR**  TheatresPVC insertion summary .r
1.4	**MCA Audit and Awareness Week – discussion led by HR and JB** To take place from 07.01.19 – 11.01.19 for all specialities with in-patients. Responses to be sent to HR and HW to collate (paper or electronic format acceptable) MCA awareness week and MCA training sessions to be held w/c 04/02/2019. Please contact JB if you would like to discuss specific training opportunities alongside those scheduled. As not all were present at today's meeting HR will contact lead nurse and medical lead for each directorate to ensure completion. HW will send HR the up to date contact list to facilitate this (actioned 13.12.18).	 MCA Week Poster 2019.docx  SS MCA Audit FINAL FINAL.docx **HR / HW**
PART 2: SAFE CARE		
2.1	**Point of Care Testing Notification** Importance of accountability and identified issues with sharing ID badges. Lag time associated with updating e-learning training record may have resulted in staff sharing ID badges. All directorates to ensure that all their PTOC trained staff have seen a copy of the memo and sign to acknowledge this. These signatures lists are to be returned to the clinical board. **Anticoagulant protocol for mechanical heart valves** A preliminary discussion was held but this needs to be ratified at Cardiology Directorate's Q&S and then returned to Clinical Board for presentation.	 FW URGENT COMMUNICATION F **ALL** **Cardiology**
	<u>Open Serious Incidents (SIs) & Closure Forms</u> • These were reviewed an additional three incidents to be added to our active list. • 8 closures completed in November, and 4 (+3) planned for December. • The majority of the incidents are attributed to pressure damage. • Thanks given to those who continue to support the RCA process. <u>Open Inquests</u> No actions required.	
2.3	<u>Patient Safety Alerts</u> Discussed. HW to follow-up with CM regarding management of life threatening bleeds from arteriovenous fistulae and grafts.	**HW/CM**

2.4	**NatSSIPs Update** An overview was provided by MH, including feedback from Liverpool visit. A more effective/efficient approach to NatSSIPs was notes. A workforce example was circulated. The use of Care Cube was discussed – with procurement presently for Cardiothoracic. An acknowledgement that medical involvement is vital to progress with the NatSSIPs agenda. UHB working group has been established however it was agree that a local level version would be beneficial. Dates to be circulated for the New Year (actioned 13.12.18). HR asked for clarification which body was leading / mandating the All Wales implementation of NatSSIPs (originally an English NHS initiative) - To be confirmed by SC.	**HW** **SC**
2.5	<u>Healthcare Associated Infections</u> • **HCAI Report** VS provided an update regarding prevalence for December 2018. One MRSA case reported (CC). High rates of MSSA. TB incident on B4 Haematology has been reported and an SI meeting has been scheduled for w/c 17.12.18 to discuss further. T5 refurbishment is not up to the standard required – this is being reviewed further following a recent Ward Walk-around – this may involve having to relocate patients again. • **Flu Update** MH confirmed that we are presently reporting the second highest vaccination figures within the UHB at 58% - which is similar to the final total last year for SS, despite being earlier in the year and in the face of some shortages of available vaccine. Vaccinations are available to order and the Leads/Champions continue to communicate to ensure the campaign runs as effectively and efficiently as possible.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	<u>Feedback from UHB QSE Committee</u> None received	
3.2	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> LD advised that the Urology Service for spinal injury patients in Rookwood being unavailable remained unresolved. This availability has been previously raised during board Q&SE Meetings with no resolution. HR asked for Clarification regarding whether there was a formal agreement/SLA in place to support the provision of the Service. Urology have raised concerns about the suitability of the area provided to the in Rookwod for the service but the nature of these concerns remain unclear. There may be a possible Estates/Environmental issue to be addressed. It was agreed that it was unsuitable/unsafe to expect patients to attend elsewhere for this service and that the service should be replaced as soon as possible – and certainly before the planned relocation to UHL in 2021. To be raised with CF and NM to progress further.	**LD**

3.3	Q&SE Clinical Board Terms of Reference Review Any comments to be sent to CF/HW for consideration. CS to send HW the modified CC TORS for information.	**ALL**
3.4	Mandatory Training ESR / IT system issues continue to be reported leading to difficulty with staff completing mandatory training and possibly leading to inaccurate compliance figures. Trainee medical staff pose a particular challenge due to their regular re-locations. HR will discuss with the Postgraduate department to see what can be done to address this. Directorates should consider IT requirements and Classroom opportunities for staff to support mandatory training, and raise concerns with LED/ESR/HW as required.	**ALL** **HR**
PART 4: ANY URGENT BUSINESS		
4.1	Any Urgent Business IP&C RCA Training Session – this was well attended and provided an opportunity to discuss with the attendees the RCA process and how improvements are taken forward. Falls Audit planned for January 2019. To utilize a modified version of the Falls Assessment which will be circulated in due course. The Assessment will be used to capture hip fractures caused by an injurious fall, but can be used for all falls moving forward. Further information will be circulated shortly, however the Audit will be focusing on how we document the initial falls assessment conducted by the medic in the clinical notes, and also use of the Hoverjack to support patients. Please ensure these practices are in place and are robust in preparation for this Audit and as part of recommended practice.	
PART 5: ITEMS TO BE RECORDED AS RECEVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	Received and noted for information: To be reviewed by the Clinical Board – any comments please feedback to HW.	
PART 6: DATE OF NEXT MEETING		
6.1	Friday 4th January, 2019, 8am, in the Critical Care Resource Room, UHW. *Please you're your apologies in advance if unable to attend.*	

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
24th January 2019
Venue: Critical Care Resource Room

In Attendance: Hywel Roberts (HR), Consultant, Critical Care and QSE Medical Lead (HR) Chair
Holly Williams (HW) Patient Quality and Safety Facilitator
Anne Marie-Morgan (AMM), Directorate Manager, Haematology, Immunology, TCT and Medical Genetics
Mary Harness (MH), Senior Nurse, Haematology
Rachel Barry (RB), Lead Nurse, Neurosciences
Gareth Jenkins (GJ), Service Manage, Haematology, Immunology and Medical Genetics
Helen Scanlan (HS), Interim Directorate Manager, N&T
Sarah Matthews (SM), Senior Nurse, N&T
Steve Gage (SG), Pharmacy
Colin Gibson (CG), Clinical Engineer, Rehabilitation Engineering, REU/ALAS
Gemma Ellis (GE), Nurse Consultant, Critical Care Outreach Team
Vince Saunders (VS), IP&C Lead
Craig Spencer (CS), Consultant, Critical Care
Bev Oughton (BO), Senior Nurse, Critical Care
Ceri Phillips (CP), Lead Nurse, Cardiothoracics
Sarah Williams (SW), Senior Nurse, Critical Care
John Martin (JM), Consultant, Neurosurgery
Navroz Masani (NM), Clinical Board Director, Specialist Services (attended first part of meeting)

Gemma Williams: PA for Specialist Services (Note taker)

PART 1: PRELIMINARIES		**Lead**
1.1	Welcome & Introductions The group introduced themselves one by one. Sarah Williams, Sister in Critical Care was welcomed to the group. Sarah will be covering the Senior Nurse in Critical Care role alongside Bev Oughton, who is covering the Lead Nurse role.	
1.2	Apologies for absence Carol Evans, Carys Fox, Rafael Chavez, Alex Murray, Claire Main, Sian Williams and Jennifer Proctor.	
1.3	To review the Minutes of the previous meeting 13th December, 2018 The minutes were agreed as an accurate record, subject to: • Suzie's surname was spelt incorrectly and should read "Cheesman" and not "Cheeseman".	GW

	• VS noted that the minutes inferred that the HCAI status was positive in the main but that this was not the case. High rates of MSSA. <u>Matters Arising</u> Item 1.3 PVC Insertion Packs/ChloraPrep usage in Theatres – HR to speak to Surgery counterpart to discuss this further (actioned 13.12.18). Item 1.4 MCA Audit and Awareness Week – HR/HW confirmed that they had contacted the Lead Nurse and Medical Lead for each Directorate to complete their MCA Audits. Item 2.1 Point of Care Testing Notification – All Directorates confirmed that all of their PTOC trained staff had seen a copy of the memo and signed to acknowledge this. Signature lists to be returned to the Clinical Board. Anticoagulant protocol for mechanical heart valves – needs to be ratified in Cardiology's Directorate Q&S and then returned to the Clinical Board for presentation. Item 2.3 Patient Safety Alerts – HW to follow up with CM regarding management of life threatening bleeds from arteriovenous fistulae and grafts. SC informed the group of an issue re the alert PSN46. Welsh Government had sent it twice under two different numbers (also used PSN47). Directorates to be aware. Item 2.4 NatSSIPs Update – HW confirmed that she had circulated the dates for the Local working group. A meeting took place yesterday (23rd Jan). Directorates need to identify a lead to take this forward. SC to clarify which body is leading /mandating the All Wales implementation of NatSSIPs. Item 3.2 Exception reports and escalation of Key QSE Issues from Directorate QSE Groups – LD advised that the Urology Service for Spinal Injury patients in Rookwood being unavailable remained unresolved. To be discussed on agenda. Item 3.3 Q&SE Clinical Board Terms of Reference Review – no comments were submitted to CF/HW for consideration outside of the meeting. GE had advised of her omission from the attendee list – this will be updated. Item 3.4 Mandatory Training – ESR/IT system issues. Directorates to flag any further issues with HW. HR will discuss the issue of trainee medical staff due to their changing locations with the Postgraduate department.	HR NG/CP HW Dirs Dirs SC GW Dirs HR
1.4	<u>Hywel Roberts and Julia Barrell, Mental Capacity Act</u> HR noted that they had tried to create a usable tool to audit MCA. HR will revise the tool for this year. Each Directorate fed back on their MCA Audit results. GW to circulate Directorate Summaries with minutes. **N&T, T4, Cardiothoracic, Critical Care, General Neuro, Haem.** JB noted that it is important to document why the person lacks capacity. It is important to show that this person can't make the decision otherwise it is assumed that they can. JB also noted that if someone has DOLS authorisation, you do still have to consider their capacity for treatment. HR noted that the audit needs to be carried out annually. HR thanked Directorates for all their hard work. Feedback on improving the tool would be welcome. HW informed the group that Mental Capacity training was available between the 4th to 7th	GW

	February 2019. HW will circulate the poster again. JB happy to meet with Directorate teams to support.	HW
PART 2: SAFE CARE		
2.1	<u>Open Serious Incidents (SIs)</u> SC fed back to the group. Currently 23 open SIs. 14 of which are related to pressure damage. 9 overdue with Welsh Government. 3 closures this week. 4 with Carol Evans. SC noted that Welsh Assembly Government have now changed the reporting process for pressure damage incidents – only now need to report avoidable pressure damage. This should mean that the UHB will now never have an overdue pressure damage incident. Should see a significant reduction in SIs. Need to ensure that the RCA process is completed within a 2-week period to avoid delays with reporting avoidable incidents to Welsh Government. <u>Inquests</u> SC noted that all new Inquests have been picked up. All new Inquests have occurred where the patient has had an accident outside of hospital so no action needed as yet from us. <u>Closure Forms for December 2018</u> The group noted that they couldn't open most of the PDF documents. GW to re-circulate them. 6 Closure Forms in December. Looking to close 4 in January. <u>Alerts</u> Again re-circulate as PDFs not opening. SC noted that one of the alerts was in relation to a shortage of Clexane – having to import from Europe.	GW GW
2.2	<u>Clinical Board RCA Improvement Plan Meeting – 08.01.2019</u> HW noted that the minutes from the last meeting had been embedded in the Agenda. The meeting focused on Falls and a discussion around the new All Wales Pressure Damage reporting process. 2 meetings have taken place now. Next meeting is in March. HW requested that the group refers to the minutes for information.	ALL
2.3	<u>Urology Cover for Rookwood</u> RB updated the group. The Spinal Injury patients in Rookwood are reliant on the Urology department as Urology care is key to them. This service has been suspended however following a period of sickness absence, and this has left the spinal patients very vulnerable to ongoing problem. No Inpatient or Outpatient support. Any patients who have reached an acute situation have been transferred back to their own Health Board for their Urology procedure and then returned to Rookwood. Some patients have had private consultations. The issue has been escalated to the Core Clinical Board Team who has subsequently discussed it with the Surgery Clinical Board Team - however there is still no Urology Service. SL noted that they have discussed with Urology re re-intstaing the service but this has not as yet come to fruition. This issue will be taken to OPG next week. Carys Fox, Director of Nursing, or NM to attend along with Jessica Castle, Director of Operations for Specialist Services. It was	

	noted that the issue is listed on the Risk Register.	
2.4	Healthcare Associated Infections HCAI Report MSSA Bacteraemia – figures not as good as last year. 12 cases over already. C.Difficile is below last year which is good. MSSA however is a concern. VRE Outbreak in Haematology. 22 cases this year. Previous year only 6. C Jeikeium outbreak also in Haematology. Ongoing meetings re this. 4 patients have had Noravirus on B1. 9 bedder closed. Main concern is MSSA Bacteraemia. Main themes 52% line related and 17.5 PVC. HR noted that he had spoken to TT re skin prep. Actually almost exclusively using skin wipes which are cheaper and more effective. It's not currently licensed for skin prep injections. Writing to manufacturers to see how Australia and New Zealand are using it. The Organisation may then need to make a decision on its use. TB case in Haematology on B4. Patient admitted in August. 2 meetings have taken place. PHW attended the meeting yesterday. The decision was not to screen patients but letters to be sent to patient contacts. Flu Update MH noted that there was a problem getting the vaccine but that this has now been addressed. Pockets of people were not getting their vaccines but generally the Clinical Board is doing quite well now. 60.9% of staff have had their injection which is good. Already better than last year.	
2.5	Health and Care Standards HW referred to the spreadsheet embedded in the Agenda. HW noted that she would like to create a working group. Keen to identify any existing colleagues to pull this piece of work together. CP noted that the last 2 years there has been a list of people identified for each standard. It was agreed that this would be continued this year. All the information has been saved on the S-Drive under Health and Care Standards. CP/HW will look into this and identify the leads and will send out the template. HR noted that there was a NatSSIPs meeting yesterday. The first step is for every Directorate to lead on the developing of LocSSIPs. Directorates to let HW and HR know of nominations before the next meeting. HW will organise.	CP/HW HW
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee SC noted that there had been an Annual UHB special meeting re Never Events and Serious Incidents (SIs) in December. No notes available as yet. Never Events and Serious Incidents from last year were discussed at the meeting, i.e. pressure ulcers, accidents, falls, common themes etc.	
3.2	Exception reports and escalation of key QSE issues from Directorate QSE groups None.	
3.3	Q&SE Clinical Board Terms of Reference Review HW referred to the Terms of Reference circulated ahead of the meeting. The group agreed that they were happy to sign them off.	
PART 4: ANY URGENT BUSINESS		
4.1	Any Urgent Business	

	LocSSIPs/NatSSIPs Meeting – 23.01.2019 – discussed above under Item 2.5. Inspections An inspection took place of Critical Care by the Faculty of Intensive Care Medicine. CS will report back to this meeting. GE Peer Review PHW GE noted that the Peer Review around the deteriorating patient took place recently - expecting report back soon. Regulation 28 SC informed the group that the Report for the Regulation 28 for the patient who took an overdose on the ward has been sent to the Coroner. Can present at the next meeting. Directorates to look at their areas.	CS Dirs
PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	Received and noted for information: For information/sharing. GW to re-send PDFs. • Tazocin Patient Group Direction - Notification signed off. Updating to allow blous fluid as well. • Patient Feedback Reports • Performance Data • Safeguarding: 'I Will Be Heard' Campaign • Winter Newsletter from Patient Safety and Quality team • MSE Newsletter • Clinic Letters	GW
PART 6: DATE OF NEXT MEETING		
6.1	Friday 15th February 2019, 8am, in the Critical Care Resource Room, UHW.	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 15th February 2019
Venue: Critical Care Resource Room
MINUTES

HCAI Focused

In Attendance:
Carys Fox (CF), Director of Nursing, Specialist Services (Chair)
Jessica Castle (JC), Director of Operation, Specialist Services
Navroz Masani (NM), Clinical Board Director, Specialist Services
Hywel Roberts (HR), Consultant, Critical Care and QSE Medical Lead (HR) Chair
Rachel Barry (RB), Lead Nurse, Neurosciences
Helen Scanlan (HS), Interim Directorate Manager, N&T
Sarah Matthews (SM), Senior Nurse, N&T
Steve Gage (SG), Pharmacy
Colin Gibson (CG), Clinical Engineer, Rehabilitation Engineering, REU/ALAS
Vince Saunders (VS), IP&C Lead
Mike Stephens (MS), Consultant, Nephrology
Jennifer Proctor (JP), Lead Nurse, Haematology, Immunology, TCT and Medical Genetics
Suzie Cheesman (SC), Patient Safety
Judith Burnett (JB), Seconded Senior Nurse, Critical Care
Sian Williams (SW), Senior Nurse, Cardiothoracics
Fiona Kear (FK), Assistant Service Manager, Haematology
Vinod Ravindran (VR), Consultant, Nephrology & Transplant
Keith Wilson (KW), Consultant, Haematology
Lisa Higginson (LH), Senior Nurse, Nephrology & Transplant
Claire Main (CM), Lead Nurse, Nephrology & Transplant
Ravi Nannapaneni (RN), Consultant, Neurosurgeon

Present:
Gemma Williams (GW), Personal Assistant, Specialist Services (Note Taker)

PART 1: PRELIMINARIES		ACTION
1.1	Welcome & Introductions CF welcomed Judith Burnett to the group, noting that she had been seconded into the Senior Nurse, Critical Care role. The group introduced themselves one by one. CF welcomed Jessica Castle back from Maternity leave.	
1.2	Apologies for absence Received from; Beverley Oughton, Ceri Phillips, Mary Harness, Rafael Chavez, Gemma Ellis, Holly Williams, Sarah Williams and Carol Evans.	
1.3	To review the Minutes of the previous meeting 24th January 2019 To be reviewed outside of the meeting. GW to circulate for any amendments required.	**GW**
1.4	Michael Stephens – Pancreas CUSUM Signal for pancreas transplant programme to indicate move - graph losses more than historical figures. Prompted internal review. All transplant programmes in	

	the UK are closely monitored by NHS Blood and Transplant. Two mechanisms are used to monitor: - CUSUM signal - Outcome reports Pancreas Advisory Group discusses the CUSUM signals. Review team results are discussed. NM noted that it appeared that there were incredibly robust processes in place and an excellent team which should be congratulated.	
PART 2: SAFE CARE		
2.1	<u>Open Inquests</u> Papers provided but not discussed <u>Open Serious Incidents</u> Currently 19 open SI's. 12 of which is pressure damage incidents. 4 due for closure in this month. <u>Closure Forms</u> 4 Closure Forms included for sign off: - IN74129 - IN56779 - In46388 - In79625	
2.2	<u>Patient Safety Alerts</u> • Safety Notice – ISN: 2019/002 • Water Hygiene and Legionella Management Safety Notices for information/action where required. VS noted that an external audit picked up that water flushing is not happening on wards as it should do. Some staff adapted the form which they shouldn't have. This is being addressed.	
2.3	<u>PSN046 – Resources to support safer bowel care for patients at risk of autonomic dysreflexia</u> RB updated the group. RB noted that some patients with MS, spina bifida are at risk of dysreflexia as when they enter hospital they may have difficulties managing their bowel care. The notice highlights some of the support available when caring for these patients at risk.	
2.4	<u>PSN047 – Management of Life Threatening bleeds from arteriovenous fistulae and grafts</u> MS noted that it wasn't uncommon for fistula patients to bleed. There are recommendations from patient safety which we already adhere to. The Welsh Renal Network Lead Nurse is requesting a lead from each hospital for an all Wales approach. CM noted that the Access Nurses provide specific education for patients and carers. Red band for fistula in situ. Knowledge of patient tested every 6 months to check that they know what they would need to do if they did start to bleed. It was noted that a green milk bottle top can be used to stop a fistula bleed.	
2.5	<u>HTA Inspection and JACIE Inspection</u> KW updated the group. Joint accreditation committee of the ISCT and EBMT. Internal society of Cellular therapy and 1st JACIE inspection in January 2013. 2nd inspection in February 2019. South Wales BMT Programme.	

	JACIE 2019 inspection feedback: • Strengths: Quality management/data management/processes/protocols. • Weaknesses: state of physical facilities at UHW site (adults). The report in February 2019 noted that the physical estate was the worst they have ever seen. Stating that the department was sitting on an outbreak waiting to happen. Only the diligence of staff and luck had meant that there had been no outbreak. Directorate team to update Risk Register. Risks escalated to Clinical Board. Processes were described as the best in Europe. CF noted that there were similar robust processes in both presentations given today at the meeting (this one and the Pancreas CUSUM presentation) which should be commended. CF noted that it was listed as the highest risk possible on the Clinical Board Risk Register. CF commented that the Board is closer to having a plan but no confirmed plan as yet. Executives, Ministers and Independent members have all visited the Department. VS noted that it was very good that the staff were complemented. Credit to the staff.	
2.6	<u>FICM Review</u> Not discussed. To be deferred to the next meeting.	**GW**
2.7	<u>Brief Update Cardiac Surgery</u> - <u>WHSSC Visit</u> JC provided an update to the group. WHSSC have raised concern re escalation processes around volume of patients/for cardiac surgery and length of time waiting. In excess of waiting 36 weeks in particular. SI reported to Welsh Government autumn of last year. The patient had died whilst waiting which was a huge concern which was 5 years ago. WHSSC requested a suite of information. On Tuesday morning there will be a commissioning visit. The format that the visit will take is a little unclear. This is a significant concern. Insufficient staff due to retirement/sabbatical. Scrub staff/anaesthetic/only 4 out of 5 surgeons.	
2.8	<u>Healthcare Associated Infections</u> <u>HCAI report – January 2019</u> VS referred to the HCAI report embedded in the agenda: • Feb to date – 0 C. *difficile* for the Clinical Board which is very good. • Unfortunately 3 MRSA bacteraemias for this year 2 of which have been attributed to Critical Care. • MSSA Bacteraemia so far 0 cases for Feb. Evidence to show better compliance on B5, T5 and C5 with VIP scoring . • E-coli – 1 case to date for February. • P.aeruginosa – 2 cases. • Klebsiella spp. – 1 case. VS noted that the Board is failing at MSSA Bacteraemia in particular. Still “1” per month as the target. 22 cases of VRE bacteraemias in haematology between January – December 2018. Only 6 the previous year. No cases to date for February. Starting to screen patients on the unit from Monday and weekly screens to see if patients are coming in with VRE or acquisition is occurring on the unit. Environmental screening has also taken place. Hand Hygiene is	

	consistently good on B4H. Commode cleaning failing on audits. Audits ongoing. Environmental audit has highlighted a number of issues with the fabric of the unit. Estates have been informed. Outbreak meetings ongoing. HR referred to the skin prep cannulation issue in theatres discussed in the previous meeting. HR was due to discuss with Tony Turley. Found in theatres a swab that contains chlorhexidine and alcohol. However, they are not licensed in Europe for skin cleansing. HR awaiting more information from the company. We also think 10-20 UHBs buying these. Will bring back an update to this forum. VS outbreaks - Flu cases on B5. 3 confirmed. With another suspected case. 3 members of staff are currently off with flu. Trying to move them to one end of the ward. - Flu vaccination rate of 63.57% which is excellent. Surpassed last year and target for this year. Strain on Critical Care 5 cases reported.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	<u>Feedback from UHB QSE Committee</u> None.	
3.2	<u>Ombudsman Report</u> Pertained particularly to our Clinical Board. Standard communication between different specialities treating patient wasn't up to standard as we would expect. Who is ultimately responsible? Pick up in Directorate Q&S Meetings.	**ALL**
3.3	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> HR noted an incident in Critical Care where some drugs were delivered but not put away in a timely manner. The cost of the wasted drugs was £2,000. Looking at processes to put in place to stop this happening again. CF noted that it was the Nurse in Charge's (NIC's) responsibility to make sure that the drugs have been put away. NIC to hold keys. Anyone can sign for the drugs but the NIC needs to be made aware.	
PART 4: ANY URGENT BUSINESS		
4.1	<u>Any Urgent Business</u> VS portable dyson fans. Implicated in 2 possible outbreaks. VS will share it. Asking to risk assess against bladdess dyson fans. CF using them in Haem. General recommendation for safe fan use. Asking areas to do a risk assessment. CM a couple of consultants have had issues with parking and managing dialysis unit. To rise with Ruth Walker, Executive Director of Nursing. CF will raise it at the Weekly Director of Nursing meeting. HR level 1 mortality review forms. Specialist Services compliance has dropped. Now 50% compliance. Problem in Critical Care and Cardiology. Measures now in place in Critical Care. Richard Wheeler, Cardiology is looking into it but not got back to HR as yet. VS Cardiac scopes – can't be sent down to theatres to be cleaned. Not available as cleaning scope room is undergoing refurbishment Reverting to Tristel wipes in the interim.	
PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	<u>Received and noted for information</u> • WHC 2019 002 Update on ordering influenza vaccines for the 2019-20 season • WHC Maintaining continuity of supply of medicines in the event of leaving	

	the European Union in a “no deal” scenario • NatSSIPS Meeting Minutes 23.1.19 • Staff Flu Vaccine Update (29.1.19) • Manual Handling and V&A Training Guidance • PSN 048 – Risk of harm from inappropriate placement of pulse oximeter	
PART 6: DATE OF NEXT MEETING		
6.1	Thursday 14th March 2019, 8am, in the Critical Care Resource room, UHW.	

MEDICINE CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE MEETING
MINUTES

HEALTH & SAFETY FOCUS

Thursday 17th January 2019
9am – 11.30am
Classroom 2, UGF A Block, Main Hospital, UHW

Attendees:	**Rebecca Aylward (chair)** **Jane Murphy** **Kath Prosser** **Suzie Cheesman** **Barbara Davies** **Gemma Murray** **Ian Dovaston** **Emma Mitchell** **Sarah Cornes-Payne** **David Pitchforth** **Samuel Barrett** **Tara Cardew**	**Dr Joe Grey** **Fran Wilcox** **Derek King** **Gill Spinola** **Lisa Lane** **Sarah Capstick** **Linda Pritchard** **Kate Bonner** **Stephanie James** **Emma Murdoch** **Lisa Waters** **Roisin Kirby *(minuting)***
Apologies:	**Sarah Follows** **Denise Shanahan** **Dr Jeff Turner** **Mudassir Pasha** **Rebecca Owen-Pursell**	**Sharon O'Brien** **Delyth Jones** **Ben Durham** **Sarah Edwards**

PRELIMINARIES		**Actions**
A1	Welcome and Introductions The group were welcomed by RA, and the group took turns introducing themselves for the benefit of those who had not been in attendance before.	
A2	Apologies for Absence As above.	
PART 1: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP & ACCOUNTABILITY		
1.1	Minutes of Previous Meeting The group were in agreement that the minutes of the last meeting were of an accurate record. All outstanding actions / matters arising in the last meeting were stood down and completed.	
1.2	Matters Arising EM confirmed that the sluice issue on A4 has been rectified. GS provided an update regarding the Transition Pathway. More information is	

	available from KP if required.	
1.3	Patient Story – Clinical Gerontology This story concerned a patient in St David's hospital. A student nurse had escalated their concerns regarding a patient who was clinically unwell and how this was escalated. Secondary to no medical cover on the ward at the time another doctor was asked to review the patient which potentially caused a delay in treatment being commenced. The patient was diagnosed with a potential sepsis and hypoglycaemia. As part of the investigation it was identified that there were missed opportunities in the afternoon with regards to the patients high NEWS and how this was escalated. The patient was 999 transferred to UHW Emergency Department in line with best practice with anti-biotic treatment commenced at St Davids. Sadly the patient passed away following arrival at UHW. The investigation identified in relation to learning outcomes that at the time staff at St Davids had not fully implemented the Sepsis pathway, this would have alerted staff to the required actions required earlier. If reviewed earlier it was likely that secondary to other pre-existing co-morbidities the patient would have been appropriately managed at St Davids. Compulsory NEWS training is being provided by Practice Development Nurses and there is a more robust doctor review cover plan in place. It has also been noted that as St David's are quite isolated, nurses can become de-skill quite quickly when not faced with the more acute and complex cases you may find at UHW/UHL. The student nurse was quite anxious and upset regarding this matter, but the situation has now helped her develop her maturity skills. EM will be sharing lessons learnt to all nursing staff in question.	
1.4	Feedback from UHB QSE Committee Please click the link below to access the notes of the last meeting. http://www.cardiffandvaleuhb.wales.nhs.uk/quality-safety-and-experience-committee- RW noted that it was pleasing to see improvements within Endoscopy and that there has been an increase in pressure damages noted by other CBs, with a new Pathway adopted in order to combat this issue.	
1.5	Directorate QSE Minutes – Exception Reporting Emergency & Acute Medicine and Gastroenterology directorate's minutes received, other areas' meetings are later in the month. No concerns to note.	
HEALTH PROMOTION PROTECTION & IMPROVEMENT		
2.1	Flu Plan 18/19 The MCB still remain at 50.4%, with the hope that this will rise to 52% secondary to additional support in Acute and Emergency Medicine, to encourage staff to have the vaccination (currently only 18% uptake in this directorate at present). CD&T are still in lead, with both Specialist and Surgery Clinical Boards achieving 60% uptake. The 'Flu Friday' campaign is tomorrow, both in Concourse, UHW and UHL. KP noted that a big thank you to Sue Patchett Ward Sister C6, was necessary for going above and beyond, vaccinating staff in other directorates as requested.	
SAFE & CLINICALLY EFFECTIVE CARE		
3.1	Dementia Focus The LPOP MHSOP team shared three presentations to the group, with a dementia focus. The first involved Dementia Care Training sessions and gave an overview of the team, the second was titled MHSOP – Behaviour That Challenge	

	sessions which discussed 'assisted touch' and its effectiveness, and the third centred on the Natural Waking Project that has been trialled within UHW and received positive feedback all round. All three presentations were well received by the group and will be circulated in conjunction with these minutes.	
3.2	Patient Safety Alerts For noting.	
3.3	New SIs 9 SIs to date. In78092: Unavoidable healthcare acquired Grade 3 pressure damage. In78583: Unavoidable healthcare acquired Grade 3 pressure damage. In79783: Injurious Injury resulting in a fracture to the neck of femur. Patient correctly identified as a high falls risk on admission with all actions undertaken in line with UHB best practice. Post falls procedures completed in line with NICE 2015 post falls procedure. In82650: Unavoidable healthcare acquired Grade 3 pressure damage. In83736: Unavoidable healthcare acquired Grade 3 pressure damage. In65452: Unavoidable Grade 3-4 and unstageable healthcare acquired pressure damage. Secondary to the nature of the pressure damage reported a full note case review was undertaken and formally agreed the pressure damage reported was unavoidable, but identified some key learning points. The patient was at the end stages of dementia with an extremely poor dietary and fluid intake. The patient was not weighed on admission which resulted in the incorrect mattress being used on initial admission, but recognised that this would not have altered the deterioration. The patient was referred to Podiatry when changes to the patients skin integrity were noted, however it was felt that there were missed opportunities to re-refer. It is recognised that the Consultant covering this area has a wound speciality which is why no further Podiatry input was potentially obtained. One of the main concerns identified from the case note review was the lack of documentation regarding the patients nutrition and whether it was in the patients best interests to not feed artificially, eg, NG feeds. Dr JG agreed that whilst the patients nutrition was discussed in the multi-disciplinary meeting there is no reference to this in the patients notes that to provide enteral feeding for a patient in the last stages of Dementia would not be in their best interests. In78796: Unavoidable healthcare acquired Grade 3 pressure damage. In82655: Reported as healthcare acquired Grade 3 pressure damage, however as part of the investigation identified that the area was covered in Fibrin and not 'slough' which is not reportable to Welsh Government. In80043: Avoidable healthcare acquired Grade 3 and Unstageable Pressure damage. Following the completion of the All Wales Pressure Damage Tool it was	

	established that the patient was known to District Nursing and evidence that the pressure damage may have already started to evolve but no grading was documented. Admitted for sepsis with a background history of tetraplegia. Investigation found that the patients pressure areas were not examined within the first 6 hours of admission which resulted in further deterioration. If the patients pressure areas had been reviewed and risk assessments undertaken in line with UHB best practice a repost mattress, strict 2 hourly Intentional Rounding and escalation for an inpatient ward bed undertaken. This could have potentially reduced the risk of further changes to the patients skin integrity. Actions undertaken included the formal instruction for all staff to ensure that all patients skin/pressure areas are checked on admission in line with best practice, and that documentation is completed in a timely manner. The Clinical Board are continuing the implementation of further education and training focusing on the correct process and identification of pressure damage, staff education and the revision of an inpatient pressure damage care plan. In79666: Avoidable healthcare acquired Grade 3 pressure damage. Deemed as avoidable as staff had failed to note the deterioration in the patients skin integrity from Grade 2 to Grade 3 and the actions required around this. The Clinical Board are continuing the implementation of further education and training focusing on the correct process and identification of pressure damage, staff education and the revision of an inpatient pressure damage care plan. In64355: Endoscopy – Following the completion of a root cause analysis investigation the patient had been incorrectly vetted for an endoscopy as urgent rather than urgent suspected cancer for symptoms of a change to bowel habits and rectal bleeding. This resulted in an endoscopy not being performed in line with NICE guidance, the patient was diagnosed with an invasive Adenocarcinoma which required surgical intervention. Confusion around the varying NICE guidelines and patient age. Actions undertaken, NICE guidance shared with all colleagues who undertake the vetting of referrals for Endoscopy/Colonoscopy procedures and shared with Primary Care Lead.	
3.4	<u>Changes to Pressure Damage reporting to Welsh Government</u> KP advised that new guidelines from Welsh Government that were implemented from 1st January 2019. Only avoidable healthcare acquired pressure damage will be reported to WG as a Serious Incident following the completion of The All Wales Pressure Damage Tool. Safeguarding project continues and that only avoidable pressure damage requires a VA1 referral.	
3.5	<u>Infection Prevention & Control Update</u> DK gave an overview of the MCB January IP&C report. A copy will be provided in conjunction with these minutes. Discussion ensued with regards to the 10 open RCAs currently within the MCB which are historic RCA's. RA reiterated the importance to close down any outstanding RCAs. KP advised that the MCB IP&C Newsletter will be up and running from next week. The Newsletter will be widely circulated throughout the MCB, and copies will be brought to the next meeting. LW confirmed all of EU and AU's new commodes have arrived so it is anticipated their scores will increased significantly now.	

DIGNIFIED CARE		
4.1	MEAU Standard Operating Procedure LW advised the group of the new Operating procedure in MEAU, UHL, for noting. BD would like to meet with LW to discuss further, particularly with regards to Senior Nurses and the newly introduced huddles. LW advised that this procedure is subject to 6-month review. All were in agreement.	
TIMELY CARE		
5.1	Stopped Clock Analysis SB had to leave the meeting due to operational pressures. Deferred.	
INDIVIDUAL CARE		
6.1	National User Experience Framework Feedback – 2 Minutes of your Time – Relevant Improvement Plans For noting.	
6.2	The Patient's Voice LP and SC met with JM last year via introduction from the Patient Experience team. LP and SC introduced themselves to the group again, and advised that they were Health & Social care facilitators, funded by the Health Board but based in the voluntary sector, whose purpose was to improve links, between the UHB and the voluntary sector, mainly providing advice. They are in contact with 1,500+ voluntary services through several networks (i.e. Age Connect and Red Cross already in the EU, which is Welsh Government funded). LW advised that they were both very useful resources and a welcomed support. SC advised the group of work they had done in 2015 with the Dental CB, in which they looked at the CB's IMTP and were able to source volunteer organisations that could support the work streams. Discussion ensued with regards to tailoring a directory to signpost staff and patients to the voluntary service that they may have use from. JM thanked both LP and SC for attending, and advised that the MCB would like to invite them to another meeting soon once we had established the areas that they could help support best.	
STAFF & RESOURCES		
7.1	Winter Pressures – Staffing Deferred due to time constraints.	
ANY OTHER BUSINESS		
8.1	Nothing to note.	
DATE & TIME OF NEXT MEETING		
	Thursday 21st February 2019, 9am – 11.30am, Venue Classroom 2 UHW	

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 15th January 2019, 08:00-10:30 hours
Seminar Room B, A BI, UGF, UHW
CONFIRMED MINUTES

Present:

Linda Walker	Director of Nursing, Surgery CB	LW
Richard Hughes	Consultant Anaesthetist (Chair)	RH
Helen Luton	Senior Nurse, T&O	HL
Andy Jones	Lead Nurse, General Surgery, Urology, ENT, Ophthalmology	AJ
Babs Jones	Educational Lead, Perioperative Care	BJ
Mark Bennion	Clinical Governance Facilitator, Perioperative Care	MB
Claire Mahoney	Infection Prevention & Control	CM
Adrian Turk	Pharmacy	AdT
Chris Williams	Quality & Safety Lead, Ophthalmology	ChrW
David Scott-Coombes	Quality & Safety Lead, General Surgery	DSC
Geoff Clark	CD, Emergency General Surgery (for Item 2.1)	GC
Nagappan Kumar	Clinical Lead, Thrombosis and Anticoagulation Group (TAG), Surgery Clinical Board (for Item 1.6)	NK
Tracy Johnson	Practice Development Nurse, T&O (for Item 1)	TJ
Catherine Evans	Patient Safety Team	CE
In attendance:		
Edwina Shackell	PA, Surgery Clinical Board	ES

Minute	Subject	Actions
19/01	**Patient Story, Trauma and Orthopaedics** TJ presented the background and timeline of Incident In590922. This patient had been admitted to a ward via ambulance from home for a planned procedure despite becoming increasingly unwell over a 2 day period. The patient became unresponsive shortly after admission. Sepsis was confirmed and treated and the patient stabilised. The planned procedure went ahead the following day, with planned transfer to ITU where the patient sadly died. Key findings: • The key point of contact for the patient had been a team member's personal mobile number. • The patient's relative was told to phone for an ambulance to admit direct to the ward for their planned procedure. • Ambulance control would not accept this request as this was not normal procedure. The team member then requested an Amber 1 call to admit direct to the ward. • Paramedics attempted twice to contact the ward to advise of the patient's NEWS score of 11 and suspected sepsis. No answer could be obtained. • The paramedics made the decision to follow instructions and take the patient to the ward.	

	• On admission to the ward, the patient deteriorated, and became unresponsive. • The Sepsis 6 pathway was then followed and the patient stabilised. Key Learning: • During the RCA process, repeated attempts to contact WAST for their processes and criteria for bringing patients to wards for planned care only had failed. Work was ongoing to try to find a way to ensure that this does not happen again. • The team no longer gives out personal phone numbers. There had been an alternative hotline in place for patients to contact. • The events were a year after the initial procedure. The patient's condition had significantly deteriorated over the previous 2 days and should have been taken to MAU at UHL. Discussion: • With regard to the medical care of a septic patient, a CT scan should have been carried out immediately. • The patient should have been reviewed and escalated to senior level immediately. • The patient should have gone to MAU at UHL immediately for a swift assessment, albeit the outcome was uncertain even had this been done.	
PART 1: PRELIMINARIES *(Chair)*		
19/02	**Welcome and Introductions** Colleagues were welcomed to the meeting and introductions made around the table.	
19/03	**Apologies for Absence** Received from Clare Wade, Gillian Edwards, Rafael Baraz, Ceri Chinn and Angela Jones	
19/04	**Declarations of Interest** None declared.	
19/05	**Approval of the minutes of meeting held 6th November 2018** Page 6, '**no C diff increase'** to be amended to, **decreased by approx. 50%** - Subject to the above, the Minutes were approved.	
19/06	**Matters Arising** To receive Action Log from the above meeting 18/41 25/9/19 AWMSG Ref 2224: Cefuroxine 50g powder for intracameral injection. AdT advised that of the two available brands, one had been approved by UHB Medicines Management Group. AJ advised that this had been discussed by consultants at the Directorate Quality and Safety forum. Discussion was continuing regarding whether colleagues wished to use this. LW noted that the issue being explored with the RCAs relating to the ophthalmology insourcing team is the use of intercameral cefuroxime. **Action: To remain on the Action Log.** 18/105 3/7/18. Orthopaedic thromboprophylaxis regimes Whilst the Orthopaedic surgeons wished to adopt the use of aspirin as a NICE approved thromboprophylaxis option post elective joint replacement surgery, they were unhappy with the NICE statement that *'At the time of publication (March 2018), aspirin did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented'*. This they felt	

	was impractical. Mr Kumar suggested further discussions were needed with the orthopaedic surgeons to explore options to resolve this. In the interim, licensed options such as enoxaparin or apixaban are being used. 18/127 25/9/18. NICE Guidance MTG37, March 2018. Not for Surgery. Forwarded to Medicine. CLOSED. 18/127 25/9/18 NICE Guidance IPG611, April 2018. To be sent to Oleg Tatarov. **Action ES** Post-meeting update 18/1/19: completed response sent to Clinical Audit by Professor Kynaston 18/136 25/9/18. Coroner's Inquest involving Surgery, but the Clinical Board had not been notified by the Concerns Team. CE confirmed that the process had been revised, and that concerns ensure that she is informed. **CLOSED.** 18/149 6/11/18: Mted IT failure. The Clinical Boards had been asked for plans to mitigate the risk. It was agreed that there was no solution. **CLOSED**. 18/151 6/11/18: Perioperative Care to address lack of documentation for cannulas inserted in Theatres. BJ confirmed that awareness had been raised, the action shared and discussed at governance forums. Care plans in process of being updated. **CLOSED.** 18/153 6/11/18: Anaesthetics: Colleagues to be reminded to escalate missing/faulty kit via an incident form and the risk register. **To remain on log.** 18/153 6/11/18: Mortality Reviews: Junior Doctors to be reminded to escalate to a consultant if Stage 2, and complete Stage 1 correctly. Mortality Reviews had improved. DSC advised that staff would make every effort to remind Junior Doctors to complete documentation correctly. **CLOSED.** 18/163 6/11/18: Regulation 28 and open inquests. Discussed with Anaesthetic colleagues. **CLOSED.** 18/163 6/11/18. Ombudsman's Report: 201700182L. Present at Formal Board for shared learning. To go to formal Board 25/1/19. **Close next meeting.**	**ES actioned 17/1/19**
19/07	**Thromboprophylaxis presentation** Mr Kumar summarised this work to date, and cited successive audit results for 2008, 2010 and 2013 for the Surgery Clinical Board. Key points were: • Since 2008 many more patients are receiving Low Molecular Weight Heparin (LMWH) appropriately. • Since October 2010 audit there has been no improvement in use of the Venous Thromboembolism (VTE) risk assessment tool, despite its inclusion in the clerking proforma. • Feb 2011 audit discovered that some patients were: a) not receiving enough LMWH (weight >100kg) b) receiving LMWH when they had contraindications c) receiving Anti Embolic Stockings (AES) when they had contraindications • Dec 2013 audit had similar results to those in Feb 2011. However, no patients received LMWH when they had contraindications. Just one patient had a fully completed VTE proforma. Less than half were wearing AES when prescribed Recommendations: • Awareness to be raised at all levels of the patient safety implications of both VTE when it is indicated and when it is contraindicated • Senior staff to emphasise the importance of compliance	

- Incorporate VTE risk assessment training and practice into medical student training
- Weight measurement to be routine on admission
- Make form user friendly
- Medicines use review and pharmacist input

Summary of progress:
The Surgery TAG and Orthopaedic TAG groups had combined to form a UHB TAG Group. In 2013 there were two deaths in Orthopaedics, as a result of which the Surgery Clinical Board TAG Task and Finish Group was formed in 2014:

- Emergency measures across the CB were undertaken to ensure patients undergoing surgery had appropriate Thromboprophylaxis (TP)
- Development of an audit tool to monitor risk assessment/prescription of VTE prophylaxis
- NICE guidance CG92 (Jan 2010) – extended TP for pts with cancer undergoing abdominal and pelvic surgery implemented:
    - Urology Sept 2014
    - Colorectal surgery (elective) Jan 2015
    - Colorectal surgery (emergency) Nov 2015
    - UGI/HPB Surgery Feb 2018
- NICE guidance NG89 (March 2018)
    - Compliant in most areas in Surgery
- Discussion on changes to practice in Orthopaedics – i.e. use of Aspirin. This was implemented for a short period in August 2018 with potential savings of £30,000 per year, and then stopped, Aspirin is off licence, which could have legal implications. This remains unresolved.
- Is AES useful? Could we save another potential £35,000 per year**?** The debate continues.

Preventable Hospital Acquired Thrombosis (HAT) reportable to Welsh Government for Surgery Clinical Board:
2015/16 - 0
2016/17 – 1
2017/18 – 1

<u>Audit 2018</u>:
Theatres: Good results
Wards: Audit of AES in 100pts across all surgical wards. 70% had a risk assessment completed. There is still work to do to achieve at least 95% compliance. Approximately 80% of patients were indicated for AES, but only 50% of those were wearing correctly.

<u>VTE and the need for TAG</u>:
Preventable
Drugs useful with minimal side effects
Evolving knowledge:
Extended prophylaxis
Changing surgical practice, e.g. early mobilisation, day surgery.

<u>Are AES useful</u>?
Stroke – no difference
Benefit of GCS in surgical patients is weak. (Estimated saving England £63m a year if stop using). No firm conclusions yet.
Do patients need LMWH and AES? It was proposed to undertake a 3 month pilot. Authorisation to proceed was awaited. his will only be for patients who cannot be given TP for another reason. HAT rates would be monitored.

<u>Discussion:</u>

	- It was confirmed that the UHB infrastructure is robust enough to identify all HAT. - DSC congratulated NK on this sterling work, which was reaping rewards. However, it was highlighted that 'one size does not fit all', e.g. for vascular surgery, Clexane is contraindicated, and HAT risk is nil. - Day surgery: patients are mobilised and go home the same day, e.g. laparotomy cholecystectomy, TP is not given. - Risk assessment sheets are photocopied multiple times and become barely readable. - Why do forms need to be signed 3 times? NK agreed to review this. If the Risk Assessment has been completed and signed by a consultant, the onus is on that consultant that all necessary assessments have been done, and they will not need to sign again. The concern with completing a prescription form without a Risk Assessment is that AES can be prescribed inappropriately. LW confirmed that the RA form must be signed to confirm that nurses can give the AES. It was confirmed that the AES must be prescribed, as well as the PT, and that both forms must be signed. - NK would review the Risk Assessment and try to make this more practical. LW noted that this had been undertaken once, but in light of the new guidance a further review may be appropriate. - NK observed that patients did not wear prescribed AES due to discomfort. - DSC paid tribute Day Surgery and SSSU staff who were continually measuring patients properly, taking significant time away from patient care on the ward. - NK advised that for abdominal surgery of < 90 minutes, with the exception of cancer, PT is not needed at all, so the argument can be made for correctly fitted AES. However there was stronger evidence for using a foot pump. - If AES were not necessary, a service redesign for Day Surgery would be needed – this would save time and documentation. - NK would review Day surgery in the coming months. At present following the guidelines ensures legal compliance.	
PART 2: PATIENT SAFETY AND QUALITY		
19/08	**National Emergency Laparotomy Results 2018.** Mr Clark explained the background and rationale of the service changes made to the Emergency General Surgery service which had been implemented from October 2017. 2010 NELA data for patient outcome for Emergency laparotomy cholecystectomy had confirmed that Cardiff and Vale were performing poorly compared with peer UK hospitals. Patients were waiting a long time in SAU with poor access to CEPOD. The principle Emergency Surgery service changes were described, these being to implement a 2 Consultant led service: Consultant led care at the front door. Consultant led surgery Changes included: Change to consultant rotas. Two 24/7 CEPOD theatres, fully staffed. New SPR rota Aug 2017 Standards had been written. NELA standards had been implemented for all consultant surgeons. An Acute Gallbladder pathway had been introduced. Patient volume: Emergency Surgery 25 – 29 patients per day on average, which could peak at 55 per day. Saturdays & Sundays, this reduced by 50% in the absence of a GP take.	

	The reduction in time patients now spent in EU, SAU and MAU was described. Time to CEPOD theatre showed improvement but there was still much work to do to reduce the 4.5 hours outside of the target time to access CEPOD. There had been no increase in operating out of hours. Compliance with NELA standards was now at 95%. 30 day mortality post laparotomy has reduced from 17%, over 3 years to 7.5%, an indication of progress and the 2nd lowest in Wales. <u>Challenges</u>: Cat 2 access to CEPOD Registrar gaps – should have 14 but currently have 12. Challenging the culture – emergencies must take priority over elective. Improve interface with GPs. Access to IT remains an issue for NELA pts, well down on national average. Discussion: RH conveyed his congratulations to the Emergency General Surgery team. It was observed that the NELA data was very encouraging. However, it was noted that the 2 consultant take had made a marginal difference to the waiting time to CEPOD, which it was suggested could be attributed to a systemic issue in that CEPOD was halted whenever there was transplant surgery, resulting in delay.	
19/09	**Standing Item: NatSIPPS Progress report** AJ would liaise with BJ. BJ reported that meetings were not well attended. Although Surgery CB progress was good, there was less confidence for other Clinical Boards. CE advised that colleagues had been asked at the previous meeting to present their work to date, but BJ noted that the same people were doing the work, and there was lack of engagement, and a medical lead. Led by Carole Evans. **Action: BJ to express the concerns of this Group at NATSIPPS meeting 18/1/19**	**BJ**
19/10	**Director of Nursing Q&S Report December 2018** For reading and noting, specifically Serious Incident summaries. Key issues: - Increase in queues in E datix – all to open the incidents, or remind staff to do so, and work to action. - Compliant with all national audits. - Medication errors consistent – 10 – 12 per month, not all attributable to SCB: o Near misses – 2 ▪ IV heparin prescribed for subcutaneous use, not given. ▪ Near miss on a ward, agency nurse subcutaneous administration Oramorph prevented. - In 79927. Two adjacent patients, one insulin dependent diabetic, the other non diabetic. Insulin had been administered to the non-diabetic patient, who was had been given the insulin. They were successfully treated and recovered - In80732. Patient prescribed both Clexane and Vitamin K. - In80431 Methotrexate, weekly dose prescribed and given daily. Two near misses POVAS - 7 Falls – 2 within the previous week. Pressure damage. Of concern. New bed rollout completed, there would be an education focus in the next 6 months. Concerns – major increase, in particular related to ophthalmology. Compliance with response targets is good for both formal and informal responses.	

	IPC – E Coli had been a significant issue, but it had been made clear that this would be expected in liver wound drains. Not related to catheters.	
19/11	**Directorate Assurance Reports:** 1. <u>General Surgery & Wound Healing, ENT, Urology & Ophthalmology</u> Key issues: - UV ENT scope decontamination work in progress for UV ENT scope decontamination - Gradual progress on Business Continuity plans - Slow progress on BC plans - Ongoing NELA audits presented 2. <u>Perioperative Services</u> Key issues: - In77340: Ophthalmology insourcing, now 10 cases. - In80951: Reverse osmolarity plant in HDU UHW developed bacterial growth. Robotic surgery suspended for 8 days, now resolved. Investigation underway. - In 87021 – corneal graft SSSU, surgery could not proceed due to medical notes being unavailable. The graft should have been returned to organ transplant team, but this failed to occur, and was therefore unable to be used. - In83740: Reduction of fractured NoF. X-ray revealed that there was no fracture. - Review re pre-assessment service. The portacabin location is felt not to be appropriate for the service. Patient complaints were being reported. Formal escalation to the Clinical Board of the concerns being raised by the Perioperative Care Directorate - regarding the use of Recovery for Critical Care patients. The Directorate and Clinical Board are in discussion with Specialist Services to ensure these patients are appropriately looked after. 3. <u>Anaesthetics</u> – RECEIVED and NOTED. An incident report had been raised regarding 5th & 6th January 2019 when CEPOD had to be suspended due to frequent requests for anaesthetic support in the Emergency Unit. The Clinical Director is aware. 4. <u>Trauma & Orthopaedics</u> - Minutes of last Directorate meeting: o In 61613 Botox wrong side. - Registered nursing vacs. A3L and B6 are reliant on agency. A recent advert had no response. There are significant gaps, compounded by medical inliers and trauma outliers. - Pressure Damage B6: two related to casts, and one frail patient. Not attributable to mattresses. West 4, Grade 2 had progressed to Grade 3, patient non-compliant. - Injurious falls – 2. RCAs underway.	
19/12	**Exception reports from Directorates/Working Groups** 1. General Surgery, Vascular , Wound Healing: o Hoping to have ERAS Prehab support appointed. o General Vascular surgery bed capacity is a challenge. 2. Head & Neck, Maxillo Facial and Ophthalmology o Ophthalmology SIs increasing o SOP for Level 1 Acute Airways is being developed and will be brought to this meeting when completed. 3. Urology - nil 4. Theatres & Anaesthetics, SSSU, Day Surgery & Sterile Services: o Two incidents both re Neuro: ▪ Weds 9/1/19, diagnostic procedure 'awake cranium', patient stopped talking mid procedure. Procedure abandoned, the surgeon lost confidence in equipment. Will be rescheduled. Investigation under way.	

	▪ 2nd incident, stealth navigation system mid operatively stopped working mid-operatively, operation abandoned. The consultant had lost confidence in the computer system and the decision was made not to continue. Patient outcome uncertain. It had become apparent that there had had been 2 previous occurrences, which had not been reported. Investigation underway. 5. Trauma and Orthopaedics – Nil.	
19/13	**Urology Gemcitabine New prescription** AJ explained the new prescription chart for the documentation of this 6 week treatment schedule.	
19/14	**Alerts and other Safety Notices** NICE Guidance 1. Surgery CB summary spreadsheet: Received and noted. Patient Safety Notice 2. *ISN 2018/008 Baxter disruption in the supply or use of Sodium Chloride 0.9% solution*. RECEIVED for awareness. 3. *PSN046/November 2018: Management of life threatening bleeds from arteriovenous fistulae and grafts*. RECEIVED and NOTED. MDAs 4. *MDA/2018/035(Wales) 16 November 2018: All T34 ambulatory syringe pumps – update concerning battery information.* Dealt with centrally via pump library. **5.** *MDA/2018/034(Wales) 16 November 2018: Suction catheters, gastro-enteral tubes, intermittent urology catheters and sterile urine drainage bags – potential breach in sterile barrier packaging*. One company, Convatec, where there is an issue that the products we have may not be sterile. **For dissemination and awareness.** 6. *MDA/2018/036(Wales) 18 December 2018: Batteries for the HeartStart MRxmonitor/defibrillator may fail to charge or to provide power*. In hand with Resus. Public Health Wales Briefing 7. *26 October 2018: Start of Respiratory Syncytial Virus (RSV) season in Wales.* For awareness. 8. *20 December 2018: Increase in acute flaccid paralysis/myelitis in the UK – reporting for investigation and surveillance*. For noting. 9. *January 2019: Influenza now circulating (January 2019).* Most surgery wards shut at moment due to flu and norovirus B2. MHRA 10. *Drug Safety Update: 21 November 2018*. For information and noting. Osidex – some small supplies.	
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
19/15	**Key Messages from Board/ Committees/ Groups** 1. UHB Medicines Management Group Notes 1st November 2018 o Hydroxychloroquinine retinal monitoring. Ongoing, needs funding. 2. UHB Medicines Management Group Notes 6th December 2018 o Item3e: Start Smart then Focus antibiotic audit sliding tool	

	○ Item 4a: UHB Medicines Code update - related to methotrexate incident. AdT to check the update for reference to methotrexate, as CE advised that this could not be found. ○ Procedure for Nurse initiation of Symptomatic Relief Medicines. Package of – package of training available. ○ 7a: Pain Pathway with Primary Care, now completed. ○ 7b: IPD Tapentadol prolonged release. IPD now agreed with Primary Care 3. Medicines Management Group draft Minutes 3rd January 2019 ○ Financial position, Month 06: 60% of savings delivered, majority within Primary Care. 2019/20 target of 2%, £3m overall. ○ 8a: Statins and fibrates. Review of health pathway, changes in recommended 1st, 2nd & 3rd line statins. 4. Clinical Board IP&C Group – draft Minutes of 19 November 2018. ○ Decontamination issues regarding robot telescopes ○ Gastroscope and colonoscope decontamination issue, RCA underway. ○ T&O surgeons looking at how to achieve a reduction in the 2% infection rates. 5. Clinical Board H&S Group. Minutes of meeting 24th October 2018 & verbal update19 December 2018. ESR remains incorrect re Fire training. 6. Decontamination Committee Minutes 17th October 2018 Site visit from the All Wales Team has generated a piece of work. RECEIVED and NOTED. 7. Safeguarding Team Newsletter Winter 2018. RECEIVED for information. 8. World Antibiotic Awareness Week 12 – 18 November 2018. Feedback awaited. 9. New “Start Smart then Focus”(SSTF) Audit Tool Use of antimicrobial audit tool, mandated by Medicines Management Group, OCG and Health Systems Management Board. AdT explained that 20 patients were to be audited per week, or 5 per week, tasked to an F1 in each area to implement and input data. **Action: Circulate to Clinical Directors, each area is auditing its own practice. LW/ES** 10. Urgent Communication from Executive Team for all staff who undertake Point of Care Testing (POCT) To raise awareness that training is mandatory, sharing of badges is not permitted under any circumstances. 11. Medication Safety Executive Briefing for Clinical Boards, Issue 25, November 2018. For reading and noting. 12. Orthopaedic Infection Quality Improvement Group Minutes 8th October 2018, Agenda 3rd December 2018. RECEIVED and NOTED. Sterile Betadine: Ophthalmology consultants required this to prevent endophthalmitis. AdT advised that 5% aqueous 30 ml pods were now available, which although unlicensed was the only source which can meet the needs of the Ophthalmic surgeons. AdT advised that 30ml of 5% is equivalent to the previous diluted dose and is specifically designed for ophthalmology. 13. Safeguarding Steering Group Minutes of 27 September 2018. Agenda 6th December 2018. Nil of significance.	

	14. Water Safety Group Minutes of meeting 12th September 2018 Disposal of empty paracetic acid containers. MB confirmed that emails have confirmed that Waste Management are content for containers to be placed in yellow bags and disposed of in the usual way. 15. Legal and Risk Services, Clinical Negligence Newsletter, December 2018 Commended for reading. 16. Patient Safety & Quality Newsletter, Winter 2018 Commended for reading. Includes methotrexate. All to note important advice for staff called to Coroners. 17. ANTT resources order details 15/05/17 With reference to the circulated email trail, BJ was not confident that the correct blue skin wipes (2% chlorhexidine, 70% alcohol) are in use across theatres, and would conduct a walkabout that day. 18. Safeguarding Maturity Matrix Improvement Plan From Public Health Wales. The UHB had compiled a response based on Clinical Board responses. Colleagues are asked to review and feed back to Andy Jones who will feedback to the January meeting. 19. HPV guidance Posters for wards, all to disseminate in clinical areas.	
19/16	**Medical Equipment Group** Minutes of Meeting 19th October 2018 Hoists: contact Clinical Engineering for maintenance. RH asked colleagues to ensure that if service developments are planned, they should ensure that all equipment requirements are included in all plans. It was noted that sacral nerve stimulation was the treatment of choice when conservative treatment failed; patients were currently treated at the expense of the supplier with regard to consumables, as part of a clinical trial. Hoverjacks: were not on a maintenance contract. It is intended to bring servicing in-house in Clinical Engineering.	
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
19/17	1. IP&C RCA database: 2. IP&C Clinical Board Update – see Surgery CB Q&S report above. December's focus had been on E Coli. Work was ongoing to improve Clinical Board compliance with IPC targets. Colleagues were thanked for the timely completion of Root Cause Analyses (RCAs). 3. Falls Report Noted 3 in month in total. 5. Pressure Damage Report Current focus had led to robust reporting and an apparent increase in reportable incidents. The Welsh Government Policy and Guidance for Pressure Damage had been published. However there had been a lack of consultation with the tissue viability nurses who had fed back amendments to LW. The Executive Nurse Director had requested a paper from Surgery CB to be taken to the February UHB QSE Committee.	
19/18	National and UHB Audit Reports: Review Annual Audit Programme All audits compliant.	

19/19	LIPS Progress Report. It had not been possible to nominate any teams from Surgery CB for the current cohort due to operational pressures.	
19/20	HIW/CHC visits: A5. AJ to review and derive an action plan.	
19/21	Transfusion Committee. The following were RECEIVED for information: 1. Minutes of meeting 12th October 2018 2. HTC Newsletter December 2018 3. HTC Quarterly Report Oct – Dec 2018 4. Cardiff & Vale UHW & UHL November 2018 Monitoring dashboard.	
19/22	Health Care Standards Process for 2018-19 These would be available on the shared drive from 28/1/19. 7 standards to complete for the Clinical Board, work led by Clare Wade.	
PART 5: GOVERNANCE		
19/23	**Concerns (Clinical Incidents, Complaints, and Claims)** 1. Open Sis, No Surprises: 16 open at present, 10 closed in December. Some almost complete. 2. Regulation 28 report & Open Inquests: Two inquests: - Fall A3L. report from Dr Johanssen required for 31/1/19. - Heulwen incident. Two statements outstanding from Site Practitioners. CE to email again, cc Jason Roberts. 3. Serious Incidents: 1. Closure forms sent to WG since 1st January 2018 – see above. 2. Closed SIs report – please see Director of Nursing Report at 2.2 above. 4. Complaints, Claims and other Concerns 1. All Open Clinical Negligence Claims 1/4/18 to 18/12/18 2 All Closed Clinical Negligence Claims 1/4/18 to 18/12/18. 160 concerns on database. People appointed on concerns team to look at. 5.1.5 Learning from any closed claims: - In17336 – Recommendations: "Consider whether it is necessary to remind the clinicians involved in this case of the benefits of copying patients into clinical letters." LW noted that this would have been of benefit with reference to the current ophthalmology issues, and is standard practice in England. It was queried whether guidance should be issued from the Medical Director.	
19/24	**Patient Surveys:** National Survey Report for Surgery (November 2018). Nil of note.	
19/25	**Research & Development** Research Training and Education Bulletin December 2018: For reading and information	
PART 6: DATES OF NEXT MEETING **Tuesday, 12th March 2019, Surgery Seminar Room, A2, UHW**		

PART 7: URGENT BUSINESS		
19/26	**1.Bare Below the Elbow –letter 9 January 2019 from Welsh Government.** Letter from the CMO and CNO. It was disappointing that some clinical healthcare staff were failing to comply. BJ confirmed that all audits identified that medical staff were non compliant every time. **Action: Clinical colleagues to communicate this message to all frontline staff.** 2.**ISN: Clexane (enoxaparin) 40mg injection 10/1/19** AdT advised that the current shortage will affect any areas until mid-February 2019.	**Clinical Q&S Leads & CDs**
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
19/27	**Recent Reports & Communications – RECEIVED for information.** <u>Welsh Government</u> 1. Flu vaccination for those aged 55 – 64 years 2018-2-19 for healthcare and custodial staff in prisons, immigration removal centres and other prescribed places of detention for adults in England. 22 November 2018. 2. Ministerial ratification of AWMSG recommendations – October 2018 3. Ministerial ratification of AWMSG recommendations – December 2018 <u>Welsh Health Circulars</u> 4. WHC(2018) 045, 6 November 2018: Ordering influenza vaccines for the 2019-20 season 5. Influenza Vaccines update Ordering for 2019-2020, 20 December 2018 6. WHC(2018) 048, 12 November 2018. National Enhanced Service Specification for non-routine immunisations for adults and children at risk.	
19/28	**Directorate Q&S Agendas/Minutes** 1. Trauma & Orthopaedics 14th December 2018, Agenda, Minutes, audit & M&M presentations 2. Anaesthetics Agenda & Minutes of meetings 17th October 2018 and 14th December 2018.	

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 22nd January 2019, 8.30am, Meeting Room, Clinical Board Offices Lakeside UHW
MINUTES

Preliminaries		**ACTION**
1.1	**Welcome & Introductions** Cath Heath, Director of Nursing (CHAIR) Avril Gowman, Senior Nurse, Acute Child Health (on behalf of Mary Glover, Lead Nurse) Eirlys Ferris, Senior Nurse, Obstetrics & Gynaecology (on behalf of Suzanne Hardacre) Jane Maddison, Beverly Thomas, Asst Directorate Manager, Community Child Health Michelle Abel, Infection Prevention Control Nurse Matt McCarthy, Patient Safety Advisor Anthony Lewis, Clinical Board Pharmacist Cheryl Evans, Directorate Manager, Obstetrics & Gynaecology Louise Protheroe-Davies, Clinical Supervisor of Midwives Paula Davies, Lead Nurse Community Child Health **In Attendance** Kirsty Hook, Board Secretary	
1.2	**Apologies for absence** Suzanne Hardacre, Meriel Jenney, Raj Krishnan, Mary Glover	
1.3	**To receive the Minutes of the previous meeting 27th November 2018** The minutes of the meeting held on 27th November were agreed to be an accurate record. **Update on Actions noted from the last meeting** **H&S Operational Group Meeting** Further to discussions at the last meeting, an extra ordinary meeting will be arranged to discuss the C&W H&S Action Plan and representative to attend the UHB Operational Group Meeting. **Archiving** It was noted that archiving at Lansdowne has been resolved and the archiving at St David's Hospital is almost complete. **Fire Door Global Link** Following issues with the fire doors at Global Link, it was noted that the door has been repaired and all issues have now been resolved. **EU Professional Standards** It was agreed that the standards would be circulated following the meeting for onward dissemination as appropriate. **Safeguarding Presentation** The safeguarding presentation was circulated in order to raise awareness following the presentation at the last meeting of the Child Death Review of ESH.	**CH/KH** **CH** **KH**

1.5	**Patient Story LP** This patient story outlines a case in which was investigated by the Surgical Clinical Board and has been presented at the Clinical Board Q&S meeting. Very thorough investigation undertaken and shared as there were lessons learnt across both Surgery & C&W Clinical Boards. This case involved a 5 week old baby diagnosed with Hirschprung's disease and subsequently admitted for surgery. Following the surgery the patient moved from theatre to the anaesthetic room for a chest xray to be undertaken. Following this the patient was slow to wake, and following this seizures commenced and therefore it was felt that further investigation was required. An external investigation was undertaken and it was highlighted that all observations undertaken in the anaesthetic room were not stored, and unable to retrieve the data and whilst this was not stored electronically, it should be documented in the notes. The pre op blood pressure was higher than average for the child's age. Root Cause of the case highlighted: • The blood pressure was at its lowest during the last hour of the theatre anaesthetic, where the BP had dropped from 50/25 to 35/15 with a sustained BP below 40/20 for 45 mins. • No new intervention was made during this time to increase blood pressure as other signs of perfusion was thought to be clinically okay. • It is possible cerebral hypoperfusion occurred during prolonged periods that the intraoperative blood pressures were below the levels suggested for neonates in a survey of Paediatric Anaesthetists in 2009. **Lessons Learnt** • Availability of pre-operative BP is important to allow tailoring of targets. • Greater common understanding of consensus intra-operative blood pressures amongst Paediatric Anaesthetists. • Pre op blood tests need to be as up to date as possible • Electronic monitoring data needs to be adequately recorded in the notes • There is currently no means of measuring cerebral oxygenation during long or high risk cases. • It should be noted that cases of seizures have been reported following anaesthesia with Propofal and Sevoflurane. The improvement plan was circulated and it was noted that there were a number of actions required from both Surgery & C&W Clinical Boards. The actions for C&W Clinical Board were discussed and it was noted that all actions have been completed and embedded into practice. Specifically, it was noted that with regards to the recording data in the anaesthetic room, the process has now changed to ensure that observations are only deleted following each case if approved by the lead anaesthetist for each case.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Review of C&W QS&PE Terms of Reference** Discussion ensued with regards to the terms of reference and whether there were any specific areas that needs to be amended. It was agreed that Health and Safety should be included as it forms part of the agenda. It was also agreed that there would be x2 designated IP&C focus meetings per year but noting that IP&C will continue to remain as part of the standing agenda. CH agreed to discuss with the Concerns Team with regards to how the themes and trends of concerns can be included and shared within the meeting. Discussion ensued with regards to membership and whether there needs to be additions/amendments to the meetings. It was agreed that estates lead would be removed, and	**CH** **CH**

	invited by exception. Medical representation should also be included and it was agreed that the Clinical Directors or nominated representatives to attend. It was agreed that the Terms of Reference would be amended following the discussions and the terms of reference were then agreed.	
2.2	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **Acute Child Health** • X3 RCA's ongoing • Hand Hygiene audits are continuing. Significant work is being undertaken in order to improve scores for bare below the elbow and reinforcing children's hand washing. • MRSA screening is continuing, and it was noted that this will be continued to ensure a consistent approach • Medication Group continues and is well attended. It was agreed that a presentation of the ten times medication errors investigations would be presented at a future meeting for lessons learnt to be shared. • Single checking medications is being progressed. • C&V Youth Board is now established and has been a very positive approach to date. • All information boards are being populated and will be implemented following completion. • X2 patients waiting over 36weeks for December and the work continues to be on target to report zero patients waiting for January 2019. • 7th Bed in PICU to meet standards has been approved and recruitment is now underway to recruit. • PACU for management of Scoliosis Patients has been approved and recruitment is underway to ensure appropriate management of these patients. • Consideration is being given to undertaking a National Advert for nursing which could be linked across all areas including health visiting etc. • Physiotherapy staffing is difficult at present and work is underway to recruit to gaps in the service. This has impacted on service delivery but work continues in order to improve. • Serious incident on PICU with regards to TPN. No issues with the patient, however it was noted that further investigation is required. **O&G** • GBS guideline is being updated to explore the possibility of women receiving IV Abx in the MLU in line with the prudent maternity care recommendations • In Obstetrics -there are currently 7 ongoing RCA's with 1 joint RCA being led by neonatal. • In Gynaecology - there is 1 RCA ongoing in Gynaecology and 1 case review awaiting sign off by clinical board • Internal QUAD audit undertaken 07.06.18 and external audit took place on 21.11.18. An action plan has been developed. • 2 x reported falls in month x1 C1 Gynae Patient normally supported to and from toilet mobilised on her own. No harm as result of fall, Patient fell on way to toilet in cubicle, x1 reported maternity baby delivered onto floor-no injury incurred. • x1 medicines error reported for maternity in December- IV amoxicillin given to neonate in bolus rather than infusion. This has been investigated. • Pressures on C1 were highlighted with regards to surgical outliers being admitted. Further discussions are taking place with regards to the patients that are safe to be nursed on gynaecology as there have been some inappropriate patients being admitted which is a risk. • Antenatal clinic at UHL will move to Cytology Building at UHL. Further work is being undertaken and it was noted that work will be required prior to relocation. Further communication will be circulated when complete.	**AG**

	Community Child Health • Ongoing issues with regards to LAC children placed out of area and lack of assessment review being undertaken. A process has been put in place in order to resolve this, however this is not sustainable. A letter is being sent to ABMU to highlight these concerns as this is not in the best interests of the children in their care. • Recruitment is underway for a Band 7 team leader for the LAC service • Issues with regards to CAMHS repatriation where it was highlighted that vacancies within the service are causing significant pressures and impact on service delivery. Some vacancies will need to go through Cwm Taf Health Board. • Discussion ensued with regards to the LIPS projects that were undertaken and it was agreed that the presentations would be presented at future meetings for sharing. • X1 Medication Error RCA which was reported by Ty Hafan. Pharmacy sessions are being set up with regards to communication and reconciliation which is hoped with make processes more robust going forward. • Ongoing RCA with community acquired pressure ulcer with GP and multi-agency service. Work continues • Child Death reported in December which needs to be investigated and it was noted that there will be a number of contributory factors that will require review. • CCNS Netbooks have been purchased which will allow access to PARIS in the home and allow increased communication, and reduction of safeguarding risks. • Recruitment continues across the Directorate, including a planned band 5 pilot and further discussions with regards to CCNS service. • Physiotherapy Demand and Capacity review is starting in January 2019. • OT Review feedback has been provided which highlighted the need for increased OT posts. • SLA with Ty Hafan for Physiotherapy has ceased and liaison is taking place with regards to the children accessing equipment. • PMH currently reporting 78% compliance for January 2019. Physio 11weeks, OT at 9 weeks and SL&T at 10 weeks for December 2018. Neurodevelopment is being reported at 30weeks, with community paediatrics at 26 weeks.	**PD**
2.3	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** No exception reporting or new risks to be considered for this meeting.	
2.4	**Paediatric Surgery Update** No specific update to note for this meeting.	
2.5	**Business Continuity Update** Work is ongoing across all Directorates in order to continue to develop plans. There were no specific issues to be noted for this meeting.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of Patients & Staff** **Update on Flu Vaccination Campaign** Jane Imperato was welcomed to the meeting and provided an update on the progress of the campaign. 57% of front line staff have been vaccinated across the Health Board. The Clinical Board are currently reported 57.1% however from the clinical board comparative data which has been collected, there is a reporting of 67.2% for the Clinical Board. This has been highlighted to Public Health however work continues in order to achieve the 60% target. Issues were highlighted with regards to access to training has impacted on the start of the immunisations sessions. There has also been a delay with regards to access to the vaccine itself for the flu champions. Work is ongoing in order to look at planning the flu campaign for next year.	

	Thanks were expressed to Jane Imperato for all her hard work to date as flu champion for this campaign.	
SAFE CARE		
4.1	**Update on Serious Incidents** There are currently 8 open incidents for the clinical board at present. Work is continuing across all cases. Since the last meeting, there have been 4 new SI's which are currently under investigation. **In82212 Community Child Health** Death of a child in the community following a possible dislodgement of their tracheostomy. **In83227 Obstetrics & Gynaecology** Stillbirth with possible issues regarding plotting of growth charts. **In83732 Acute Child Health** Potential delay in performing biopsies and communication issues with paediatric oncology MDT and another Health Board. **In83453 Obstetrics & Gynaecology** Neonatal death – cause of death currently unascertained. Potential coroner's inquest.	
4.2	**Closure Forms for noting / Sign Off** There were no closure forms to note for this meeting.	
4.3	**SBAR's for Sign Off** **AS (Datix 259710)** This SBAR relates to a neonatal right fractured clavicle following instrumental delivery. A chest x-ray was undertaken on admission to the Neonatal Unit where the fracture was diagnosed. Baby S suffered a birth injury in the form of a clavicular fracture most likely as a consequence of shoulder dystocia following a forceps delivery. Shoulder dystocia is an uncommon and unpredictable event. The recommendations from the case were noted as; • Shoulder dystocia guidance to be discussed with the neonatal team to explore the benefits of having imaging if manoeuvres are used at a shoulder dystocia. • To review newborn examination training to identify if there is anything being missed during examination. Discussion ensued with regards to the Birth injury tool being used and it was agreed that this would be shared at the next meeting for information. **BB (Datix 261772)** This case outlines the incident of baby sustained subgaleal haemorrhage, dural tear and subdural haemorrhage following instrumental delivery. Whilst baby developed an injury, it was noted that this is a recognised complication of ventouse delivery. There were no concerns with regards to the management of the case as it was felt to be the safest method of delivery of this case. **Lessons learnt** • When a potential risk factor is disclosed there should be clear evidence of a follow up plan for this within the notes. • If a risk from previous birth is identified, the Maternity Record should be requested where possible.	

- Any identifiable risk factors antenatally should be communicated in the antenatal notes.
- While Guidelines are useful to steer safe practice, variations should be documented with rationale and Consultant supervision.
- For difficult deliveries it is beneficial to consider a debrief for both the family and staff involved.

Recommendations

- Documentation review- AWMR and Intrapartum Plan of Care ('Green Sheet') may need review and cascade to all practitioners to record, date and action any identified risks.
- Staff to sign and print/stamp all entries.
- Obstetric Staff to ensure adequate maternal and team debrief where there has been deviation from usual practice, adverse outcome, or both

SDL

Concerns were raised with community midwife of lack of movement of right arm following discharge home. Mum did a self-referral to CAU, where a fracture was diagnosed. A full investigation was undertaken which highlighted that Baby D-L suffered a birth injury in the form of a clavicular fracture most likely as a consequence of shoulder dystocia following a forceps delivery. There were no concerns with the management and appropriate and timely manoeuvres were used in accordance with the Royal College of Obstetrics and Gynaecologists green top Shoulder Dystocia guideline.

There were no direct lessons learnt from the case however incidental learning was identified.

Discussion ensued and it was noted that as a result of a few cases being identified, it was agreed that a review of the last 12 months would be undertaken in order to ensure that this is not a new issue, and that it is that reporting of incidents has improved. There was further discussion with regards to ongoing review of some of these patients, where it was highlighted that this will also have an impact on community physiotherapy service which will need to be understood appropriately.

RCA Report & Action Plan TW

The case involved 14year old patient admission from Neville Hall who died following transfer. The background to the case was shared. It was noted that due to bed pressures, there was a plan for the patient to be treated at Bristol however there was significant deterioration and the patient was admitted to PICU. Whilst there was a delay to transfer, it was noted that this would not have impacted on the adverse outcome of the case.

The actions highlighted were noted, and it was noted that a patient flow co-ordinator has been implemented (on a pilot basis) in order to manage flow and demand. This has had a positive impact to date, and work is ongoing in order to review options for continued investment. A number of the actions have been embedded in practice and work continues.

PG (Datix 276521/276523)

Baby suffered a birth injury in the form of a fractured humerus as a result of a shoulder dystocia following ventouse delivery. There are no concerns with the management of the shoulder dystocia, manoeuvres used were appropriate and timely and in accordance with the Royal College of Obstetrics and Gynaecologists green top shoulder dystocia guideline (March 2012, Green-top guideline No. 42).

There were no lessons learnt highlighted as part of the investigation. Recommendation noted as; Shoulder dystocia guidance to be discussed with the neonatal team to explore the benefits of having imaging if manoeuvres are used at a shoulder dystocia.

	RS (Datix 281198) Baby Smith suffered a birth injury in the form of a clavicular fracture most likely as a consequence of a shoulder dystocia. There were no concerns with the management of and appropriate and timely manoeuvres were used in accordance with the Royal College of Obstetrics and Gynaecologists green top Shoulder Dystocia guideline (March 2012, Green-top guideline No. 42) There were no lessons learnt highlighted as part of the investigation. Recommendation noted as; Shoulder dystocia guidance to be discussed with the neonatal team to explore the benefits of having imaging if manoeuvres are used at a shoulder dystocia.	
4.4	**Infection Prevention Control Update** The report was noted for information. • New guidance with regards to Bare Below the Elbow has been received and included for information • Audits are continuing and discussions are ongoing with regards to ensuring adherence to in house guidance with regards to transfers from other hospitals • Norovirus on Rainbow Ward has been reported, this is being highlighted as a result of a change in reporting and this is being managed appropriately • FIT Testing continues • The Clinical Board are on target for all tier 1 targets • ANTT data is being received and figures are currently being reported at circa 70% • There has been a significant increase with regards to patients being admitted with flu, namely patients of 2 and under which information has been shared with Public Health. **HCAI Bi-annual Infographics (Apr - Sep 18)** Noted for information.	
4.5	**Safeguarding** No issues to note for this meeting.	
4.6	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • Internal Safety Notice 2019/001 - Clexane supply • Message from Welsh Government - Influenza Season 2018-19 Use of antivirals now recommended in line with NICE guidance. • Message from Welsh Government - Drug Alert Class 2, Action Within 48 Hours, Actavis Group Ptc Ehf, Irbesartan /Hydrochlorothiazide 300 / 12.5mg Film-Coated Tablets; Irbesartan / Hydrochlorothiazide 150 / 12.5mg Film-Coated Tablets. • Message from Welsh Government - MDA/2018/037 - Fabian +nCPAP evolution, Fabian Therapy evolution and Fabian HFO – Risk of total loss of patient ventilation. • Influenza Briefing note from Public Health Wales 9-Jan-19 • Message from Welsh Government - MDA/2018/034 - Suction catheters, gastro-enteral tubes, intermittent urology catheters and sterile urine drainage bags – potential breach in sterile barrier packaging • Message from Welsh Government - MDA/2018/035 - All T34 ambulatory syringe pumps – update concerning battery information • Message from Welsh Government - PSN046/November 2018 - Management of life threatening bleeds from arteriovenous fistulae and grafts Discussion ensued with regards to the change to clexane supply to a different product which will impact on the training provided for patients to administer themselves within Obstetrics. There is no availability of syringes for the training. AL agreed to review this outside of the meeting.	**AL**

	All the safety alerts were noted for information. There were no specific exceptions to report for the Clinical Board for this meeting and the group were asked to ensure that the notices were shared as appropriate throughout their Directorates to raise awareness.	**ALL**
4.7	**Scoliosis Patients Management Plan** A number of scoliosis patients require HDU capacity post operatively which was impacting on service provision. A plan was implemented to review different options to manage these patients through additional capacity. X2 beds were commissioned in order to schedule the patients accordingly which would allow the staff to manage the patients appropriately. This has been a positive impact and has reduced cancellations significantly. Agreement has been received for funding from WHSSC in order to continue this plan and fund the required staff to manage the patients going forward.	
4.8	**SBAR - NICU – Neonatal Transitional Care (NTC)** Joint work undertaken with Neonatal and Midwifery to review the transitional care guidelines against the BAPM care guidelines. It was noted that there would need to be an increase in staff on transitional care in order to meet the guidelines. The recommendations were noted, however it was agreed that this will need further discussion with the Clinical Board in the first instance with regards to financial implications etc.	**CH**
4.9	**SBAR for Paediatric Oncology Capacity** The SBAR was noted for information. This has been submitted to WHSSC for consideration. Currently there are particular pressures within paediatric oncology which will impact on the availability of beds. The demand requires that additional capacity is opened (x3 beds) in order to manage the service going forward including pharmacy input and daycase capacity. It is also anticipated that shared care agreement with Carmarthen is likely to impact and result in some patients needing to be cared for at UHW.	
DIGNIFIED CARE		
5.1	**Latest Cleaning Scores Report** The cleaning scores report was noted for information. There were no specific issues to highlight for this meeting. St David's Children's Centre should also be included as part of the report and CH agreed to follow up.	**CH**
5.2	**Children's Rights Update** Meetings have taken place with the Youth Board and Operational Group. Induction training is being developed and it was agreed that some training would need to be mandatory and work is taking place as to how this training will be accessed. Discussion ensued with regards to social media, and it was noted that information would need to be circulated with regards to membership agreement and roles and responsibilities and the correct mechanisms of sharing views/concerns etc. Media training was welcomed and further discussions are taking place with communications. A chair will be elected and roles and responsibilities and terms of office will be agreed. The youth board members have also been part of the redesign of CAMHS services within St David's Children's Centre and also took part in CCNS interviews which has been very positive and inspiring work to date. Further work is being undertaken as to how the charter will be embedded within the hospital and it was agreed that children's champions should be identified in other clinical boards.	

TIMELY CARE		
6.1	**Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes – for information** The dashboard was shared for information. Significant work has taken place across all areas and thanks were expressed to all for the continued hard work in achieving the targets. TPE was discussed, and whilst there has been a decrease there has been a significant improvement.	
6.2	**Update on LAC Out of Area Assessment** Discussed as part of item 2.2.	
INDIVIDUAL CARE		
7.1	**Update on latest 2 minutes of your Time feedback** No specific feedback to report for this meeting.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
8.1	**Safety and Quality Sessions 2019** Noted for information.	
8.2	**Patient Discharges without Discharge Summaries** Information was shared for information and request has been made that the areas are made aware at the time so that actions can be undertaken appropriately.	
8.3	**Zero Tolerance Report – December 2018** Noted for information and shared with clinical leads in order to drive this forward.	
ANY OTHER BUSINESS		
9.1	**Antibiotic Stickers** It was noted that the antibiotic stickers are not being used well within the CHFW and requests were made to reinforce the use of the stickers. **TTH Medicines** Discussion ensued with regards to TTH medicines and it was noted that the message needs to be reinforced that all medicines should be double checked by Pharmacy prior to being taken home by patients. **Use of HPV** Algorithm has now been produced highlighting when HPV should be used. **PROMPT Training** Very positive comments have been received with regards to recent PROMPT training undertaken within maternity, of which the unit has been classed as an exemplar for others. Well done to all.	**AG** **AG**

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled for **Tuesday 26th February 2019, 8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW**

<u>2019 Meeting Dates</u> (4th Tuesday of the Month, between 8.30 – 10.30am unless otherwise stated)

Tuesday 26th March, Meeting Room, Clinical Board Offices, Lakeside (H&S FOCUS)
Tuesday 23rd April, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 28th May, Meeting Room, Clinical Board Offices, Lakeside (IP&C FOCUS)

Tuesday 25th June, Meeting Room, Clinical Board Offices, Lakeside (H&S FOCUS)
Tuesday 23rd July, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 27th August, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 24th September, Meeting Room, Clinical Board Offices, Lakeside (H&S FOCUS)
Tuesday 22nd October, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 26th November, Meeting Room, Clinical Board Offices, Lakeside (IP&C FOCUS)
Tuesday 17th December, Meeting Room, Clinical Board Offices, Lakeside (H&S FOCUS)

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Dental Clinical Board

Minutes of Quality, Safety & Experience Committee Group Meeting
Thursday 14th March 2019 – 8.00AM
Large Seminar Room, Ground Floor, University Dental Hospital

Present:

Andrew Cronin (Chair)	(AC)	Shannu Bhatia	(SB)	Eira Yassien	(EY)
		Wil McLaughlin	(WM)	Ivor Chesnutt	(IC)
Rowena Griffiths	(RG)	Gurcharn Bhamra	(GB)	Nick Drage	(ND)

Apologies:

Barbara Chadwick	Melanie Wilson	Caroline Sutton
Catherine Evans	James Gillespie	Julia Charles

In Attendance:
Jonathan Peck (JP)

		ACTION
PRELIMINARIES		
1.1	**Welcome & Introductions** AC welcomed everyone to the meeting of the Quality, Safety and Experience Group. **Rowena Griffiths presentation – Never Event Oral Medicine Clinic** A patient's review appointment was requested for six months (October 2017). The patient was not seen in October 2017, as requested. The patient was seen on 24th April 2018 on the Oral Medicine Clinic. The patient had a biopsy on 30th April 2018 under general anaesthetic. He attended a follow-up appointment on 4th May 2018 and was informed of cancer diagnosis. The group discussed and noted the mechanisms now in place. EY noted that the patients' 'time out' on the Patient Management System should be investigated to provide further information on what may have happened. RG commented that all patients on that day were to be checked to ensure they have been given appointments if necessary.	
1.2	**Apologies for absence** Received as above.	
1.3	**To receive the Minutes of the previous meeting** The minutes of the Quality, Safety & Experience meeting held on the 10th January 2019 were reviewed and confirmed to be accurate and correct. **Matters Arising** • With regard section 6.1 of the last meeting minutes – '3 'break glass' incidents by a single member of staff.' AC had again spoken with the person involved but still had little understanding as to why this person would need to access confidential	

	patient records as part of an audit project. Having reviewed, the person has been written to informing them in detail as to what their responsibilities are and should there be further incidence then action would be taken. • RG took the opportunity to inform the group that: o The post for Dental DSDU Manager had been advertised internally. o The re-certification audit for DSDU was to be undertaken on the 2nd, 3rd & 4th of April 2019.	
MONITORING & REPORTING – DENTAL CLINICAL BOARD SUB GROUPS		
2.1	**Oral Surgery, Medicine, Pathology & Radiology** **- Mr N Drage** The minutes from the OSMP Audit Group meeting held on the 12th February 2019 were received and noted. ND summarised the meeting and informed the group a number of presentations had been given including: • **Grace Kelly presentation -** Consent & Application of Mental Capacity Act (2005) in Dental Practice. • **Melanie Wilson** - National Prescribing Audit • **Olivia Barratt** - Re-audit of Patient Satisfaction on Oral Medicine Out Patient Clinic 2018. • **Hannah Bradley** - Urgent suspected cancer referrals: assessment of the appropriateness of referrals to the Oral Medicine department of Cardiff Dental Hospital. • **Neha Thakerar** - Are we following our protocol for biopsy reviews on Oral Medicine clinics?	
2.2	**Restorative Dentistry** **- Mr G Bhamra** The minutes from the Restorative Audit Group meeting held on the 19th February 2019 were received and noted. GB summarised the meeting and informed the group a number of presentations had been given including: • **Grace Kelly presentation -** Consent & Application of Mental Capacity Act (2005) in Dental Practice. • **Amar Patel presentation –** Audit 6739: A retrospective study of the treatment outcomes for periodontitis at Cardiff Dental Hospital. • **Jann Siew Chin presentation** – Audit proposal: An audit to assess the outcome of endodontic led micro surgery. AC noted that GB had informed the group that this meeting would be his last as restorative dentistry audit lead. GB informed the group that Liam Addy would be the new audit lead.	
2.3	**Joint Orthodontic and Paediatric Dentistry** **- Mrs S Bhatia** The minutes from the Joint Orthodontic and Paediatric Dentistry Audit Group meeting held on the 12th February 2019 were received and noted. • SB summarised the meeting and informed the group a number of presentations had been given including: • **Yamama AlSabah presentation –** Audit 6744: A local re-audit of unfitted orthodontic appliances at University Hospital Wales.	

	• **Emily Jones and Angharad Robinson presentation -** Audit: 6746: Record keeping in inhalation sedation patients. • **Emily Jones presentation –** Periodontal diagnosis in the context of the 2017 classification system of periodontal diseases and conditions. • **Saarah Juman presentation –** Audit proposal: Quality of Lateral Cephalometric Radiographs Used for Orthodontic / Orthognathic Surgery Treatment. • SB informed the group that the children's safeguarding register had been reviewed and patient notes had been examined to update the register. • SB had informed the group on behalf of Mechelle Collard that on GA consent forms clinicians should also write 'damage to any other structures'. • Rachel Parkes had informed the group that she had been trying to set up intravenous sedation clinics for teenagers. As there was currently no consultant lead, no clinics were able to be booked as yet. SB had advised her to speak to Grace Kelly to discuss her possible supervision for a few sessions. • SB brought to the groups' attention that Smile Week was in the near future and shared a pamphlet of information as to what this would entail. • SB noted that audit meetings in April have been delayed. IC explained that this was to enable all audit group members to attend a demonstration from representatives of the SALUD appointment management system. The software has been updated with an improved user interface. With the forthcoming introduction of e-RMS (electronic referral management system) it is possible the two systems may be integrated to create a paperless system. IC did acknowledge that further reassurances from IT would be needed before this was progressed.	
2.4	**Community Dental Service** **- Mr W McLaughlin** WM informed the group there had not been a recent CDS Q&S meeting to report on. It was also currently unclear how the meetings would progress with a different management structure due to the separation from Cwm Taf. IC commented that any CDS Q&S meeting minutes would now go to the Surgical Quality & Safety committee and was no longer part of this setup. WM requested CDS be removed as an agenda item from this meeting.	
2.5	**DSG HSC: Minutes of the Dental Division and School H & S Advisory Group** **- M Wilson** The minutes from the H & S Advisory Group meeting held on the 31st January 2019 were received and noted.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Patient Story / Audit Presentations	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
4.0	WHC/2015/001 - Improving Oral Health for Older People Living in Care Homes in Wales – Dinah Jones WHC 2008 (008) – Designed To Smile – Dinah Jones	

SAFE CARE		
5.1	Risk Register- Rowena Griffiths review and revision	
5.2	**Incident Reports** • UDH & CDS Incidents 070119 - 080319 The document was received and noted. SB noted in particular: o In86555 – A patient under investigation for a diagnosis of being on the autistic spectrum and also has sensory issues regarding any physical contact with others ran off from the Health Centre as he couldn't wait. SB would share this incident at audit as the personal safety advice staff were given as part of the incident outcome was to keep themselves safe in such situations and to always think of their own safety first.	
5.3	Medicines Management Audit Report	
5.4	**New Medical alerts** • 37324_NHS Wales Patient safety fracture fixation plates WEB The document was received and noted.	
5.5	Medical devices/equipment issues	
5.6	Decontamination CDS WHTM01-05	
5.7	HIW Inspections and report	
5.8	**Infection, Prevention & Control** • AC acknowledged the SDCEP August 2018 implementation advice for the prevention of infective endocarditis and its use within UDH for incorporation into the appendices of the UDH Antimicrobial Guidelines. AC requested the information be disseminated and any concerns be fed back to AC and MW. ND commented that it would be useful for MW to speak to audit groups regarding the advice.	
5.9	NatSSIPs – Julia Charles	
EFFECTIVE CARE		
6.1	**Monitoring of CB Clinical Audit plan** • Ongoing Audits as at 110319 The document was received and noted.	
6.2	Research and development	
DIGNIFIED CARE		
7.1	Initiatives to improve services for people with: • Dementia Nothing to report • Sensory loss Nothing to report	

	• Mental Capacity Act Nothing to report	
TIMELY CARE		
8.1	**RTT & Waiting list issues - Eira Yassien** EY reported that waiting lists had been reduced. However, patients waiting for a first appointment were still high with over 1000 waiting in Oral Surgery alone.	
INDIVIDUAL CARE		
9.1	**Concerns** • UDH & CDS Concerns 070119 - 080319 The document was received and noted.	
9.2	**Compliments** • Compliments The document was received and noted.	
9.3	**Safeguarding** • Protocol for the Resolution Differences - Endorsed Nov 2018 The document was received and noted. • Vale of Glamorgan report_ FINAL REPORT The document was received and noted. • Vale of Glamorgan_Exec summary_FINAL The document was received and noted. • Home Office Approval Letter - DHR Vale of Glamorgan The document was received and noted.	
9.4	Patient Experience	
STAFF AND RESOURCES		
10.1	Employee of the Month	
10.2	**Staffing levels – Eira Yassien** EY noted a current shortage of staff in the Dental Records department which was causing operational problems and work to build up. Vacancies had been advertised and filled for some administration roles with start dates given. Recent interviews for secretarial posts had been unsuccessful with no attendees. An external bank agency has been contacted for a temporary solution.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
	Reg 28 Response - LR-jb-01-7238 no password The document was received and noted.	
	National report (January 2019 returns) – DEN The document was received and noted.	
Any Other Business		

	ND updated the group that the 'risk/benefit' procedure has gone live on SALUD. The printed forms will be going live on the 1st April 2019.	

Date and time of next meeting:

Thursday 9th May 2019	8:00 AM	TBA