



QUALITY, SAFETY AND EXPERIENCE COMMITTEE

**9am on Wednesday 6th December 2017
Corporate Meeting Room, UHB HQ
University Hospital of Wales**

QUALITY SAFETY AND EXPERIENCE COMMITTEE
9am on 6th December 2017
Corporate Meeting Room, HQ, University Hospital of Wales

AGENDA

PART 1: Items for Action		
1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	Oral
4	Minutes of the Special Committee meeting held on 17 th October	Chair
5	Action Log	Chair
6	Chair's Action Taken since the last meeting	Oral - Chair
Governance, Leadership and Accountability		
7	Patient Story	CB Specialist Services
8	Specialist Services Clinical Board Quality, Safety and Experience Assurance Report	Clinical Board
9	Community Health Council Report	CHC
10	CHC Report: Older People in Community Hospitals – Avoiding Boredom and Loneliness	Executive Nurse Director
11	Policies for Approval	
1	Safety Notices and Important Documents Management Policy	Director of Corporate Governance
2	DNACPR All Wales Policy Review	Medical Director
3	Medicines Code	Medical Director
4	Preceptorship for Newly Qualified Nurses and Midwives Policy and Procedure	Executive Nurse Director
5	Discharge from Hospital Policy and Procedure	Chief Operating Officer
12	Quality Safety and Improvement Framework Update	Oral Asst. Director Patient Safety & Quality
13	Implementation of the Refreshed Patient Experience Framework	Asst. Director Patient Experience
14	Health and Care Standards Proposed Approach for 2017 Self Assessment	Executive Nurse Director
Theme 1: Staying Healthy (Health Promotion, Protection and Improvement)		

CARING FOR PEOPLE
KEEPING PEOPLE WELL



GIG CYMRU
NHS WALES

Bwrdd Iechyd Prifysgol
 Caerdydd a'r Fro
 Cardiff and Vale
 University Health Board

Theme 2: Safe Care		
15	Patient Safety Walkrounds	Executive Nurse Director
16	Neonatal Improvement Plan Following Acinetobacter Baumannii Outbreaks	Executive Nurse Director
17	Infection Prevention and Control – Position Against Tier 1 Infection Reduction Expectations For Healthcare Associated Infections	Executive Nurse Director
18	Cleaning Update November 2017	Director of Planning
19	Health and Care Standards: 2.9 Medical Devices , Equipment and Diagnostic Systems	Director of Therapies and Health Sciences
20	Corporate Risk and Assurance Framework	Director of Corporate Governance
21	UHB Self Assessment against Health and Care Standard 2.6 Medicines Management – Mid Year Update	Medical Director
22	Development of Paediatric Single Point of Entry	Chief Operating Officer
23	Patient Safety Solutions – Alerts and Notices – Update on Outstanding Areas of Non Compliance	Executive Nurse Director
Theme 3: Effective Care		
24	Cancer Peer Reviews – Colorectal Cancer	Medical Director
25	Mortality Data and Mortality Review	Medical Director
Theme 4: Dignified Care		
26	HIW Practice Inspection Report - Primary Care General Medical Services and Dental Governance	Executive Nurse Director
27	HIW Activity Update	Executive Nurse Director
28	HIW Ophthalmology Thematic Review	Executive Nurse Director
Theme 5: Timely Care		
Theme 6: Individual Care		
Theme 7: Staff and Resources		
PART 2: Items to be recorded as Received and Noted for Information by the Committee Papers are available on the UHB website		

29	Learning Disabilities Specialist, Secondary and Primary Care Services	<i>Director of Therapies and Health Sciences</i>
30	Removal of “ Statutory ” Supervision of Midwives and a New Model for Wales	<i>Executive Nurse Director</i>
31	Minutes from Clinical Board Quality Safety and Experience Sub Committees 1. Clinical Diagnostics and Therapeutics – August and September 2. Mental Health – September and Lessons Learned and October 3. Primary, Community and Intermediate Care - July 4. Specialist Services – 30th July, Aug x 2 and September 5. Medicine – August and October and A&E waits in June/July and August /September 6. Surgery – July 7. Children and Women – August 8. Dental – September	<i>Chief Operating Officer</i>
32	Agenda for the Private QSE	
33	Items to bring to the attention of the Board/other Committee	Oral – <i>Chair</i>
34	Review of the Meeting	Oral – <i>Chair</i>
35	Date of next meeting 9am on Tuesday 13 th February 2018 Proposed Dates for 2018/19 • 13 February and 17 April (already in diary) • 12 June • 14 August or 18 September • 16 October (Special Meeting) • 18 December • 19 February & 16th April 2019	

**UNCONFIRMED MINUTES OF THE SPECIAL ANNUAL MEETING OF THE
QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT
9AM ON 17 OCTOBER 2017
CORPORATE MEETING ROOM, HEADQUARTERS, UHW**

Present:

Susan Elsmore	Independent Member, QSE Chair
Maria Battle	UHB Chair
Michael Imperato	Independent Member – Legal
Stuart Egan	Independent Member – Trades Unions

In Attendance:

Abigail Harris	Director of Planning
Angela Hughes	Interim Asst. Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Catherine Salter	Staff Health and Safety Representative
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Salter	Staff Representative
Gill George	NHS Delivery Unit (Observer)
Dr Graham Shortland (part)	Medical Director
Dr Laura Potts (part)	Welsh Clinical Leadership Fellow (Observer)
Maria Roberts	Patient Safety Manager
Matt McCarthy	Patient Safety Facilitator
Melanie Harris	NHS Delivery Unit (Observer)
Ruth Walker	Executive Nurse Director
Steve Curry	Chief Operating Officer

Apologies:

Akmal Hanuk	Independent Member – Community
John Union	Independent Member - Finance
Sara Moseley	Independent Member – Third Sector
Peter Welsh	Director of Corporate Governance
Robert Chadwick	Director of Finance
Sharon Hopkins	Director of Public Health
Stephen Allen	Chief Officer, Cardiff and Vale of Glam CHC

Secretariat:

Julia Harper

QSE 17/172**WELCOME AND INTRODUCTIONS**

The Chair, Cllr Susan Elsmore introduced herself as the new Chair of the Committee and welcomed everyone to the meeting, in particular, the new Independent Member, Mr Michael Imperato and informed Committee that the UHB Chair and former QSE Chair, Miss Maria Battle would remain as a Member and Mr Stuart Egan joined the Committee until the year end.

QSE 17/173 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 17/174 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. None were declared.

QSE 17/175 MINUTES OF THE COMMITTEE HELD ON 12th SEPTEMBER 2017

The Minutes of the last meeting were **RECEIVED** and **APPROVED**.

QSE 17/176 ACTION LOG FOLLOWING THE LAST MEETING

The Committee **RECEIVED** the Action Log and **NOTED** the number of actions that had been completed. These would be removed. The action log was updated as follows:

QSE 17/090 Regulatory and Accreditation Visits to CD&T – Miss Battle confirmed that a letter of commendation had been sent. **Complete**

QSE 17/135 Dental CB QSE Assurance Report – Miss Battle confirmed that a meeting was planned with the new WOD Director.

QSE 17/177 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

No action had been taken in between meetings.

QSE 17/178 ANALYSIS OF TRENDS AND THEMES IN SERIOUS INCIDENTS AND NEVER EVENTS

The Executive Nurse Director, Mrs Ruth Walker advised the Committee that this was a Special Annual Meeting to provide assurance around actions taken on serious incidents (SIs) and ensure they were managed robustly. In previous years the focus of the meeting had been on processes but these were now well embedded in Clinical Boards.

The UHB had been somewhat slow in closing SIs because of the need to demonstrate thorough investigation, analysis, solution and action but the position of 282 open SIs last year had improved and now stood at 80. There had also been a slight decrease in the number of SIs reported. It was stressed that overall, the percentage of serious incidents that lead to harm

was less than 1% compared with the number of treatments provided in the UHB.

Mrs Walker also advised the Committee that the UHB had seen a rise in the number of incidents reported relating to patient falls as well as Grade 3&4 pressure damage.

The report identified a number of themes from SIs and the Executive Nurse Director explained the internal governance and performance management arrangements for SIs.

It was noted that a number of issues affected the time taken to investigate and close an incident: the availability of staff and case notes, the length of the patient pathway and in particular, POVA referrals that required multi agency investigation. Community incidents and deaths referred to the Coroner often resulted in lengthy investigations. Welsh Government was always kept advised of process delays. The Board received a report on SIs at every public meeting – the only UHB that reported and published such information openly.

The Committee discussed the reporting of pressure damage and the difficulty of definitions. The UHB had to report hospital acquired pressure damage but this was tricky to determine within the 24 hour reporting requirement. All patients had an assessment on admission and ongoing assessment if identified as being at risk. When investigating if the pressure damage occurred while in hospital and could have been avoided, there had to be a balance, for example, maintaining a stable spine through the use of a collar could lead to pressure damage. In addition, in the community, a person's choice to sleep in a chair as opposed to going to bed could also increase their susceptibility to pressure damage.

The Committee considered the importance of patient flow, length of stay and delayed transfers of care that all resulted in patients staying longer in hospital and thus, there was a higher potential for falls. Positively, a falls lead had taken up post recently.

There was a fine balance between the need to mobilise patients and the potential to fall, but the need to maintain independence though mobilisation was very important. A video link to a case study would be circulated to the Committee.

Action – Mrs Julia Harper

ASSURANCE was provided by:

- The level of scrutiny applied internally and externally to the Serious Incident reporting process. Serious Incidents were reported and investigated within the required process. Furthermore, closure of SIs with Welsh Government (WG) was monitored at the Executive and Clinical Board performance reviews and by WG. Periodically, Internal Audit undertook related assurance reviews. The Delivery Unit also applied scrutiny to Never Event processes.

The Quality, Safety and Experience Committee:

- **NOTED** the report and **AGREED** that appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.

**QSE 17/179 PAEDIATRIC NASO GASTRIC TUBE NEVER EVENT
(PRESENTATION)**

Avril Gowman, Senior Nurse, Paediatric Surgery and Becky Williams, Deputy Ward Manager attended the meeting and gave a presentation on a naso gastric tube never event that occurred in May 2016. Ms Gowman gave a summary of the incident, the root causes and the remedial action taken. Importantly, there had been no similar occurrence in the last 18 months.

The Committee noted that the Policy had been revised, but not yet agreed and a timeframe for approval was requested.

Action – Mrs Carol Evans

The Committee also saw for themselves one of the training mannequins and noted that more would be purchased following evaluation of the most appropriate type. This enabled all novice nurses to practice in safety.

The staff had managed to maintain a good relationship with the family by being honest and open and by sharing the root cause analysis and the action that had been taken. The family, though initially angry, had confirmed they would have no reservations using the Children's Hospital again.

The Clinical Board had set up a 6 month supernumerary preceptorship programme for newly qualified nurses. This has been warmly welcomed by staff and had improved staff retention.

The Chair thanked colleagues for the excellent presentation.

**QSE 17/180 USE OF WORLD HEALTH ORGANISATION
CHECKLIST (PRESENTATION)**

Dr Linda Walker, Director of Nursing, Surgery and Dr Richard Hughes, Consultant Anaesthetist and Chair of the Surgery Quality and Safety Sub Committee gave a presentation on the use of the WHO checklist that had been in use across the world since 2009/10. Despite the checklist, UK figures showed a rise in the number of retained foreign objects and wrong site surgery.

As the WHO checklist was only used in operating theatres, it had become clear that a system was required in other areas that undertook invasive procedures. This led to the development of National Safety Standards for Invasive Procedures (NatSSIPs), supported further by Team Briefing and Debriefing.

It was important to ensure all staff were aware and trained in the use of the tools and that junior staff felt able to challenge senior colleagues if they did not follow the procedures. Senior Management supported staff and took action when necessary and clinical leaders audited the quality of the checklists to ensure they were being completed thoroughly. The move towards Debrief was innovative and part of a 2 year research project. In addition, this had already spread to the resuscitation team who championed the project across the UHB.

The Chair thanked colleagues for the excellent presentation.

QSE 17/181 NATIONAL SAFETY STANDARDS FOR INVASIVE PROCEDURES FOLLOW UP (NatSSIPs) (PRESENTATION)

Mr Matt McCarthy, Patient Safety Facilitator gave a presentation on the 13 standards and the gap analysis for areas undertaking invasive procedures outside theatres. In addition, he drew attention to the information available on the UHB intranet pages and the availability of a shared drive.

The Executive Nurse Director, Mrs Ruth Walker reminded Committee that the presentations demonstrated the depth and breadth of patient safety work that was ongoing throughout the UHB. She thanked the Patient Safety Team for all their work and for being ahead of the curve. The Medical Director agreed to support this work through the nomination of a medical lead.

Action – Dr Graham Shortland

ASSURANCE was provided by:

- Work that has progressed to implement the Standards to date.
- Infrastructure that was established to roll out implementation across the UHB over the next two years.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the progress that has been made to date and the implementation plan.
- **AGREED** to report compliance with Patient Safety Notice 034 – Supporting the Introduction of the National Safety Standards for Invasive Procedures.

QSE 17/182 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

It was agreed to provide assurance to the Board that lessons were being learned from SIs and the UHB was proactively taking forward improvement actions.

QSE 17/183 ANY OTHER BUSINESS**1. Feedback from NHS Delivery Unit**

The Chair invited colleagues to give any feedback on the meeting. Ms George and Harris were grateful for the opportunity to attend the meeting and were pleased to see the examples of the learning, the team approach and the sharing of lessons and good practice with other services. They suggested that the CSI Team be asked to share and embed success stories across the UHB.

The Committee noted the constant improvement journey.

QSE 17/184 DATE OF NEXT MEETING

The next meeting would be held at 9am on Wednesday 6th December 2017. Dates for 2018/19 were also proposed:

13 th February	17 th April
12 th June	14 th August or 18 th September
16 th October	18 th December
19 th February 2019	16 th April 2019

ACTION LOG FOLLOWING QSE COMMITTEE OCTOBER 2017 MEETING

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 17/024 QSE 17/048 QSE 17/084 QSE 17/132	21.2.17 18.4.17 20.6.17 12.9.17	Ward Bathroom Refurbishment		Analysis of comparative data – new bathroom - effect on falls and infection rate. Further work on impact of use of colour on falls and use of transportable toilet bags.	C Evans	No significant decrease – except for C1 so further analysis to be undertaken. It was anticipated this could be done by January 2018 following recruitment into the Falls post.
QSE 17/56	18.4.17	Patient Safety Solutions Alerts and Notices		Share with the UHB evidence obtained from patients regarding wristbands.	S Allen, CHC	This would be shared at a meeting on 15th September .
QSE 17/088 QSE 17/132	20.6.17 12.9.17	CHC Report		To support the UHB, instigate national debate on repatriation. Visit findings and feedback to be regularly shared with the Equalities Manager	CHC D Price CHC D Price	Impact of this on UHB to be provided to the CHC by Mr Steve Curry.
QSE 17/101	20.6.17	Cancer Peer Review – Brain		Raise structure of the network with WHSSC Chair of Quality and Safety Committee (G Shortland to brief Chair). Undertake work on	M Battle (Dr G Shortland) Dr G Shortland	Maria Battle and Medical Director (MD) have met. Discussed the “Systems Rules” that we need to develop across South Wales. Chair and MD will meet with previous MD WHSSC and new WHSSC Chair to discuss and take

5

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				system rules on flows and collaboration		forward.
QSE 17/135 QSE 17/176	12.9.17 17.10.17	Dental CB QSE Assurance Report		Raise with WOD Director concerns about mandatory training	M Battle	October update - a meeting had been set up.
QSE 17/138.3	12.9.17	Nutrition and Catering Policy		Update recently agreed Policy to include work on NG tubes when this is ready.	F Jenkins	Policy will be updated again once the recommendations of the working party have been agreed.
QSE 17/179	17.10.17	Never Event NG Tube		Provide timeframe for approval of revised policy.	C Evans	
QSE 17/139	12.9.17	Out of Date Policies		Plan to update all out of date policies within 6 months	C Evans	By April 2018
QSE 17/152	12.9.17	Carers		Request Mrs Hughes liaise with LED to update mandatory training	A Hughes	Discussions being held with LED
QSE 17/181	17.10.17	NatSSIPs		Nominate a Medical Lead	G Shortland	Dr Shortland seeking nomination in discussion with AMD Patient Safety and Clinical Effectiveness
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS/OTHER COMMITTEES						
QSE 16/192	18.10.16	Critical Care Outreach Team		Clinical Model for managing the deteriorating patient to be agreed.	Dr G Shortland	This item had been considered at Committee several times without agreement on a way forward for an action plan and timeline. Joint discussions taking place with Executive Nurse Director and
QSE 17/048	18.4.17	(Identifying and Managing the Deteriorating				
QSE 17/099	20.6.17			Discuss at Management	S Curry	

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		Patient)		Executive the options for strengthening on site clinical and managerial support. Finalise ongoing shape and purpose of services at UHL through the acute medicine review with the Planning Team.	A Harris	scoping actions in place to take forward. Full discussion to be held at at QSE meeting in June 2017 . Dec 16 - a new lead for UHL has been identified and is in place Mrs Harris reported that the current arrangements will not change. A clinical services model was being developed. It was agreed to keep this on the agenda.
QSE 17/023	21.2.17	Care of Deteriorating Patient		Ensure all differing views are taken into account when scoping the way forward	Dr G Shortland	(Linked to the above work) Report with action plan and timeline to be provided for QSE in September 2017 – Deferred to December
QSE 15/135 QSE 16/006	01.09.15 23.2.16	Corporate Risk and Assurance Framework Exception Report -		Business Case for Critical Care Outreach (CCO) and Hospital at Night to be considered at Investment Panel.	G Shortland	December 2016 update: Awaiting funding for Advanced Nurse Practitioners to address Hospital at Night
QSE 16/202 QSE 17/023	13.12.16 21.2.17	Care of the Deteriorating		Need to resolve Critical	G Shortland	February 2017 - Reported to HSMB in December that more

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		Patient : Critical Care Outreach Service		Care Service issues at UHL.		work was required to make the plan resource neutral. Update agreed for September 2017 (Linked to 2 items above)
QSE 15/171 QSE 16/148 QSE 17/005 QSE 17/048 QSE 17/132	20.10.15 13.9.16 21.2.17 18.4.17 12.9.17	Trends and Themes in SI's		Revisit decision on patient wristbands.	R Walker	Feb 2017 - Solution agreed but funding yet to be identified for 2017/18. Present report for funding consideration to the Management Executive and provide more detail for the next QSE meeting in June . Business case now going to BCAG 13 TH June 2017. Board advised it was anticipated for QSE in December 2017 . This was taking longer to scope and at Chair's request, would remain on the agenda until a decision was made.
QSE 17/017	21.2.17	HIW Ophthalmology Thematic Review		Progress report including complaints on waiting times and cancellations to be received in September	R Walker	QSE September 2017 Deferred to December 2017 Report on December agenda but need to raise details of waiting time complaints at the meeting
QSE 17/057	18.4.17	Patient Falls		Undertake analysis of the data to identify hotspots, reasons for the fall and whether it was	C Evans	Work is underway by Falls Delivery Group. Considered in general at the Special meeting of the QSE in October 2017 –

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				appropriate for the patient to be on that ward.		included in Trends and Themes. Specific detail of action is ongoing.
QSE 17/107	20.6.17	Single Rooms, Isolation Rooms and Decant		To be discussed at HSMB	A Harris	To HSMB in November 2017 Deferred to December 2017
QSE 17/054 and QSE 17/055	18.4.17	Quality Safety and Improvement Framework		Receive monitoring report in October or December.	C Evans	QSE December 17 Verbal update to be received at meeting
QSE 17/103	20.6.17	HIW Activity – Single Point of Entry for Children		Progress report on plans for a single point of entry for Paediatric Emergencies	S Curry	QSE September 2017. Deferred to December
QSE 17/105	20.6.17	Management of Outpatient Follow Ups and Endoscopy		Receive update report early next year.	S Curry	QSE February 2018
QSE 17/098	20.6.17	CRAF		Comments to P Welsh on whether the risk descriptors and controls identified were adequate to provide assurance to the Committee by 20 th July.	ALL Members and Attendees P Welsh to correlate.	Comments being considered as an integral part of risk review to ensure risk descriptors are more meaningful and understood and controls more measureable. Anticipated by April 2018
COMPLETED ACTION SINCE LAST MEETING						
QSE 17/090 QSE 17/176	20.6.17 17.10.17	Regulatory and Accreditation Visits to CD&T		Letter of commendation to be sent to Clinical Board	M Battle	Complete

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 17/138.3	12.9.17	Nutrition and Catering Policy		Strengthen Policy re carers and split policy from procedure. Publish Policy	C Morgan / F Jenkins J Harper	Complete and published 3.11.17
QSE 17/135 QSE 17/176	12.9.17 17.10.17	Dental CB QSE Assurance Report		Share feedback with Mandatory Training Steering Group	C Salter	Concerns shared with LED. Complete
QSE 17/178	17.10.17	Analysis of Trends / Themes in SIs		Circulate video link to a case study.	J Harper	Complete
QSE 17/051 QSE 17/084	18.4.17 20.6.17	Mental Health CB QSE Report		Refresh work on sensory loss and arrange walkround with representative of the deaf community.	I Wile	Complete
QSE 17/009	21.2.17	CHC Report – Boredom and Loneliness		Receive an update in 6 months to a year.	R Walker	QSE December 2017. On agenda. Complete
QSE 17/054 and QSE 17/055	18.4.17	Patient Experience Refreshed Framework		Receive monitoring report in October or December.	A Hughes	QSE December 17. On agenda Complete
QSE 17/053	18.4.17	Donation of Organs and Tissues after Death Policy		Identify a Patient Story linked to faith for a future Board meeting.	A Hughes	November 2017 Board meeting Organ Donation Team to attend the November Board Complete
QSE 17/096	20.6.17	Independent Review – Acinetobacter NNU		6 monthly progress report to be received	R Walker	QSE December 2017 On December agenda. Complete
QSE 17/149	12.9.17	Cancer Peer Review –neuro		Share report with HIW	Dr G Shortland	Report agreed and action plan in place.

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		endocrine tumours				Complete

5

SPECIALIST SERVICES QUALITY REPORT	
Name of Meeting :	Quality, Safety and Experience Committee
Date of Meeting:	6 th December 2017
Executive Lead :	Executive Nurse Director
Author :	Director of Nursing Ext 48705
Caring for People, Keeping People Well :	This report summarises the quality, safety and experience issues for patients and staff in Specialist Services Clinical Board. It is aligned to the quality components of the UHB's ten year Shaping our Future and Wellbeing Strategy 2015-2025. Key to this is working with our local and national population, communities and partner agencies to provide services with a prudent approach to healthcare that makes services, and focuses on the Clinical Board's governance arrangements and the delivery of safe, effective and dignified care.
Financial impact :	Not Applicable
Quality, Safety, Patient Experience impact:	This report provides assurance on the work of the Specialist Services Clinical Board on a range of quality, safety and patient experience issues. It is aligned to the NHS Outcomes Framework focusing on the Clinical Board's governance arrangements and the promotion of health, delivery of safe, effective and dignified care. Further, it summarises key areas of improvement for access to services and plans to further improve access
Health and Care Standard Number:	All standards
CRAF Reference Number:	All but predominately this report relates to 5 Operational and Clinical Excellence, 6 Resources, 7 Tertiary Centre of Excellence, 8 Governance and 9 Values and Behaviours.
Equality and Health Impact Assessment Completed:	Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE

- Internal Audit Risk Management Report 2016
- Leadership and management approach of the Clinical Board Core Team and Directorate Management Teams having open, inclusive and transparent MDT core business and processes
- Regular performance management
- Governance and QSPE priority within the Clinical Board and Directorates

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **NOTE** the progress and approach taken by Specialist Services Clinical Board to date and its planned actions
- **APPROVE** the approach taken by Specialist Services Clinical Board

SITUATION

This report provides details of the clinical governance arrangements in Specialist Services Clinical Board in relation to Quality, Safety and Patient Experience.

It identifies the achievements, progress and planned actions to maintain the priority of QSPE.

Specialist Services Clinical Board links with all elements of the strategy but in the past year has made strides to align specifically with “Home First” and “Working better together across care sectors through people, innovation, improvement, research and technology”

BACKGROUND

Specialist Services provides high quality, specialised clinical care to people with complex health needs and serious disease. The services provide for the wider regional and Welsh population e.g. neurosurgery and organ transplantation. We act as a “hub” for clinical networks across South Wales in some highly specialised areas e.g. congenital heart disease, blood and marrow transplantation. The services also generally provide secondary care to the local Cardiff and Vale population.

The Specialist Services Clinical Board comprises seven clinical Directorates with associated clinical services and sub-specialties. The Clinical Board has a budget of £150m and a current workforce establishment of 1710 WTE staff including 815 registered nurses.

The Clinical Board has 330 inpatient beds along with four Day Units and several specialty specific outpatient suites.

Due to the high volume of activity and diversity of the services provided, risk in the Clinical Board is high and therefore robust risk management arrangements are in place to reduce the risks to our service users and staff.

In summary, the Specialist Services Clinical Board Quality, Safety and Patient Experience aims are:

- Ensuring that there is a process in place to continually review the quality and safety risk register and taking action to mitigate risks on an ongoing basis;
- Maintaining a culture of improving quality, safety and patient experience across all teams and all staff; and

- Ensuring a positive culture of staff engagement, development and understanding of everyone's responsibility for safe and quality care.

This report provides assurance of the progress being made with the Specialist Services Clinical Board with regards to:

- The NHS Wales Health Delivery Plans
- The Clinical Board's IMTP
- Quality and Safety agenda
- Infection Prevention and Control Annual work programme
- Health and Care Standards
- Patient experience
- Financial governance
- Organisational Development and Workforce Planning

ASSESSMENT

Governance, Leadership and Accountability

Following consultation with the Directorates some years ago, the Clinical Board QSPE meetings are held every 3 weeks. There are up to date Terms of Reference based on the Corporate Committee and the agenda uses the format agreed with the Patient Safety Team.

The meetings are chaired by the Director of Nursing or the Medical Lead who has a session allowance for the role.

The meetings are well attended by the Directorates' Lead and Senior Nurses, Medical Leads and Directorate Managers. Also in attendance are Director of Operations, Head of Finance, Clinical Board Director, Clinical Board Lead Pharmacist, IP&C Specialist Nurse and Patient Safety Facilitator.

As sub groups to the QSPE group the Clinical Board has a HCAI group, an Information Governance Group and a Health and Safety Group.

A lead for each Health and Care Standards self-assessment is identified who collates the responses from all of the Directorates and from those develops the areas for improvement over the year.

Key areas for improvement in 17/18 are identified below

Health and Care Standard	Rating	Key Improvements
3.2 Communicating Effectively	Improving	• Implementation of communication sheets in all clinical areas • Patient Passport 'Read with Me' project to be utilised throughout the Clinical Board. • To review the pilot of the Follow-Up Clinic in Critical Care with the possibility of initiating this fully.
1.1 Health Promotion, Protection and	Improving	• Introduce pre assessment into Neurosurgery • Improve on frontline staff flu vaccination

Improvement		- numbers - Roll out smoking cessation model developed in Cardiac - Cover pressure damage avoidance in pre assessment clinics
2.1 Managing Risk and Promoting Health and Safety	Improving	- Timetable of H&S meetings - Feedback loop into CB QSPE - Develop 17/18 audit plan - Constantly monitor RR and reduce scores where applicable
4.2 Patient Information	Improving	- To continue to progress timely responses to concerns and maintain improvement. - Continue to review patient information with user groups and adapt as needed - Review formats and availability of information for patients - Ensure staff training in MCA is maintained and updated - Roll out the UHB Hot Boards when they are available

Every Directorate has a Risk Register based on robust risk assessment. The Clinical Board Risk Register is updated 3 monthly, as new risks are identified or when the RAG rating changes.

The highest risks in the Clinical Board on the risk register are:

Risk	Mitigation	Current Risk
Insufficient Critical Care Capacity for the UHB particularly on the UHW site	- Surge capacity identified to 100% via CITU and recovery. Ideally this should only be utilised at times of major incident or pandemic due to requirement to maintain RTT. - Planning for Critical Care Expansion is progressing	25
Unacceptable waiting time for BMTs. Increase in number of patients requiring BMT. Financial implications and pressure on capacity. Risk Impact: Patients relapsing on waiting list with potential of dying. Unsuitable environment on ward B4H and Day Unit.	- Policies, protocols, guidelines, procedures in place. - MDT discussion prior to patients being placed on waiting list. - Internal meetings and discussions to monitor waiting list. - Issue escalated to Executive Board - Regular forecasts of activity and waiting times submitted. - Regular meetings with WHSSC and Phase 3 agreed resulting in some extra posts to support B4H ward and	25

	Day Unit. • There is a commitment to replace the ward but where to and the potential timescales have not been identified. This is short of the requirement to co-locate all elements of the service in order to improve the patient pathway and the inadequate environment • Commenced ambulatory treatment on Tenovus Mobile Unit to try and reduce pressure on Day Unit. • Piloting Ambulatory Care Service to treat patients as day cases or at home to release bed capacity. Ambulatory Care Practitioner employed to develop patient pathways, SOPs and ensure all governance arrangements are met.	
Sustainability of services provided at Rookwood Hospital due to poor condition of infrastructure. Roof in old house leaking badly, patients are seen in these areas and staff are working in rooms with mould and fungus growing on walls. No area identified to allow for emergency evacuation of a ward.	• Remedial work to the environment on Ward 4&5 has been undertaken. • Remedial work to the environment on Ward 7 has been undertaken. • Directorate is escalating issues to Clinical Board and Estates. • Clinical Board escalating risk to Executive Board. • New boilers in place but not fully functioning yet	25
Insufficient number of toilets/washrooms. Increased risk of cross infection, existing facilities difficult to access in C4. Bathrooms on T5 present a significant risk to patients as they flood when used and water ingresses into ward	• Policies, protocols, guidelines in place and complied with. • Cleaning schedule reviewed monthly with Facilities. • Remedy for T5 bathrooms being sought by Estates	20
Environment in Cardiac Outpatient Department in corridor on B1 is unfit for purpose. Patients are sedated for procedures with no recovery area, patients are consented in	• Chairs replaced. • Staff compliant with BLS. • Clinics have been reduced to prevent crowding but this has had a negative effect on waiting times. • Extra staff have been placed in	20

corridor, patients have been resuscitated in the corridor.	highest risk areas T1 identified as new unit, was used for NICU and date for move delayed from August 16 to October 16 to January 17 to Nov 17. Now expected to move in February 2018	
IT support for standalone servers which are precarious and may result in loss of data .Lack of Server storage space for neurophysiology tests such as EEG and video telemetry.	- Hard copies of information in patient files, when patient already referred into service. - IT lead for Clinical Board identified. - Neuro Physiology - old/archived data is deleted off the system under a defined/agreed process.	20

Staying Healthy (Theme 1)

Every winter, flu vaccinations are a priority for Specialist Services staff and patients. As at 31Jan 2017, 54.9% of staff had been vaccinated exceeding the then target.

As at 03 Nov 2018, 42.6% of staff had been vaccinated against the new target of 60%. This is considerably ahead of the position at the same time last year.

Long term patients in Rookwood Hospital have been vaccinated as per the norm. In agreement with the Clinical Board, Haematology are offering the vaccine to patients attending the Day Unit. This is in order to respond to the fact that patients attend Day Unit regularly and may be averse to also attending their GP, the fact that GP vaccines are offered to some patients later than they could be vaccinated in the Day Unit and to reduce the burden of flu on patients and the subsequent impact on haematology inpatient beds. As in previous years Critical Care admitted several patients with flu last winter; this caused isolation issues as the unit only has one cubicle. Wards B4Haematology, B5 and T5 (Nephrology and Transplant) had a number of patients suffering from Flu A and were cited in the No Surprises submission to Welsh Government in January 2017.

The Clinical Board is currently prioritising the following public health issues:

- Linked to both the South East Cluster Plan and the UHB Heart Disease Delivery Plan, Cardiology has developed weekly one stop Breathlessness/Heart Failure clinics within GP practices. Clinics are located within areas servicing the most deprived 5th of the population.
 - Clinics fully established in North Cardiff and Rumney Medical Centres, running alternate weeks.
 - 2 GP champions and nurse practitioner successfully completed the Bradford Cardiology course.

- Primary Care Co-ordinator appointed.
- Patient stories and feedback survey completed.

Outcomes/Results

- First year- 37 clinics, 138 new patients seen to date on a 'one stop' basis
- 34% of patients diagnosed with heart failure
- DNA rate < 3%
- Primary/Secondary care working in collaboration
- Links created with the British Heart Foundation and Public Health Wales

New Haemodialysis Satellite Units have been opened in

- Penarth Road – Cardiff South. This moved from West Wing site and covers the Vale and South Cardiff.
- Cleppa Park to cover Gwent area and moved from the Royal Gwent site.
- Pontypool was opened as a brand new catchment area to cover Pontypool and Torfaen and reduce the number of people having to travel across valleys to Merthyr dialysis units.

- Undertaking work with Public Health to understand the reasons for low referral rates from Cwm Taf for Cardiology services. Discuss implications for any increases with WHSSC aligned to the Heart Disease Delivery Plan.
- Further embedding the Optimising Outcomes Policy by undertaking a piece of targeted work in Cardiothoracics supported by Public Health.
- Making Every Contact Count training has been targeted in Cardiology Outpatients. A model for referral to smoking cessation for all appropriate patients has been started, it is being refined constantly based on patient opinion and take up of services offered

The Clinical Board supports a psychological model of care for both patients and staff. As such, there is a Consultant Psychologist Lead for the Clinical Board supporting psychologists in many Directorates. Psychology interventions for patients and staff are used effectively in Critical Care, Neurosciences, Haematology, Clinical Genetics and Nephrology and Transplant.

A priority for some time is to introduce psychology services for cardiology patients and scoping the service and benchmarking is underway.

The Clinical Board and Neurosciences has been successful in securing funding from WHSSC for Nurse Practitioners to support patient pathways and pre assessment of elective patients has been commenced. This will be expanded in the coming year

Safe Care (Theme 2)

The Clinical Board has a Lead or Senior Nurse Representative for Safeguarding, Falls Management and Pressure Ulcer Prevention. They undertake specific pieces of work within the Clinical Board and feedback via the QSPE Group.

Sepsis

All areas are assessing patients utilising the Inpatient Sepsis Screening and Action Tool and where appropriate the Sepsis 6 Pathway. This is supported by Critical Care Outreach Team.

Serious Incidents

A Never Event was reported to Welsh Government in June 2017. This was a retained guide wire within a central venous line on Critical Care. The patient came to no harm. A full RCA was undertaken and the incident is now closed.

A number of recommendations and actions have been made to address the findings of the investigation:

- Handover to be postponed should an arrest or emergency situation occur during staff shift change for nurses and medical staff.
- Simultaneous CVC insertion must only be carried out by a consultant or by a doctor who is competent in single CVC insertion under direct supervision of a consultant. Simultaneous CVC line insertion must only be carried out in ICU, Paediatric ICU, Emergency Unit resuscitation area, Cardiac Anaesthesia and Radiology.
- There is no ready reminder that the guidewire has not been removed. It is not visible in the CVC. It is not required for any subsequent steps. Therefore, the following recommendations are made as highlighted on a Safety Newsflash published by the Royal College of Emergency Medicine in August 2017
 - Ensure guidewire management is a two person process (operator and observer)
 - Visual confirmation of guidewire removal by both persons
 - Verbal communication of guidewire removal by both persons
 - Documentary confirmation of guidewire removal by both persons
 - Training and education to emphasise appropriate control of guidewires
- Electronic bundle software should be considered. This is being explored in Critical Care via work to improve nasogastric tube safety in the first instance.
- A change in the equipment should be considered so that an important step, for example, suturing, flushing, sampling or applying sterile

dressings, cannot be carried out without the guidewire having been removed first. An example is the WireSafe device available from Venner Ltd.

- Patient Safety Team to circulate the Safety Newsflash published by the Royal College of Emergency Medicine in August 2017.
- Patient Safety Team to ensure the lessons identified from this incident are captured by the local National Safety Standards for Invasive Procedures (NatSSIPs) task and finish group central line workstream.

Concerns

Currently the Clinical Board has 11 open concerns.

All concerns are firstly considered resolvable by making early contact with the patient/complainant and dealing with the concern promptly and informally. 70% of concerns in the Clinical Board are managed informally. The remaining concerns are complex, tend to include at least 2 Directorates and frequently more than 1 UHB due to the tertiary specialties.

The Clinical Director of Cardiology recently asked a patient who had raised concerns to write her patient story. This has been presented at Directorate and Clinical Board QSPE meetings and is very compelling. The CD is contacting the patient and following her response this approach will be evaluated and used more frequently.

A report on concerns management from Nov 16-Nov 17 is below

30 DAY CONCERNS

DATE CONCERN RECEIVED	TOTAL	ACK'D WITHIN 2 DAYS	INTERNAL PERFORMANCE		PTR PERFORMANCE						PENDING CONSENT	*EXCLUDED
			READY WITHIN TARGET	READY BREACHING TARGET	ISSUED WITHIN TARGET	ISSUED BREACHING TARGET	ONGOING WITHIN TARGET	ONGOING BREACHING TARGET				
November 2016	1	1 100%	1 100%	0 0%	1 100%	0 0%	0 0%	0 0%			0 0%	0 0%
December 2016	1	1 100%	0 0%	1 100%	0 0%	1 100%	0 0%	0 0%			0 0%	0 0%
January 2017	1	1 100%	1 100%	0 0%	1 100%	0 0%	0 0%	0 0%			0 0%	0 0%
February 2017	1	1 100%	1 100%	0 0%	1 100%	0 0%	0 0%	0 0%			0 0%	0 0%
May 2017	3	3 100%	3 100%	0 0%	3 100%	0 0%	0 0%	0 0%			0 0%	0 0%
July 2017	1	1 100%	1 100%	0 0%	1 100%	0 0%	0 0%	0 0%			0 0%	0 0%
August 2017	8	8 100%	4 50%	1 13%	6 75%	1 13%	0 0%	0 0%			0 0%	0 0%
October 2017	1	1 100%	0 0%	0 0%	0 0%	0 0%	1 100%	0 0%			0 0%	1 100%
TOTAL	17	17 100%	11 65%	2 12%	13 76%	2 12%	1 6%	0 0%			0 0%	1 6%

Infection Prevention and Control

The Clinical Board has a work plan for improvement which has been presented at the Corporate IP&C Committee

C. Difficile

Number for April 16 – March 17 was 42, a reduction on 15-16 The Directorates with most cases are not unexpectedly Haematology and Nephrology & Transplant where patients are immunocompromised and unfortunately are susceptible to recurring episodes. A period of increased surveillance was initiated in February 2017 on B5 Nephrology as there was a

rise in cases. There was a rapid response to this which has been praised by the UHB Director of IP&C and presented at Big Room.

Actions included:

- Increased incidence multi-disciplinary meetings (as well as monthly IP&C meetings)
- All RCAs completed and discussed at the above meetings.
- Action Plan Developed;
 - Actichlor as standard disinfection all beds and all of bed areas.
 - HPV cleaning all cubicles post infection and rolling programme of ward areas.
 - All hoists have disposable slings and infected patients have disposable BP cuffs & stethoscopes
 - Increased audits and feedback on Hand Hygiene, Bare Below Elbow and commodes
 - A letter has been sent from Clinical Board Director to all medical staff re HH & BBE. Individuals with poor compliance will be seen by the Clinical Director and subsequently by Clinical Board Director if there is not sustained improvement.
- C4C no problems with cleanliness
- Antimicrobial audits –
 - Indication 100%, Appropriateness 100%
 - Good at review at 48 hours
 - Vancomycin 1st line treatment
 - Fidaxomicin on 1st reoccurrence
 - Reduced of Proton Pump Inhibitors, usage was previously high
- Patients are isolated on occurrence of diarrhoea, where possible rather than waiting for a result
- GDH +ve cases are isolated
- 027 strain isolated which is frequent in renal patients and associated with severe disease and re occurrence.

As of 14th November 2017 the ward is **77 days** without a case

MSSA

Numbers for April 16 – March 17 was 39, a reduction on 15-16.

The PICC line service is being rolled out in Cardiology.

Cardiology is undertaking a pilot of Intentional Rounding for peripheral lines

All areas undertake Visual Infusion Phlebitis (VIP) scoring but on audit, practice is not consistently applied. Therefore, some work is being undertaken on this.

MRSA

Disappointingly numbers for April 16 – March 17 were 5, an increase on 15-16

Actions:

- The Clinical Board and each Directorate has a monthly multidisciplinary HCAI meeting which is a sub-group of Clinical Board QSPE.
- The Clinical Board line service is being rolled out in Cardiology. This means patients requiring long term antibiotics will no longer need a central line; they will have a peripherally inserted central catheter (PICC). This will reduce the incidence of line acquired bacteraemias.
- PVC packs are being used throughout the Clinical Board.
- Aseptic Non Touch Technique ANTT is already practiced in Haematology and Critical Care and is progressing well in all other Directorates

Compliance with patient safety alerts:

There is a gap in relation to use of Valproate in adolescent girls and women of child bearing age.

All patients seen by the Neurosciences Epilepsy Service are provided with information every time they come to clinic and starting a women on valproate is not a decision taken lightly. However, only a small fraction of women on valproate are seen by the epilepsy service and so the work is continuing via the Medication Safety Executive group.

There is concern about the increasing number of violent incidents involving some patients' behaviour towards staff. Recently, a female RN was admitted to High Care Neurosciences Unit for a short period following an assault by a patient during which she was struck on the back of her head by a fire extinguisher. All support is provided to staff including both physical and psychological care.

Effective Care (Theme 3)

The most recent NCEPOD report Acute Non-Invasive Ventilation: Inspiring Change was published in July 2017. The report focuses on the quality of acute non-invasive ventilation clinical care, for patients aged 16 years or older who are admitted to hospital. This report is very pertinent to the Clinical Board and Critical Care. The recommendations and standards have been mapped to the care available in Critical Care which has demonstrated compliance. The Clinical Board Director has been discussing the issues with the CBD for Medicine Clinical Board in order to provide any support required for the Respiratory Service.

The Clinical Board has an up to date local clinical audit plan. The medical Quality and Safety leads provide a progress update in the Clinical Board QSPE biannually.

Neurosciences is collaborating with CUBRIC (2) with regard to state of the art facilities and research opportunities between the UHB and Cardiff University. The Clinical Board is involved in ensuring the planning and implementation of robust governance arrangements between the two organisations. The appointment of a Research Nurse is complete, the nurse will be a UHB employee working with Cardiff University.

Dignified Care (Theme 4)

The Clinical Board is reviewing the approach to specialising to ensure safe, dignified care of patients with cognitive impairment, promote safe mobilisation and ensure safety of staff.

The MCB Enhanced Care Model, is being reviewed and amended by the Clinical Board Practice Educator Forum to reflect needs of SpS patients. Included in this is a targeted piece of work on reducing patient falls in conjunction with Practice Development in Mental Health. The number of falls in the Clinical Board is increasing; however, it is important to note that injurious falls are reducing.

The Clinical Board has a network of Dementia Champions being led by a Psychologist from Neurosciences. All Clinical Board clinical areas are adopting "Read About Me" for patients with cognitive impairment. B4 Neurosciences ward has recently been refurbished and specific interventions have been made to support patients e.g. hand rails have been placed along the corridors and a specific decision was made not to use IP&C floor signs due to the evidence that this distresses patients with cognitive impairment and may increase falls.

Two Specialist Nurses lead for the Clinical Board on care of patients with Learning Disabilities. The Lead Nurse who has led the work for the UHB has presented at Clinical Board QSPE meeting and the Directorates are adopting the care bundle. There has been some excellent work undertaken with regard to pre hospital planning for patients with learning disabilities.

Fundamentals of Care – Every ward has recently completed the Health and Care Monitoring System (previously called Fundamentals of Care) annual audit and action plans are in development. Data and action plans are monitored via Nursing Board and professional 1:1 meetings between the Director of Nursing and Lead Nurses.

Unannounced Dignity Inspections are overall, demonstrating that patients are receiving compassionate, individualised and dignified care. Recurring issues pertain to documentation (this is an issue across the UHB) and the environment.

CHC inspections are demonstrating similar issues. All action plans are developed, updated and monitored by the CB Director of Nursing.

HIW has made one inspection in the Clinical Board this year as a result of an Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) incident in Cardiac Day Case Unit. During their visit they took the opportunity to inspect some components of the Health Care Standards. There were no immediate actions required, concerns were raised about management of patients' notes when the main desk was unattended, and a plan has been put in place to manage this. There were no other significant concerns raised.

The Lead and Senior Nurses have a rota for night visits, during which all wards in the Clinical Board are visited. Care and practices are observed;

it also provides an opportunity for staff to discuss any issues in relation to individual patients and their night time care. The practice of auditing each other's areas is enabling the sharing of good practices across the Clinical Board and a "new pair of eyes" will see issues that may have become invisible to the incumbent Sister/Charge Nurse.

The UHB Values and Behaviours have been embedded in the Clinical Board. The Head of Workforce and OD, Director of Nursing and the Clinical Board Director have visited all Directorates to talk to staff about what the values and behaviours mean to them, how they should be used in all interactions and what the Clinical Board's expectations are. They also run throughout the core objectives for senior team members. Digressions are managed proactively with appropriate action being taken in a timely way.

Timely Care (Theme 5)

Community Cardiology Clinics have been introduced as described earlier. Nurse led clinics have been introduced in all Directorates and are evaluating well with patients.

Advanced Practice is ongoing in the Clinical Board. Critical Care train one Advanced Critical Care Practitioner per year and a programme for Myeloma and Bone Marrow Transplant is underway. Advanced Practitioners ensure patients receive the right care at the right time when Drs are under constraints. However, it is very clear that there is still a large element of their role that is nursing.

It became evident that the Epilepsy Service was not able to see first seizure patients within the target 2 weeks. Also patients were not being followed up in a timely way. Telephone clinics have now been introduced, the 2 week target is being met; patients with epilepsy are frequently unable to drive so attending the hospital is difficult for many, patient evaluation of the telephone follow up is good.

The Neurosurgery waiting list is currently a concern for the Directorate, Clinical Board and UHB. The new Interim Director of Operations is working very closely with the Directorate and plans have been put in place to manage the waiting list including long waiters.

Individual Care (Theme 6)

The Clinical Board is progressing with the National User Experience Framework mostly in quadrants 1 and 4.

All inpatient areas of the Clinical Board are participating in National Satisfaction Surveys. All results are shared at QSPE meetings particularly considering the comments that our patients are making about all aspects of the care they receive. There are themes to be noted; comments on quality of food are frequent and suggest improvements could be made; all staff in the teams from housekeepers to consultants are generally praised for their care and compassion.

Once winter starts the concerns raised by patients in relation to being cold increase. Extra blankets are provided and more hot drinks are offered. C

Block at UHW is a common cause for concern which has been discussed with Estates.

Rookwood is also an area of concern, new boilers have been installed but already concerns have been raised on the wards and Out Patient Clinics about inadequate temperatures and extra heaters are in place.

We are also now undertaking patient surveys in the Directorate Day Units to garner the experience of patients that frequently come into hospital to receive vital treatments such as haemodialysis or chemotherapy.

Patient evaluation of new services is vital; feedback from patients being treated on the Tenovus vehicle is very positive.

The Neurosciences Directorate is reviewing its clinic letters to:

- Consider provision in Braille
- Increase font size
- Include information on hearing loops

Electronic Assistive Technology - Neurosciences has also received 2 years funding for staff & equipment provided by WG for communication aids.

Patient care plans in Neurosciences have been reviewed and rewritten to ensure they are more individual.

Volunteers are important members of the team providing support to patients; Neurosciences had a team of volunteers visiting the neurosurgical ward to talk, read and listen to patients. Many of those were Health Sciences students and so have moved on. The Directorate is now in the process of recruiting more volunteers. The Volunteer Service Manager is attending the next Clinical Board Nursing Board to discuss an integrated approach to volunteers.

The Clinical Board encourages fully involving carers in the development and implementation of multidisciplinary care planning. Also, to continue providing care during inpatient stays, they know the patient and it is important to listen to them and involve them as much as possible in patients' care.

The handy man role has now been rolled out across Cardiothoracic Services, Nephrology and Transplant and Neurosciences. We consider this an essential role in supporting patient environments and are utilising him to install hand rails, change toilet seats of a contrasting colour to assist the visually impaired and further support patients at risk of falls and to assess where other interventions will support patient experience and safety.

Staff and Resources (Theme 7)

Finance

- The Clinical Board financial position at the end of Month 7 is **£0.339m surplus**.
- The Clinical Board savings target is **£2.400m**
- Progress against this target is:

£2.636m green identified = 110%
£0.311m amber identified = 13%
£0m shortfall against target

- The recurrent full year effect CIP position is a **£0.015m surplus**.
- Year end forecast **£0.758m surplus**

Workforce

Specialist Services Clinical Board consists of approximately 1700 WTE staff; the professional groups break down as follows:

Staff Group	Establishment WTE
Additional Professional & Technical	9.72
Additional Clinical Services Inc. HCSW	303.69
Administrative and Clerical Inc. Senior Managers	204.86
Allied Health Professionals	41.66
Estates and Ancillary	1.00
Healthcare Scientists	99.23
Medical and Dental	235.28
Nursing and Midwifery Registered	814.79
TOTAL	1710.23

The Safe Staffing Act does not currently apply to Directorates within Specialist Services. However, there is provision within the Act for it to be applied in any clinical area and decisions are now being made as to what clinical areas from the Clinical Board should be included. Therefore, in preparation, the Clinical Board has been taking part in the collection and interpretation of acuity and dependency data which is triangulated to advise on the number of staff required to meet the needs of that group of patients.

All the establishments currently meet the requirements of the Act. In fact, due to the tertiary and specialist nature of the patients being cared for in the Clinical Board, the ratio of staff to patients may seem high when compared to other areas and Health Boards. This is one of the areas where the use of professional judgment is key due to the case mix of patients and their acuity and dependency.

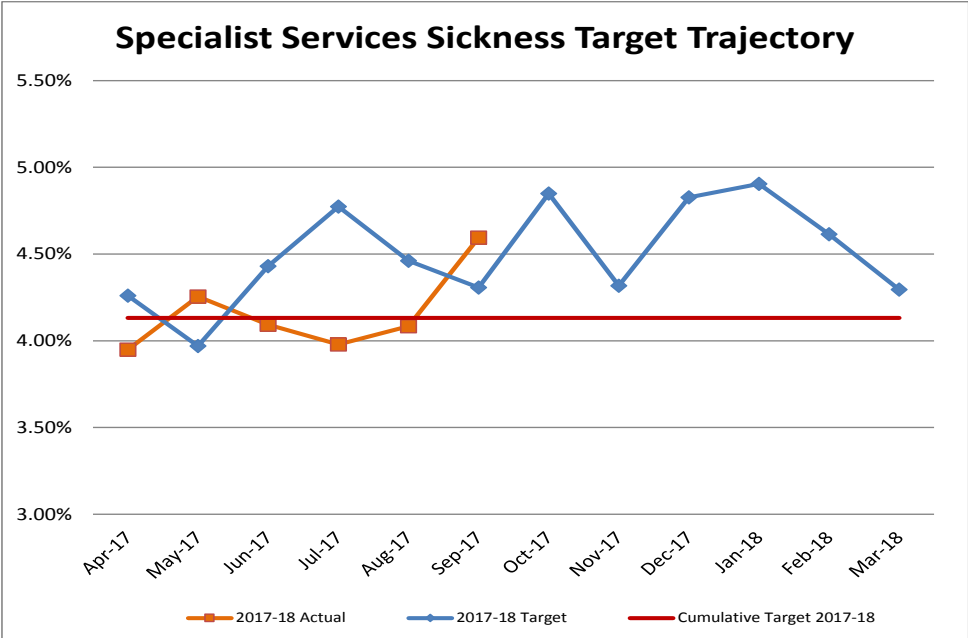
Nurse recruitment is proving challenging across all areas on the NHS. In line with the UHB's requirement for there to be at least 95% of all Band 5 nursing posts substantively filled, it is pleasing to note that the Clinical Board has

achieved this and maintained the position at >96% for 8 months. This is due to the efforts of the Lead and Senior nurses and use of innovative ways to recruit. Critical Care holds three specific recruitment days per year, each one being successful at recruiting 20-30 registered nurses. Neurosciences is holding a specific event at the end of November to hopefully manage some specific issues in Neurosurgery.

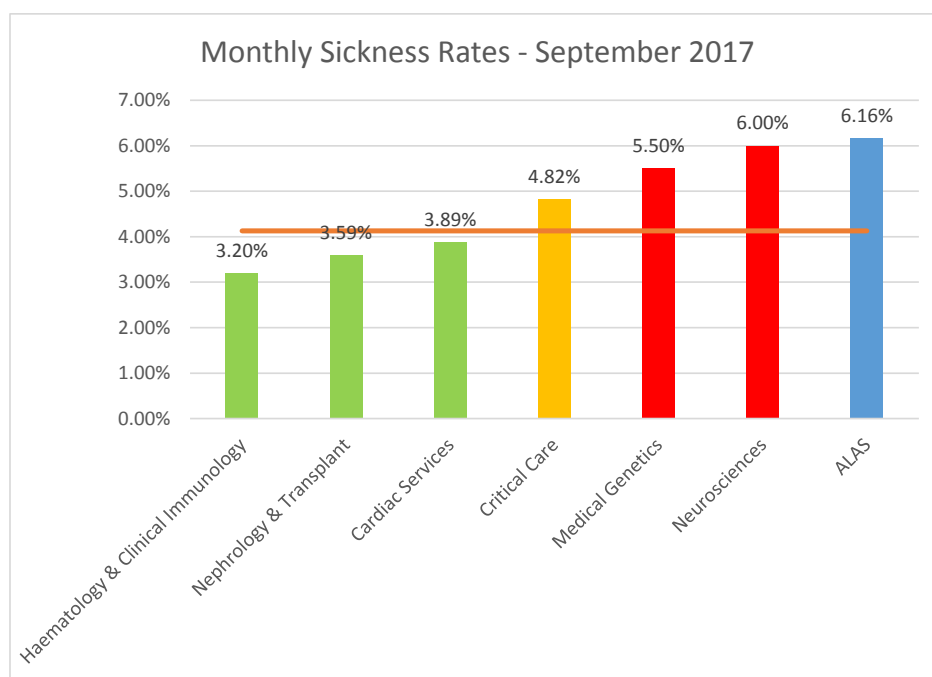
Other disciplines that are difficult to recruit to are those where there is a very small cohort of staff across the UK e.g. Neurophysiology, recruitment is currently proving difficult and is contributing to an increase in waiting times.

Specific KPIs related to workforce are below:

Sickness Absence

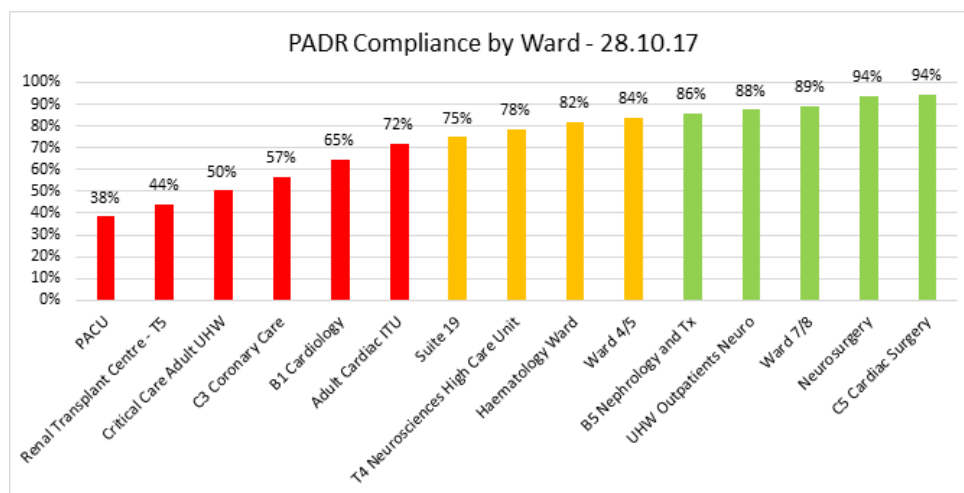


All Directorates are performing well against the cumulative target of 4.13%



PADR Compliance on 30th June 2017

The PADR activity for the Clinical Board overall is 68.02% against a target of 85%. No directorates are currently meeting the target but individual wards and departments are. Directorates are asked to implement plans to achieve the 85% target. Named breakdown reports have been provided to areas with very low compliance.



Core objectives have been developed for and agreed with Clinical Directors, Lead and Senior Nurses, Sisters/Charge Nurses and Directorate Managers. These are used during appraisal and are strongly linked to UHB and Clinical Board priorities and values.

To stand alongside these the Clinical Board is currently developing a Leadership and Management Framework for the same staff groups. This will ensure core development requirements to support staff in their roles are available and undertaken.

Disciplinary Cases

The Clinical Board is currently working through 2 Disciplinary cases. Individuals have received allegation letters and investigations are currently taking place.

Month Received	No. of cases
4 months and under	1
4 months to 6 months	0
6 months to 12 months	0
Over 12 months	1

The one case that is over 12 months has been particularly complex and has been delayed for a number of reasons including the availability of individuals to attend a disciplinary hearing. This has now been arranged over 3 days.

Sickness Dismissals

	June	July	September
ST Final Stage	6	6	6
ST Terminations	0	0	0
LT Terminations	0	0	1
Ill Health Retirements	1	1	1
Total sickness Terminations	1	1	2

Grievances / Dignity at Work Cases

There is currently 1 live formal grievances within the Clinical Board.

Staff Engagement

The Clinical Board has long recognised the importance of listening to and engaging with staff. There is a strong Partnership Forum within the Clinical Board and relationships with trade union partners is strong and open.

Following an anonymous letter from a member of nursing staff related to the management and leadership of a ward, a full staff survey was undertaken. The results were hugely positive and the same survey is now being used in other areas. Where the results are not so positive, remedial plans are put in place according to specific issues. E.g. to support retention in Critical Care, new starters are now interviewed 3 months post appointment to garner their views about what more could be done to support them, as a result an extra

Practice Educator has been appointed. A focus group which includes all disciplines has also been established.
The Clinical Board publishes a quarterly newsletter which staff contribute to.

Staff within the Clinical Board were very successful in the most recent Staff Recognition Awards. We were particularly delighted that RN Erica Cooke who works in Critical Care in UHL won the inaugural Kate Granger Award for her work supporting a patient who at the time had required permanent ventilation in Critical Care for more than 2 years to visit her home and go out for dinner with her husband.

Ann Parkes, Clinical Nurse Specialist in Cardiology won the Clinical Nurse Specialist of the year at the very recent RCN Nurse of the Year Awards.

In celebrating the achievements of our staff it is appropriate to complete this paper with a poem written by a 16 year old boy about his experience in the care of our Neurosurgery service.

Superheroes

Today I'd like to talk
About Superheroes, not the type
You see in magazines,
Or that wear capes.

The type that work in hospitals.
Give up their time, not just
To save people's lives and nurse
Them back to health.

They also keep patients company
And are a friend to them,
Even just a smile can make
A lonely patient's day.

I've been fortunate enough to
Have the pleasure of having
The company of these superheroes.
They really have changed my life.

I wish I could return the
Good they have kindly gave
To me for four months of my
Short sixteen years of life.



Scrutiny Overview Report

CHC Visiting Activity

Reporting Period – 08/07/17 to 08/09/17

November 2017

Index

<i>Section</i>	<i>Page</i>
Summary of Scrutiny Activity	1
Visiting Overview	2
Follow-Up Visits	4
Recommendations	5
Visit Details	6
Forward Planning	8

Summary of Scrutiny Activity

Reporting Period – 08/07/17 to 08/09/17

This report is a considered overview of the scrutiny visiting activity from all visits undertaken between the 8th July 2017 and 8th September 2017. In total 10 visits were planned to be undertaken and all were completed. However, one visit report has been excluded as it wasn't submitted within the agreed timeframes.

Next Reporting Period – 09/09/17 to 27/10/17

The January Scrutiny Overview Report will incorporate all visit reports from the visits undertaken between the 9th September 2017 and 27th October 2017. In total 6 visits have been completed and are currently within the reporting process.

Looking Forward

The CHC has a schedule of visits planned until March 2018 and each visit will be incorporated in to future overview reports.

In order to represent the views of the local community, we actively seek experiences in advance of, or during, our visits. We welcome all experiences, positive or negative. If you do wish to share your views/experiences on any of our planned visits, please contact us using the details below:

Telephone: 02920 750112
Email: cavog.chiefofficer@waleschc.org.uk
Address: Pro Copy Business Centre (Rear)
Parc Ty Glas
Llanishen
Cardiff
CF14 5DU

Visiting Overview

Cardiff and Vale UHB

Concerns

Upon review of the visiting reports in the reporting period, the CHC has mapped the concerns and identified the following themes and/or noteworthy issues:

-  **Maintenance** – In 5 of 9 visit reports, members commented on either the maintenance of the ward environment or the bathrooms. Of particular note were the bathroom facilities located in the 'new' Cardiff and Vale Therapy Centre in Splott, where there were toilets with flushes not operating and broken hand dryers and handles. This despite the service only locating to this facility in June of this year. Comments were also passed by patients who said "it has not been refurbished to the standard of the other rooms in the Centre".
-  **Infection, Prevention & Control** – The CHC noted, in 4 of 9 visit reports, that there was a lack of hand washing signs in bathrooms/toilets. This includes a recently refurbished bathroom on Ward A5 South.
-  **Parking** – In 3 of the visit reports, difficulties in parking were noted by patients accessing sites. All 3 reports were from visits to the University Hospital of Wales site, with the visit to Suite 19 the most concerning. Despite there being 5 bays outside the Unit, there are no designated spaces for a person with disabilities and this can cause access issues.

Good Practice

The CHC has been able to identify the following elements of good practice from its visiting reports in this period:

-  **Patient Experience/Staff** – In 7 of the 9 visit reports, members were able to provide positive comments related to the high level of patient satisfaction experienced and the level of care provided by UHB staff. It should be noted that there were no adverse comments made in the remaining 2 reports, merely a lack of reference to this topic.
-  **Information** – 4 of the visit reports contained comments relating to the information available within the ward, department or Unit communal areas. This included information on the services provided, how to raise concerns and the CHC Advocacy Service.
-  **Hospital Environment** – The cleanliness and state of the environment was highlighted as being of a high standard in 3 of the 9 visit reports.

 **Day Rooms/Activities** – In previous reports, reference has been made to the lack of Day Rooms and or support services that may have an impact on patient independence and mobility whilst on a hospital ward. In 2 of the 9 visit reports in this period, the CHC members noted that both Ward C7 and Ward West 2 had this provision, which was welcomed by patients.



Follow Up Visits

Resulting from our visits, members make recommendations for the improvement of the health service they have scrutinised. In turn, the Health Board/NHS Trust formally responds to these recommendations, identifying how they will action them and, in most cases, allocate a timeframe.

In order to sign off on these recommendations, the CHC undertakes follow-up visits a minimum of 6 months after the original visits, purely to determine whether recommendations have been actioned or not.

This report is a summary of the follow-up activity undertaken prior to the drafting period for this document, that being 27th October 2017. In total 1 follow-up visit was planned to be undertaken and this was completed.

Cardiff & Vale UHB: Ward C3 Cardiac, UHW (14th August 2017)

Date of Previous Visit: **19th July 2016** Date of UHB Action Plan: **6th January 2017**

In total 1 recommendation was made during the original visit, which was provided an attributable action by the UHB, which was subsequently agreed by Council. In regard to this single recommendation, it was considered that it had been met in its entirety.

Cardiff & Vale UHB: Radiology, Barry Hospital (16th October 2017)

Date of Previous Visit: **18th August 2016** Date of UHB Action Plan: **15th December 2016**

In total 1 recommendation was made during the original visit, which was provided an attributable action by the UHB, which was subsequently agreed by Council. In regard to this single recommendation, it was considered that it had been met in its entirety.

Cardiff & Vale UHB: Ward 4-5, Rookwood Hospital (25th October 2017)

Date of Previous Visit: **14th June 2016** Date of UHB Action Plan: **26th September 2016**

In total 3 recommendations were made during the original visit, all of which were provided an attributable action by the UHB, which was subsequently agreed by Council. Of these 3 recommendations, it was considered that all 2 were achieved in their entirety, with 1 being partly met.

Cardiff & Vale UHB: Ward 7-8, Rookwood Hospital (25th October 2017)

Date of Previous Visit: **9th August 2016** Date of UHB Action Plan: **15th December 2016**

In total 7 recommendations were made during the original visit, all of which were provided an attributable action by the UHB, which was subsequently agreed by Council. Of these 7 recommendations, it was considered that all 3 were achieved in their entirety, with 0 being partly met. The action(s) considered not to have been met are provided below:

- ✚ All Provides the CHC with information on how it will address reinstating the night and weekend service provided by the Ty Hyfryd facility. This absence of this full service is impacting on the ability to prepare patients for returning home, leading to substantially longer stays on the ward unnecessarily. ***In light of the length of time until a potential move to Llandough, this site needs to be reconsidered as part of the Rookwood refurbishment programme.***
- ✚ Provides the CHC with information on how overnight facilities can be provided for patients' relatives following similar approaches being adopted in other regional services.
- ✚ Should provide the CHC with a timeline for when new guidance will be issued on the use of emergency pull cords in patient areas. Despite being told these had been provided, they are still not in situ.
- ✚ Should provide the CHC with information on how the lack of hearing loops can be addressed and missed opportunities; of providing the loops as part of ward refurbishment, can be avoided in the future. Ward areas are advised to purchase portable systems, if required.

Cardiff & Vale UHB: ALAC, Rookwood Hospital (25th October 2017)

Date of Previous Visit: **16th September 2016** Date of UHB Action Plan: **1st November 2016**

In total only 1 overarching recommendation was made during the original visit. However, in total, 10 defined action points provided by the UHB, which were subsequently agreed by Council. Of these 10 points, it was considered that 7 were achieved in their entirety, with 0 being partly met. The action(s) considered not to have been met are provided below:

- ✚ A painting schedule has been agreed for the main areas and work will commence October 2016 with a 3 month timeframe for completion. Only the seminar room appeared to have been painted.
- ✚ The removal of clutter had been achieved but had been replaced with more ceiling tiles.
- ✚ The two portacabins removed and suitable storage facilities located as a priority.

Summary of CHC Recommendation/Action Performance

Made	Achieved	Partly Achieved	Not Achieved	% Actioned
22	14	1	7	68%

* Please note, % actioned = sum of achieved + partly achieved



Recommendations

Any recommendations made in this section of the report are additional to the recommendations made by members in regard to individual visits. They arise from thematic issues identified within this overview report, inclusive of the follow-up section.

Cardiff & Vale University Health Board (UHB) Visits

1. **UHB** – To consider the implementation of the successful handyman scheme on wider service areas in order to maintain UHB estate to an acceptable level. Furthermore, in all new developments, whether in new builds or renovations, consider requirements for all patient areas. This should avoid a repeat of the issues faced in the Cardiff and Vale Therapies Centre.
2. **UHB** – To provide hand washing signs, for placement in all UHB toilet/bathroom facilities.
3. **UHB** – To review the dedicated parking arrangements outside the Suite 19 Renal Unit, with a view to making provision for patients with mobility issues. This builds upon the recommendation in the Suite 19 report, which indicates a need to monitor the parking as it is often used inappropriately.

Follow-up visits:

The Cardiff and Vale University Health Board is asked to provide an urgent action plan, within 2 weeks of the CHC Council meeting on **13th November 2017**, in regard to addressing agreed actions that have yet to be completed following previous CHC visit reports.

Visit Details

Reporting Period – 06/05/17 to 07/07/17

Type	Date	Service	Site	CHC Team	Appendix.
Announced	17/07/17	Physiotherapy Department	Cardiff South East	Brenda Chamberlain (L) Alison Walker	01
Announced	18/07/17	Ward A5 South	University Hospital of Wales (UHW)	Rob Henley (L) Valerie Evans	02
Announced	24/07/17	Orthodontic Department	Dental Hospital @ UHW	Steven Place (L) Pat Matthews	03
Announced	31/07/17	Pelican Ward	Childrens Hospital for Wales (CHW)	Pat Matthews (L) Gareth Williams	Excluded
Announced	01/08/17	Outpatients Department	Cardiff Royal Infirmary (CRI)	Steven Place (L) Jane Jenkins	04
Announced	04/08/17	Ward A5 North	University Hospital of Wales (UHW)	Gareth Williams (L) Alison Walker	05
Announced	07/08/17	Outpatients Department	St Davids Hospital	Judy Simove (L) Jane Jenkins	06
Unannounced	09/08/17	Ward C7	University Hospital of Wales (UHW)	Jill Shelton (L) Eifion Pritchard	07
Announced	11/08/17	Ward West 2	Llandough Hospital (UHL)	Rob Henley (Lead) Jane Jenkins	08
Announced	14/08/17	Suite 19 (Dialysis)	University Hospital of Wales (UHW)	Alison Walker (Lead) Pat Matthews	09
Type	Date	Service	Site	CHC Team	Appendix.
Follow-Up	14/08/17	Ward C3 Cardiac	University Hospital of Wales (UHW)	Alison Walker (Lead) Pat Matthews	10
Follow-Up	16/10/17	Radiology Department	Barry Hospital	Lesley Jones (Lead), Matthew Wedlake	11
Follow-Up	25/10/17	Ward 4-5	Rookwood Hospital	Val Evans(Lead), Eleri Jones	12
Follow-Up	25/10/17	Ward 7-8	Rookwood Hospital	Val Evans(Lead), Eleri Jones	13

Follow-Up	25/10/17	ALAC	Rookwood Hospital	Val Evans(Lead), Eleri Jones	15

Next Reporting Period – 08/09/17 to 27/10/17

Type	Date	Service	Site	CHC Team	Stage
Announced	11/09/17	Endoscopy Unit	University Hospital of Wales (UHW) and Llandough Hospital (UHL)	Gareth Williams, Brenda Chamberlain,	
Unannounced	13/09/17	Endoscopy Unit	Llandough Hospital (UHL)	Gareth Williams, Moawia Bin-Sufyan	
Announced	25/09/17	Eye Clinic(s)	University Hospital of Wales (UHW)	Eleri Jones, Bablin Molik	
Announced	16/10/17	Community Dental Service (CDS)	Barry Hospital	Lesley Jones, Matthew Wedlake	
Announced	18/10/17	Ward East 6	Llandough Hospital (UHL)	Steven Place, Jane Jenkins	
Announced	27/10/17	Chemotherapy Inpatient Unit	Velindre Cancer Centre	Jane Jenkins, Leighton Rowlands	

Forward Planning

Date	Service	Site	Date	Service	Site
01/11/17	General Practice	To be Confirmed	12/02/18	Restorative Dentistry Department	Dental Hospital @ UHW
03/11/17	General Practice	To be Confirmed	14/02/18	Island Ward	Childrens Hospital for Wales (CHfW)
06/11/17	Ward East 2	Llandough Hospital (UHL)	21/02/18	Ward East 4	Llandough Hospital (UHL)
07/12/17	General Practice	To be Confirmed	23/02/18	Radiology Department	Dental Hospital @ UHW
12/12/17	General Practice	To be Confirmed	26/02/18	Oral/Maxillo-Facial Surgery	Dental Hospital @ UHW
15/12/17	Gwenwyn Ward	Llandough Hospital (UHL)	28/02/18	Rainbow Ward	To be confirmed.
18/12/17	Ward T2 Colorectal	University Hospital of Wales (UHW)	05/03/18	Ward C4	University Hospital of Wales (UHW)
20/12/17	General Practice	To be Confirmed	09/03/18	Ward C1	University Hospital of Wales (UHW)
05/02/18	Physiotherapy Dept	University Hospital of Wales (UHW)	19/03/18	Morfa Day Unit	Barry Hospital
08/02/18	Midwifery & Consultant Led Units	University Hospital of Wales (UHW)	26/03/18	Children's Kidney Centre	Childrens Hospital for Wales (CHfW)

* Please note, unannounced visits are not publicised in advance

COMMUNITY HEALTH COUNCIL REPORT: OLDER PEOPLE IN COMMUNITY HOSPITALS: AVOIDING BOREDOM AND LONELINESS
Name of Meeting: Quality, Safety and Experience Committee Date of Meeting 6 th December 2017
Executive Lead : Executive Nurse Director
Author : Senior Nurse Standards and Professional Regulation – 02920715440 Lynda.jenkins2@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy. In particular, delivering outcomes that matter to people, offering services that deliver the improvements in population health that our citizens are entitled to expect, being a great place to work and learn.
Financial impact: There may be financial implications associated with the improvement opportunities within the CHC report in terms of upgrading the environment of care and provision of funded activities.
Quality, Safety, Patient Experience impact: This report highlights the practices regarding boredom and loneliness in hospital which can affect the health and well being of patients.
Health and Care Standard Number 6.2 People's Rights
CRAF Reference Number N/A
Equality and Health Impact Assessment Completed: No

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Current status and future plans are reported through the Quality Safety and Experience Committee
- The Health Board has considered and formally responded to the Community Health Council

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the progress made to provide engagement and activities for patients
- **NOTE** the challenges identified in providing engaging activities for patients

SITUATION

Following the formal receipt in February 2017 of the Community Health Council (CHC) report into Avoiding Boredom and Loneliness in hospital, it was agreed that an update report on the progress made with the opportunities for improvement would be presented to the Quality, Safety and Experience Committee in December 2017.

The report seeks to assure the Committee that a considerable amount of work is already being progressed in pockets across the Health Board in order to improve the patient's experience through activity and engagement. Actions are also being considered in response to the opportunities for improvement made in the report.

BACKGROUND

The CHC is an independent watchdog of the National Health Service within Wales. The CHC represents the interests of the public in the health service and works with the NHS, inspection and regulatory bodies. There are seven CHCs in Wales who represent the patient voice within their respective geographical areas.

As part of their role, the CHC undertakes general inspection and monitoring visits as well as themed inspections to secondary and primary care sectors, care homes and private hospitals who take NHS patients. The inspection and monitoring visits are a means to evaluate the quality of services from a patient/public view as well as encouraging the spread of "best practices" through publication of their reports.

ASSESSMENT AND ASSURANCE

For November and December 2016, the CHC undertook a round of themed visits to 48 wards in 35 hospitals in Wales to see how NHS organisations are providing opportunities to alleviate boredom, support social interaction and reduce loneliness. Although the focus was on community hospitals, they also visited acute hospital wards where it was likely that older patients would be experiencing long stays.

In this Health Board, the following wards were included:

- University Hospital of Wales (UHW): C7 and B7
- University Hospital Llandough (UHL): East 3, East 7 and West 2
- The Barry Hospital: St Barrucs
- Rookwood Hospital: Ward 5
- St David's Hospital: Elizabeth Ward

The CHC has issued a report that provides the overall findings and opportunities for improvement in general for the Welsh Health Boards and Trust. The review was informed by observation and speaking to staff and patients.

Overall, they found that the picture across Wales was varied and included:

- positive examples of wards providing a variety of activities to support interaction,
- wards described as barren and depressing that provided few or no activities. The leadership and motivation of staff made a difference to the patient experience.

The report has been presented under the following eight themes and to add context, examples of the findings for each theme have also been included:

1. Staying in touch through technology

- Variable access to Wi-Fi
- Limited access to Charging facilities / PAT testing
- Inconsistent infection control advice regarding the use of digital devices on wards.

2. Television and Radio

- Problems associated with lack of space, provision of communal TVs and noise levels/ preferences
- Provision of movie nights/ viewing of sporting events in some areas
- Lending system for portable DVD players available in some areas

3. Remote Control and headphones

- Missing , or no availability of remote control and headphones
- No bed side access to hospital radio

4. Newspapers, Books, Printed Materials and Games

- Patients without visitors often went without
- Trolley rounds not widely available
- Inconsistent infection control advice regarding the use newspapers etc
- Examples where ward libraries, lending library service , coloring books , games are provided
- Examples of Activities Nurses, Dementia Support workers

5. Arts, Crafts and Creativity

- Examples where patients can knit, paint, participate in gardening, music therapy and mediation
- Inconsistent infection control advice regarding the use of the above in ward areas

6. Visiting

- Examples of both fixed and flexible visiting
- Age limits imposed
- Examples of where Volunteer visitors are used.

7. Encouraging and Maximising Socialisation

- Patients feeling bored, lonely or isolated
- Wards encouraging social interaction
- Ward layout limiting opportunities for interaction.
- Good examples of lunch clubs and group activities

8. Personal Appearance and Self Esteem

- Nurses assisting with makeup, hair care and shaving.
- Limited access to hairdressing service
- Access to clean clothes or laundry facilities was an issue

A report of findings was also issued to each individual Health Board. Within Cardiff and Vale UHB, the report confirmed that there are examples of good practice across each area visited. Perhaps not surprisingly, the report found that the level of social activity seemed noticeably higher in the Community hospitals as compared with UHW and UHL. The majority of patients also reported that they were happy with the staff and services provided and did not consider themselves bored. Despite this, the specific opportunities for improvements for NHS Wales which have been identified by the CHC as a means to improve the older people's overall experience of care in hospital were reviewed and plans for improvement were agreed.

Table 1 provides an update on the improvement plans that were presented in the February 2017 report.

Table 1 Opportunities for Improvement

Opportunities	Current Status	Plan
Consideration of reinstating Day rooms	Inconsistent across the UHB. Some areas have large airy dayrooms others do not.	There are currently no plans to re-instate day rooms on wards without day rooms. However new developments such as the Mental Health Service for older persons and the Adult Mental Health Unit have day/communal day and dining rooms incorporated. Update : no change
Consideration of reinstating ward trolleys with newspapers, magazines and other small items	Service provision is not consistent across all sites. UHW - RVS provide a trolley service across the site. UHL - service is provided by Facilities, but due to staff availability, the service does not cover all wards.	The Facilities team are undertaking a feasibility study to determine whether operating a similar service at UHW, Barry and St David's hospitals would be beneficial and affordable. There are no plans to remove the service at UHL which is provided by the Facilities Department Update : no change
Provide a good supply of free reading material including large print books, e-Books and audio books	A number of ward areas have a lending library for patients.	Plans are in place to provide the Discharge Lounge at UHW with e-books and audio books.

	Within UHL, there is a lending library service provided by volunteers from the Community. These volunteers are adults with learning disabilities and are supported by their Key workers. The Infection Prevention and Control (IP&C) department have advised that precautions have to be taken during outbreak situations when sharing devices.	Provision to other areas is being considered in line with the availability of funding as well as volunteers to monitor the use and security of the equipment. Update The Discharge Lounge, UHW has a provision of audio books. Provision to other areas has been considered, but has not been progressed due to the requirement to monitor the use and security of the equipment.
Provide more access to Pets As Therapy dogs	IP&C allow therapy dogs in to care setting following discussion. Pet therapy has been used in Rookwood hospital.	Clinical Boards are able, should they wish, to progress communications with IP&C, to introduce Pet Therapy. Update Dogs are visiting sporadically e.g. Percy at the Crisis Recovery Unit. Patient Experience and Infection Prevention and Control teams will meet to discuss further with a view to developing a procedure
Provide magazines, quiz books, word searches etc	Patient Experience provides Digital Reminiscence Therapy Equipment which provides access to films, jigsaws, painting, board games, signing, etc. The availability of the equipment is limited.	IP&C have no objection to this but care has to be taken during outbreak situations Bids for further equipment have been presented to Charitable funds for individual areas.

		Update C7 have purchased their own DRT equipment and the Patient Experience equipment is being used on A7 and B6. The aim is to expand to C6 but this is volunteer dependent. In April 2017 a Knit and Natter group was commenced at the Information and Support Centre at UHL. People attend from the community as well as some patients from the ward. After Christmas an Arts and Craft Group will commence at UHL on a Friday afternoon. This will be managed by staff and volunteers from the Patient Experience team. .
Provide adult colouring books and pencils	Wards areas have purchased colouring books.	IP&C advises care has to be taken during outbreak situations. Update: no change
Avoid PAT testing issues by providing USB charging points at the bedside	Charging facilities are not available.	The provision of charging points at each bed head would require significant investment and there are currently no plans to progress. Consideration could be given to installing such facilities as wards are refurbished. Update : no change

Increase the speed, bandwidth and coverage of free hospital Wi-Fi	Free internet access is provided from all Wi-Fi Access Points.	The UHB Internet site has been increased from 200Mb to 700Mb. Update Additional Wi-Fi has been installed in both Barry Hospital and St David's Hospital .
Provide support for individuals who wish to learn to use digital devices – possibly working with high school and six form college volunteers, as has been done in South Wales.	The service was offered to the UHB in line with the “getting Wales on line” project , at that time there was no uptake from Clinical Boards.	No further action
Provide headphones, small radios, DVD and CD players, tablets and e-readers on loan – working with charities to raise funds where appropriate	Some areas currently have equipment in place, however this is not consistent across the UHB.	Patient Experience are currently exploring means of bringing back the radio service to the bed side in all areas. Discussions have already commenced regarding the current infrastructure and availability for funding for disposable headphones that would be required. Update This has not progressed.
Remove all ‘paid for’ bedside TV and telephone services (<i>as soon as contracts permit</i>) and develop the use of “smart TV” and digital streaming services which will provide a large range of content, allowing individual patient preferences to be taken into account	Paid for bedside TV and phones have been removed from bed sides across the UHB. Some ward areas have provided ceiling mounted TVs for patients, or where day rooms are available, TVs, DVDs are available.	Ongoing local provision.

Provide access to Art and Music Therapy for people who are in hospital for long periods	There are examples where art and music therapy has been provided. Ad hoc concerts are also provided throughout the year from the Royal College of Music and Drama. This is also available through the Digital Reminiscence Therapy Equipment which provides access to paint, sing-alongs, etc.	Charitable funds bids have been made to support the provision of art and music therapy within Barry Hospital and University Hospital Llandough. Update This year further monies has been secured to provide music throughout the UHB, targeting wards where patients are unable to leave. 20 concerts planned via Music in Hospitals whilst Harmoni Cymru providing sessions throughout UHW and Noori proving sessions at stroke, mental health and older people wards at UHL. We have agreed a pilot with Welsh National Opera to commence at C7 UHW in November Also, the "Ukulele Nights" access all sites and visit once a month. We are looking to build our Music to our Ears programme http://www.cardiffandvaleuhb.wales.nhs.uk/music-to-our-ears There are also three ART students from USW who started in October, one at UHL and two at UHW; they are going to be based for 18 weeks on A7, B6 and West 4. The pilot will be evaluated with the aim to continue for this next year.
Provide access to gardens and open spaces when the weather is good	Access to gardens is provided across a number of sites : including Hafan y Coed East 7 and 8	Once developed, The Orchard at UHL will provide a tranquil garden environment for patients, visitors and staff.

	St David's and Barry Hospitals	Update Planning has commenced on the Orchard project at UHL with 80 trees due to be planted this year We are also working to introduce Bees to the UHB estate. initial discussion regarding a specialist spinal injury garden at UHL in the future to support the transfer of spinal injury patients from Rookwood Hospital to UHL
Create Dementia-friendly areas	Outside of Mental health areas, progress has been made with one ward developing an activity room with the support of the dementia advisory team. The advisory team train and advise staff.	Once set up, the aim is to use Volunteers to support the activities. Future development will include era appropriate assessments so that the fabric and furnishings reflect the age profile of patients. Update At the Information and Support Centre, UHL the Dementia Care Advisors hold a session weekly on a Wednesday for carers to drop in 4-6pm There has been the launch of the 'Read about me' at the Nursing and Midwifery Conference. The Mental Health Volunteer has been working as part of the Grand Dementia Challenge Project (with Cardiff University) to help to transform various rooms within the MHSOP wards in UHL. The most recent transformations are a 1960's style 'Seaside Cafe' room on East 10 and the

		laying of Astroturf and erecting of furniture on the adjacent outdoor space (the flooring was previously a wire mesh which was decidedly un-dementia friendly). This is in addition to having designed and created facsimiles of 1950's living rooms on East 18 and East 12. Outside of these Mental Health wards , assistance has been provide to help to plan and construct a similar room on East 7 in UHL and is currently working to do the same on East 8.
Look at new patient-centred roles for Health Care Assistants in co-ordinating patient activities to reduce loneliness and boredom	Activity coordinators are already available in Mental Health Services. There are examples in some areas where the provision of activities are provided by the ward teams as part of their daily role in caring for patients, for example, lunch clubs, afternoon tea. Activities are also supported by Volunteers.	There are currently no plans to develop specific activity roles for HCSW. A pilot is underway on how to maximise the care and support for patients who may require enhanced care due to cognitive impairment and there may be an option in the future to explore the need for a new activities role. Update The pilot has been positively evaluated with benefits for patients, staff and the Health Board and the aim now is to roll out across the Health Board. A new activities role has not been progressed.
Increase availability of Volunteer Visitors – especially for patients that have no visitors	Attempts have been made to recruit more volunteer visitors. Where there has been a designated person on the ward to liaise with	Patient Experience will continue to explore options of increasing the support for volunteer visitors.

	the volunteer, this works well.	Update Recruitment is ongoing through the usual channels as well as Cardiff and Vale College and Cardiff University. Specifically for Mental Health wards, 80+ student volunteers (who are co-managed by the Health Board Mental Health Volunteer coordinator and Student Volunteering Cardiff) are deployed during term time to run various activities within MHSOP, Adult Acute, Forensic and rehabilitation inpatient wards in Hafan-y-Coed and Park Road .
Ensure visiting times and ward policies enable carers and families to continue to be involved in care	Ward visiting times are displayed at the entrance of wards and are also available on the UHB internet page. Where appropriate, families are welcome to be involved in the care.	Continue with family/carers friendly visiting hours offering appropriate level of flexibility. Update Guidance for nurses when carers wish to provide care for their relative/friend whilst they are in hospital is currently being developed; this will include flexibility of visiting hours Protected mealtimes is in place across the UHB, where family members and carers are encouraged to attend the ward to assist the friend/relative at mealtimes; this is also re-iterated within the John's Campaign work that is currently taking place.

Provide laundry services for patients without visitors	Some ward areas have washing machines in place whilst others are exploring options. A laundry service is available in Mental Health Services for Older People.	Corporate nursing will explore with the Facilities team the feasibility of extending the laundry service. Update A patient clothing service is provided for Mental Health Wards within the UHB, these wards are contracted. All wards at Hafan y Coed have washing facilities but extending this provision across to other wards is constrained on the basis of cost and space constraints.

REVIEW OF SAFETY NOTICES AND IMPORTANT DOCUMENTS MANAGEMENT POLICY AND PROCEDURE	
Name of Meeting :	Quality Safety and Experience Committee
Date of Meeting:	6 th December 2017
Executive Lead :	Director of Corporate Governance
Author :	Corporate Governance Manager 029 2074 3111
Caring for People, Keeping People Well :	Our culture is to maintain relevant and up to date documents
Financial impact :	£
Quality, Safety, Patient Experience impact :	It is a vital part of governance and risk management to maintain a register and method of speedy and accurate circulation of safety notices and important documents.
Health and Care Standard Number	Governance Leadership and Accountability
CRAF Reference Number	8.2.3 Comply with relevant, up to date and accessible policies, procedures and other control documents
Equality Impact Assessment Completed:	Yes – positive impact (generic EHIA for Admin-type policies)

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The former Policy has been in existence for several years within the UHB and has been reviewed and updated with the support and contribution of key staff.
- The Equality and Health Impact Assessment for Admin-Type Policies agreed last year is relied on to support this Policy.
- Consultation has taken place across the UHB and following meetings, comments received have been incorporated into the updated version.

The Quality Safety and Experience Committee is asked to:

- **APPROVE** the updated Safety Notices and Important Documents Management Policy and Procedure.
- **APPROVE** the full publication of the Policy and Procedure in accordance with the UHB Publication Scheme.

SITUATION

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, it requires a comprehensive suite of policies, procedures and written control documents.

The Safety Notices and Important Documents Management Policy was due for review last year. The updated policy has changed to reflect a change in

titles, the committee structure, appropriateness of Liaison Officers and escalation procedures for non-compliance. The updated Policy is being presented to the Committee for approval as a decision reserved for the Committee in accordance with the [Written Control Documents Development and Approval Procedure](#) / [UHB Scheme of Delegation](#).

The UHB receives safety information notices and other important documents, e.g. Inspection Reports from a number of different organisations. The majority of these are sent to the Chief Executive but they may also be sent to other departments and individuals responsible for those operational aspects. Some notices require an immediate response and action. Due to the variety of ways that this information can enter the UHB it is difficult to identify corporately whether appropriate action has been taken and required responses have been sent. From time to time, internal safety notices are also issued within the UHB. These also need to be communicated and monitored in a controlled way.

The UHB must be able to demonstrate that it has responded appropriately to information that is received. There must be robust audit trails that confirm appropriate actions have been taken within the required time period.

The arrangements for dissemination of safety information notices and other important documents, together with the roles and responsibilities of individuals within the UHB are detailed in the Safety Notices and Important Documents Management Policy which the Quality Safety and Experience Committee is asked to approve.

BACKGROUND

The Safety Notices and Important Documents Management Policy was developed to ensure that:-

- there is a consistent approach to the dissemination of Safety Notices and Important Documents;
- staff are clear of their roles and responsibilities with regard to the need to respond to these documents; and
- there is a robust audit trail providing evidence of compliance and action taken. Achieving these aims will ensure that the UHB acts within the legislative and regulatory framework.

ASSESSMENT

Within an organization where the primary focus is on caring for people and keeping people well, it is important to ensure that there is a sound governance framework upon which to base working practices

The policy is applicable to the following information for which the generic term Safety Notices and Important Documents is used:

- MHRA Medical Device Alerts
- Estates and Facilities Alerts
- Pharmaceutical Alerts
- Product recalls and Manufacturer Field Safety Alerts

11.1

- External Patient Safety Alerts
- NICE Guidance
- NCEPOD Documents
- Security Alerts
- Welsh Risk Pool Technical Guides
- Healthcare Inspectorate Wales (HIW) Reports
- Regulatory agency reports e.g. Health and Safety Executive, Fire Authority, Human Tissue Authority
- Accreditation visit reports
- Ministerial Letters
- Internal Safety Notices

This list is not exhaustive and from time to time other “Important Documents” may be received which require an equivalent response by the UHB.

The Policy is intended to strengthen existing practices. There are no resources required and it can be implemented immediately once approved.

The primary source for dissemination of this policy within the UHB will be via the intranet. Documents are also routinely made available externally via the UHB internet site. This ensures that the UHB fulfils the requirements of its Publication Scheme under the Freedom of Information Act.

Consultation took place in line with UHB Policy on 22 August 2017 and a number of concerns were raised as to the appropriateness of some responsibilities and the robustness of the management process. As a result, a meeting was convened with those stakeholders on 25th October and agreement was reached to further amend Appendix 1 of the Procedure – Designated Liaison Officers.

Document Title: <i>Insert document title</i>	1 of 2	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Reference Number: UHB 069 Version Number: 2	Date of Next Review: <i>To be included when document approved</i> Previous Trust/LHB Reference Number: T202
Safety Notices and Important Documents Management Policy	
Policy Statement To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will develop and describe effective arrangements to ensure relevant actions are taken by individuals in response to any safety or governance information received by the UHB. Procedures and other written control documents translate these principles into more detailed instructions or guidance including individual responsibilities.	
Policy Commitment Our Policy will ensure there is a consistent approach to the dissemination of Safety Notices and Important Documents. This will assist staff to identify their roles and responsibilities and to ensure appropriate actions are taken with regard to Safety Notices and Important Documents. In addition, we will have a robust audit trail providing evidence of compliance and action taken.	
Supporting Procedures and Written Control Documents This Policy and the supporting procedures describe the following with regard to managing Safety Notices and Important Documents: • The types of Safety Notices and Important Documents • The arrangements for receipt, management and action required • The role of the Liaison Officer Other supporting documents are: Records Management Policy Records Retention and Destruction Protocol	
Scope This policy applies to all of our staff in all locations including those with honorary contracts.	
Equality and Health Impact Assessment	The Policy relies on the generic Equality and Health Impact Assessment undertaken for Administrative-Type Policies.

Document Title: <i>Insert document title</i>	2 of 2	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Health System Management Board
Accountable Executive or Clinical Board Director	Director of Corporate Governance
<u>Disclaimer</u> 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 <u>Governance Directorate.</u>	

Summary of reviews/amendments			
Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Quality Safety and Experience Committee 9 August 2011		This was a revised document brought up to date from the former Trust
2	Quality Safety and Experience Committee		The document was reformatted and split into a policy and separate procedures and updated to reflect changes in structure and titles. The former Policy/Procedure is already embedded and there is no change to the UHB's commitment.

Document Title: Safety Notices and Important Documents Management Procedure	1 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

Reference Number: <i>TBA unless document for review</i> Version Number: 1		Date of Next Review: tbc Previous Trust/LHB Reference Number: This was part of policy T202/UHB 069
Safety Notices and Important Documents Management Procedure		
Introduction and Aim These procedures support the Safety Notices and Important Documents Management Policy. The aim of the policy and supporting procedures is to:- • Ensure that there is a consistent approach to the dissemination of Safety Notices and Important Documents. • Assist staff with identifying their roles and responsibilities and to ensure appropriate actions are taken with regard to Safety Notices and Important Documents. • Ensure that there is a robust audit trail providing evidence of compliance and action taken.		
Objectives To ensure the UHB has appropriate effective arrangements to support staff managing important safety and governance information received by the UHB.		
Scope This procedure applies to all of our staff in all locations including those with honorary contracts and will be particularly important for the nominated Liaison Officers. It also includes the arrangements for ensuring that primary care contractors are kept appraised of certain categories of information.		
Equality and Health Impact Assessment	An Equality Impact Assessment has not been completed for the procedures. This is because this procedure has been written to support the implementation the Safety Notices and Important Documents Management Policy which relies on the Generic EHIA for Administrative-Type Policies.	
Documents to read alongside this Procedure	Safety Notices and Important Documents Management Policy	

Document Title: Safety Notices and Important Documents Management Procedure	2 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

Approved by	Quality, Safety and Experience Committee

Accountable Executive or Clinical Board Director	Director of Corporate Governance
Author(s)	Corporate Governance 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
1			In line with revised formatting rules for policies and procedures, this procedure has been extracted from the UHB's former policy. The opportunity was taken to update the content to reflect revised structures, titles and responsibilities to ensure more robust implementation (Appendix 1).

Document Title: Safety Notices and Important Documents Management Procedure	3 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

SAFETY NOTICES AND IMPORTANT DOCUMENTS MANAGEMENT PROCEDURE

CONTENTS Page No.

1	Introduction	4
2	Policy Statement	4
3	Types of Safety Notices and Important Documents Included in this Policy	4
4	Arrangements for Managing Safety Notices and Important Documents	5
5	Roles and Responsibilities	6
6	Resources	8
7	Training	8
8	Further Information	8
9	Implementation	9
10	Audit	9
11	Distribution	9
12	Review	9

Appendices:

1	Designated Liaison Officers and Responsible Committees	10
2	Safety Notices/Important Documents Compliance Form (cover sheet)	12
3	Audit Tool for the Management of Safety Notices and Important Documents	14

Document Title: Safety Notices and Important Documents Management Procedure	4 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

1. INTRODUCTION

The Cardiff and Vale University Local Health Board (UHB) receives safety information notices and other important documents, e.g. Inspection Reports from a number of different organisations. The majority will be sent to the Chief Executive but they may also be sent to other key departments and individuals. Some notices require an immediate response and action. Due to the variety of ways that this information can enter the UHB it may be difficult to identify whether appropriate action has been taken and required responses have been sent by the UHB.

From time to time, internal safety notices are also issued within the UHB. These also need to be communicated and monitored in a controlled way.

The UHB must be able to demonstrate that it has responded appropriately to information that is received. There must be robust audit trails which confirm that appropriate actions have been taken within a reasonable time period.

The arrangements for dissemination of safety information notices and other important documents, together with the roles and responsibilities of individuals within the UHB are highlighted in the policy and these procedures.

2. POLICY STATEMENT

It is policy of the UHB that appropriate and effective arrangements are made to ensure relevant actions are taken by individuals in response to any safety or governance information received by the UHB. For the purpose of this document this type of information will be described as Safety Notices and Important Documents. The categories/types of notices covered by the policy and procedure are outlined below. All staff responsible for taking action on receipt of a Safety Notice or Important Document will be clearly identified.

3. TYPES OF SAFETY NOTICES AND IMPORTANT DOCUMENTS INCLUDED IN THIS POLICY

The policy and procedures are applicable to the following information for which the generic term Safety Notices and Important Documents is used:

- MHRA Medical Device Alerts

Document Title: Safety Notices and Important Documents Management Procedure	5 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

- Estates and Facilities Alerts
- Pharmaceutical Alerts
- Product recalls and Manufacturer Field Safety Alerts
- External Patient Safety Alerts
- NICE Guidance
- NCEPOD Documents
- Security Alerts
- Welsh Risk Pool Technical Guides
- Healthcare Inspectorate Wales (HIW) Reports
- Regulatory agency reports e.g. Health and Safety Executive, Fire Authority, Human Tissue Authority
- Accreditation visit reports
- Ministerial Letters
- Internal Safety Notices

This list is not exhaustive and from time to time other “Important Documents” may be received which require an equivalent response by the UHB.

4. ARRANGEMENTS FOR MANAGING SAFETY NOTICES AND IMPORTANT DOCUMENTS

4.1 Within the UHB the following overarching arrangements have been put in place to ensure the appropriate distribution and collation of information:-

4.1.1 For each category of information there is a nominated lead known as the “Liaison Officer” who is responsible for distributing the information to the designated leads within the UHB (see Appendix 1).

4.1.2 The Liaison Officers will ensure that the Safety Notices and Important Documents are sent to appropriate staff for action. They will have written procedures explaining these arrangements and they will endeavour to ensure that information is appropriately targeted.

4.1.3 Safety Notices and Important Documents will be divided into categories A and B. Category A documents will require immediate action. Category B documents must have action taken within a specified time scale. This may be mandated within the document or determined by the Liaison Officer following consultation with the appropriate Director.

4.1.4 The UHB will attempt to direct external agencies to send Safety Notices and Important Documents to the appropriate addressee. The majority will also be sent to the Chief Executive. However, with the high volume of information being sent to the UHB there may be occasions when a document is received by an individual who is not the

Document Title: Safety Notices and Important Documents Management Procedure	6 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

designated Liaison Officer or the Chief Executive. This may occur when, for example, a Ward Sister/Charge Nurse receives a product safety notice from a manufacturer, or a Director is sent a Ministerial Letter or similar document. If this should occur the Safety Notice or Important Document must be forwarded to the identified Liaison Officer (see Appendix 1). The Liaison Officer will then distribute the information in accordance with this policy.

5. ROLES AND RESPONSIBILITIES

5.1 UHB Board

The UHB Board has ultimate responsibility for ensuring that effective arrangements are in place to ensure the appropriate dissemination and action following the receipt of Safety Notices and Important Documents.

5.2 Committees/Sub Committees of the Board/Management Group

Each of the Safety Notices and Important Documents will be monitored for compliance via appropriate committees/sub committees of the Board/management group; the responsible committee/group is listed in Appendix 1. Each committee will determine how they will undertake this monitoring role.

5.3 Director of Corporate Governance

The Director of Corporate Governance has delegated responsibility for ensuring that there are clear arrangements in place to ensure the appropriate dissemination and review of Safety Notices and Important Documents. He is supported in this role by the Directors who have delegated responsibility for the specific areas covered within the Safety Notices and Important Documents e.g. the Executive Nurse Director will be responsible, via the appropriate Liaison Officer, for the dissemination and review of HIW Reports.

5.4 Liaison Officers

Liaison Officers have been identified for each type of Safety Notice and Important Document (see Appendix 1). They are responsible for:-

5.4.1 Documenting the procedure that they will follow on receipt of a Safety Notice or Important Document.

5.4.2 Ensuring that Safety Notices and Important Documents received are reviewed and wherever practical identifying the specific Directorates/Clinical Boards that are required to take action.

5.4.3 Ensuring that all relevant Safety Notices and Important Documents are forwarded in an appropriate and timely fashion to the identified leads within the Directorates/Clinical Boards for action or information.

Document Title: Safety Notices and Important Documents Management Procedure	7 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

5.4.4 Ensuring that where a Safety Notice or Important Document is sent to a Directorate or Clinical Board it is also sent to the Clinical Board Director of Operations for information to allow them to fulfil their responsibilities.

5.4.5 Ensuring that where appropriate the UHB Covering Sheet is attached to the Safety Notice or Important Document (see Appendix 2) identifying that action is to be taken and a response is required, or that it is for information only.

5.4.6 Discussing with other Liaison Officers or key individuals any Safety Notices or Important Documents not covered by this procedure that require clarification/agreement of the action to be taken.

5.4.7 Collating all responses received from the Clinical Boards and Directorates following receipt of a Safety Notice or Important Document for their action and escalating non-compliance to the appropriate Executive Director

5.4.8 Co-ordinating the audits as specified in the procedure.

5.4.9 Maintaining a record of the Safety Notices and Important Documents for which they are the Liaison Officer and a summary of the action taken that can be shared with the appropriate committee/management group for assurance

5.5 Clinical Board Teams/Executive Directors

Clinical Board Teams and Executive Directors have overall responsibility for ensuring that appropriate action is taken within their Clinical Board/Directorate or area of responsibility.

Where necessary they will ensure that information is considered at their Clinical Board Quality and Safety/Health and Safety sub Committee meetings.

5.6 Directorate/Locality Teams

If it is identified that a Safety Notice or Important Document is of relevance to a specific Directorate or Locality a copy will be sent to the Clinical Director, Directorate/Locality Manager and Lead Nurse.

The Directorate/Locality Teams will on receipt of a Safety Notice or Important Document:-

5.6.1 Confirm to the Liaison Officer the relevance of the Safety Notice or Important Document to their area of responsibility and inform them of the Nominated Lead. This will depend on the nature of the document e.g. Lead Nurses may act as the Nominated Lead for clinical

Document Title: Safety Notices and Important Documents Management Procedure	8 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

supplies, Clinical Directors may act as the Nominated Lead for NICE guidance.

5.6.2 Ensure that information received is forwarded, if necessary, in an appropriate and timely fashion to the appropriate areas under their control in accordance with a written Directorate Procedure.

5.6.3 Ensure that appropriate action is taken by the areas under their control and that they receive confirmation of this.

5.6.4 Risk assess the issues involved and add the assessment to the Risk Register as appropriate.

5.6.5 Collate the Directorate/Locality response and report the actions that have been taken to the identified Liaison Officer, using the covering sheet provided.

5.7 Director of Operations – Primary Care

The Director of Operations – Primary Care will ensure that appropriate arrangements are in place to disseminate Safety Notices and Important Documents to primary care contractors. These arrangements are as follows:-

5.7.1 The NHS Wales Shared Services Partnership (SSP) will send Safety Notices and Important Documents to primary care contractors on behalf of the UHB. The information will include MHRA Medical Device Alerts, Patient Safety Alerts and Public Health Wales Alerts. These publications will be sent direct to the SSP from the Welsh Government.

5.7.2 The SSP will also send other Important Documents to primary care contractors at the request of the UHB. This will include NICE Guidance and Ministerial Letters.

5.7.3 A copy of all information sent to primary care contractors will be sent to nominated individuals within the Primary Care Directorate.

These are as follows:-

- Clinical Governance Manager – Primary Care
- Locality Pharmacy Leads (Title to be agreed)
- Head of Unscheduled Care – Primary Care

5.8 Director of Nursing – Primary, Community and Intermediate Care Clinical Board

The Clinical Board Director of Nursing, Primary, Community and Intermediate Care will ensure that appropriate arrangements are in place to disseminate Safety Notices and Important Documents to nursing homes. This will be facilitated by the Locality Lead Nurse – Cardiff North and West. The SSP will send them the information to assist them to fulfil this function.

Document Title: Safety Notices and Important Documents Management Procedure	9 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

6. RESOURCES

This procedure largely reflects existing practice and therefore no additional resources are required.

7. TRAINING

It is not envisaged that any formal training will be required as a result of the review of the policy and procedures. However, the policy and procedures will need to be brought to the attention of the identified Liaison Officers, Directorate, Locality and Clinical Board Teams who will need to take note of their responsibilities.

8. FURTHER INFORMATION

MDA Liaison Officer Information Pack
Medical Devices Agency Reporting Adverse Incidents and Disseminating Medical Device Alerts (DB2011(11))
Welsh Assembly Government/Department of Health Estates and Facilities Alert ((2008) 001)

9. IMPLEMENTATION

These procedures reflect existing practice and therefore can be implemented immediately. Where changes have been made to manage the process more robustly, this has been done in agreement with the departments concerned.

10. AUDIT

An audit against compliance with this policy and procedures will be undertaken by the appropriate Liaison Officer. This will be on 10 percent, or a minimum of 5 Safety Notices and Important Documents (whichever is the greater) received within each financial year (see Appendix 3).

Each of the Safety Notices and Important Documents will be monitored for compliance via specific committees/sub committees of the board or, where appropriate, a management group; the responsible committee/management group is listed in Appendix 1. Each committee/management group will determine how it will undertake this monitoring role.

Document Title: Safety Notices and Important Documents Management Procedure	10 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

11. DISTRIBUTION

The policy and procedure will be available via the UHB Intranet and Internet sites. Where staff do not have access to these resources the line manager must ensure that they are aware of the contents where appropriate.

12. REVIEW

The policy and procedure will be reviewed to reflect any changes in guidance or legislation. As a minimum it will be reviewed 3 years after the date of approval.

It is hoped that in the future the whole system process can be managed through migration to e datix.

Document Title: Safety Notices and Important Documents Management Procedure	11 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

APPENDIX 1**DESIGNATED LIAISON OFFICERS AND RESPONSIBLE COMMITTEES****CATEGORY “A” ALERTS FOR IMMEDIATE ACTION**

Type of Safety Notice	Liaison Officer	Department	Responsible Committee / Group
MHRA Medical Device Alerts*	Head of Procurement	Procurement Department 8 th Floor, Brecknock House UHW	Medical Equipment Group
Estates and Facilities Alerts	Head of Performance and Energy Jon.mcgarrigle@wales.nhs.uk and Tina.neale@wales.nhs.uk	Capital Estates and Facilities, Lakeside UHW	Health and Safety Operational Group
Internal Safety Notices (Health and Safety)	Head of Health and Safety	Health & Safety Unit 4 th Floor Denbigh House UHW	Health and Safety Operational Group
Internal Safety Notices (Patient Safety)	Patient Safety Manager	Patient Safety Department, PSA Building UHW	Quality Safety and Experience Committee
Pharmaceutical Alerts	Clinical Director of Pharmacy	Pharmacy Department UHW	Medicine Management Group
Ministerial Letters	Director of Corporate Governance	Governance Directorate, HQ, UHW	To be determined by subject
Product Recalls and Manufacturer/Fie Id Safety Notices*	Head of Procurement	Procurement Department Brecknock House, UHW	Medical Equipment Group
Security Alerts	Head of Performance and Energy Jon.mcgarrigle@wales.nhs.uk And Tina.neale@wales.nhs.uk	Capital Estates and Facilities, Lakeside UHW	Personal Safety and Security Strategy Group

Document Title: Safety Notices and Important Documents Management Procedure	12 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

CATEGORY “B” ALERTS FOR ACTION WITHIN SPECIFIED TIMESCALE

Type of Safety Notice	Liaison Officer	Department	Responsible Committee
External Patient Safety Information/Notices	Patient Safety Manager	Patient Safety Department, PSA Building, UHW	Quality Safety and Experience Committee
NICE Guidance	Quality and Safety Improvement Manager	Patient Safety Department, PSA Building, UHW	Quality Safety and Experience Committee
NCEPOD Documents	Quality and Safety Improvement Manager	Patient Safety Department, PSA Building, UHW	Quality, Safety and Experience Committee
Healthcare Inspectorate Wales Reports (excluding Mental Health Act)	Assistant Director of Patient Safety and Quality	Patient Safety and Quality Department, Brecknock House UHW	Quality, Safety and Experience Committee
Healthcare Inspectorate Wales Reports (Mental Health Act)	Director of Nursing Mental Health Clinical Board	Mental Health , Clinical Board Hafan y Coed, UHL	Mental Health and Capacity Legislation Committee
Welsh Risk Pool Technical Guides	Head of Risk & Corporate Governance	Governance Directorate, 4 th Floor Denbigh House, UHW	Quality, Safety and Experience Committee
Regulatory Agency Reports/Accreditation Visit Reports	Director of Corporate Governance	UHB HQ UHW	Quality, Safety and Experience Committee

*** In addition Clinical Engineering will be sent directly all of these Safety Notices to allow them to co-ordinate a response with the Head of Health and Safety and Assistant Director of Finance/Procurement**

Document Title: Safety Notices and Important Documents Management Procedure	13 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

APPENDIX 2

SAFETY NOTICE/IMPORTANT DOCUMENT COMPLIANCE FORM

Section A (to be completed by Liaison Officer)

Organisation From: e.g. MHRA, NICE

Document Title:

Document Reference:

Electronic Link: e.g. hyperlink if available

Date of Issue:

Status of Document: e.g. For Action/Information

Post holder sent to
for action/information:

Date Response from above post holder required by:

Response to be sent to:

Section B - Action Taken/Progress To Date:

Name:

Designation:

Directorate:

Clinical Board :

Date:

Section C - Office Use Only

Document Title: Safety Notices and Important Documents Management Procedure	14 of 15	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:		

<i>Data Entry Number:</i>	<i>Date</i>	<i>Initials:</i>

APPENDIX 3**AUDIT TOOL FOR MANAGEMENT OF SAFETY NOTICES AND IMPORTANT DOCUMENTS**

An audit against compliance with this policy will be undertaken by the appropriate Liaison Officer. This will be on 10 percent, or a minimum of 5 randomly selected Safety Notices and Important Documents (whichever is the greater) received within each financial year

1.	Reference Number	
2.	What is the type of Safety Notice/Important Document	
3.	What date was the Safety Notice/Important Document received in the UHB?	
4.	Which department/departments received the Safety Notice/Important Document?	
5.	What date was the Safety Notice/Important Document circulated within the UHB?	
6.	Who was the Safety Notice/Important Document circulated to?	
7.	How many responses were received?	
8.	How many responses indicated action had been taken?	
9.	Comments	

11.1**Name:****Designation:****Directorate:****Clinical Board:****Date:**

**CARING FOR PEOPLE
KEEPING PEOPLE WELL**



**GIG
CYMRU
NHS
WALES**

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

APPROVAL OF ALL WALES DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) POLICY

Name of Meeting: Quality, Safety and Experience Committee

Date of Meeting: 6 December 2017

Executive Lead : Medical Director

Author : Senior Nurse, Resuscitation Service 02920 748297

Caring for People, Keeping People Well : Achieve joined up care based on 'home first', avoiding harm, waste and variation, empowering people and delivering outcomes that matter to them.

Financial impact : £ actual figure or approximate

Quality, Safety, Patient Experience impact :

This is a revision to the All Wales Policy that has provided an opportunity for significantly improving the end of life care. In addition, it provides for patients being cared for at the end of their life in more appropriate care settings with dignity and respect.

Health and Care Standard Number 3.2, 3.5, 4.1

CRAF Reference Number 8.2.3

Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Dissemination of information across the UHB.
- Training of Staff.
- Audit of DNACPR (Annual).
- Audit of 2222 calls (ongoing).

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the revised Sharing and Involving – All Wales Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy **and**
- **APPROVE** the full publication of the All Wales Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy in accordance with the UHB Publication Scheme.

SITUATION

Welsh Medical Directors were involved in producing an All Wales Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy, Quick Reference Guide and Patient Information Leaflet, which was approved for implementation by the UHB in December 2014.

The documentation has recently been updated with the key changes to the policy being, for ease of reference please see below a list of the main changes made to the documents.

Policy

Page 4 – a new first paragraph has been inserted

Page 11 – The Schematic has been revised to reflect the changes to the Quick Reference Guide

Page 18 - paragraph 8.3 last sentence added in 'should immediately share and document their concerns.'

The Quick Reference Guide has been revised throughout, specifically:

Having the discussion and reaching the decision – removed 'justifiably' from 2nd paragraph, 2nd sentence; removed last paragraph referring to NAAD

Schematic – Note for clinicians - Added **NAAD refer to section 5.5.2.

Documenting and communicating the DNACPR decision – changed medical professional to doctor in first paragraph; second paragraph added 'in a timely manner'; removed reference to the senior clinician being the GP in the community; last sentence added 'in the clinical notes/record' instead of 'on the form'.

Further key issues – added in 'applicable' in relation to Advanced Decisions; added 'and the DNACPR decision should be recorded on the All Wales DNACPR Form' to the last sentence.

Review of DNACPR decision – removed first sentence and replace with 'A new DNACPR form would only be required/needed if the decision has changed.' removed last sentence relating to information sharing

Clinical note – added in reference to Section 8.2

For more information – added in reference to TalkCPR

BACKGROUND

At the beginning of 2012 the Chief Medical Officer asked a core group of senior clinicians from across NHS Wales to review existing arrangements and to develop a unified approach across Wales for DNACPR. The publication of the NCEPOD Report 'Time to Intervene?' on 1st June 2012 gave added impetus to the need for a clear framework. Taking account of best practice from other parts of the UK, the core group first produced a draft DNACPR Form and an algorithm to support decisions. This documentation was tested at three workshops held across Wales involving a wide range of stakeholders and clinicians.

ASSESSMENT

The All Wales Policy, Form, Quick Reference Guide and Patient Information Leaflet have been developed and updated through an extensive engagement process and have been insitu since implementation. The documents require formal adoption by the UHB prior to dissemination.

The development of the all Wales framework for DNACPR has been grounded in the public sector equality duty principles of evidence;

11.2

transparency; engagement and leadership to ensure that it impacts in a fair and positive way. Two stakeholder reference groups were arranged to inform relevant third sector organisations of what was proposed. Focused engagement has also taken place with Mencap Cymru and the Older People's Commissioner. All Wales Medical Directors have been kept regularly informed of progress in the development of the updated all Wales Policy.

The policy and supporting algorithm ensures that every effort is made to involve the individual and/or those closest to them in a DNACPR decision. A standardised form records adult DNACPR decisions ensuring effective communication of the individual's resuscitation status between all members of the multi-disciplinary healthcare team involved in their care across a range of settings. This supports the improvement of patient care by the prevention of inappropriate, undignified and potentially harmful CPR attempts at end of life but will ensure that DNACPR decisions refer only to CPR and not to any other aspect of the individual's care or treatment. Monitoring and evaluation audits have been developed to support the policy's implementation and effectiveness. The policy provides a decision making framework to ensure the patient's wishes are respected and reflects the best interest of the individual and provides benefits that are not outweighed by burdens.

As a result of National Audit and changes to the Policy, wide consultation was undertaken to ensure that the policy/procedure met the needs of all stakeholders. The consultation was undertaken through meetings of the All Wales Steering group – the UHB was represented by the Chair of the Resuscitation Committee and the Senior Nurse of the Resuscitation Service. The comments made by stakeholders were incorporated into this revised version of the Policy which will be reviewed on an Annual basis.

The primary source for dissemination of this policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

11.2



“Sharing and Involving”

A Clinical Policy For Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) for Adults In Wales

Revised Policy: Version 3 July 2017

11.2

NHS Wales
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

Contents

	Page No.
1. Introduction and Objectives	4
1.1 Purpose, scope and objectives of this policy	4
2. Definitions	6
2.1 Cardiac Arrest	6
2.2 Cardio-pulmonary resuscitation (CPR)	6
2.3 Do not attempt cardio-pulmonary resuscitation (DNACPR)	6
2.4 Joint Statement	6
2.5 Mental Capacity	6
2.6 Independent Mental Capacity Advocate (IMCA)	7
2.7 Advance Decision to Refuse Treatment. (ADRT)	7
2.8 Lasting Power of Attorney for Health and Welfare or Court Appointed Deputy	7
3. Policy Development and Implementation	7
3.1 Process of Policy development	7
3.2 Principles of Policy implementation	7
4. DNACPR in Practice – Key Principles	8
4.1 When DNACPR status is unknown	8
4.2 Circumstances when CPR would not restore circulation and breathing	8
4.3 DNACPR Discussion – openness, with confidentiality and partnership	8
4.4 DNACPR Discussion – communication with those close to the patient	8
4.5 Documentation of the DNACPR discussion	9
4.6 Wider communication of the DNACPR decision	9
5. Making a DNACPR decision	9
5.1 When should a DNACPR discussion be contemplated?	9
5.1.1 If CPR will not restart the patient heart and maintain breathing	10
5.1.2 If the potential adverse effects of CPR outweigh any potential benefit	10
5.1.3 When a valid and applicable Advance Decision to Refuse Treatment (ADRT) by CPR exists	10
5.1.4 Status of a DNACPR during a high risk clinical intervention	10
5.2 A Framework for DNACPR Decision	11
5.3 How a DNACPR discussion should be conducted?	12
5.4 DNACPR and mental capacity	12
5.5 Deciding that a case warrants a decision	13
5.5.1 DNACPR	13
5.5.2 NAAD (Natural, Anticipated and Accepted Death)	13
5.5.3 DNACPR for a patient with an ADRT	14
5.6 Who should have the DNACPR discussion with the patient	14
5.7 Requirements of the senior responsible clinician	14
5.8 Senior oversight for every DNACPR decision	15
5.9 Responsibilities of the senior responsible clinician	15

NHS Wales
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

	Page No.
6. The All Wales DNACPR Form	15
6.1 Documentation of DNACPR decisions	15
6.2 Whole system recognition of the All Wales DNACPR form	15
6.3 The completed DNACPR decision	16
6.4 Data capture and communicating the DNACPR decision	16
7. Review of a DNACPR decision	17
7.1 Routine review of a DNACPR decision	17
7.2 Urgent DNACPR reviews	17
7.3 Cancellation of a DNACPR decision	17
8. Special circumstances related to DNACPR	17
8.1 DNACPR decisions and high risk invasive procedures	17
8.2 Unpredictable, unforeseen and reversible clinical events	18
8.3 A clear request for CPR when CPR is not clinically in the patient's best interest	18
8.4 Patients with Implantable Cardioverter Defibrillator devices (ICDs)	19
8.5 When clinical care extends between health sectors or across borders	19
9. Training on DNACPR and community awareness	19
10. Measurement and clinical audit in NHS Wales	20
10.1 Audit of DNACPR in Wales	20
10.1.1 Processes and NHS administration	20
10.1.2 Clinical and Professional aspects (Audit points 1-16):	20
10.1.3 Communication and Teamwork	20
10.1.4 Privacy, dignity and respect for patients and families	21
11. References	21

DNACPR Form (Adult) DO NOT ATTEMPT CARDIO- PULMONARY RESUSCITATION (DNACPR) DECISION is included at the end of this document.

1. Introduction and Objectives

Health professionals have a strong duty to make sure people who should have CPR receive it and those that should not, do not.

Cardio-respiratory resuscitation (CPR) can, in theory, be attempted on any person following a cardiac arrest. However, the clinical outcome is largely dependent on the individual clinical factors that led to the arrest. In many instances the procedure does not result in a good clinical outcome. There is significant risk of harm and prolonged suffering from CPR - including long term neurological effects and the need, in some cases, for prolonged admission to ITU and a possible further cardiac arrest resulting from the underlying disease process.

Inappropriate attempts at CPR can lead to unnecessary distress for patients, their family and trusted friends, may involve the Ambulance Service and even the Police which can clearly cause further distress.

The clinical intervention of CPR as a result may not be appropriate for all patients. It therefore follows that a decision not to attempt CPR should be reached on the basis of a proper, appropriately informed discussion with patients involving those who are particularly important to them.

There has been increased focus on matters relating to Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR). This is possibly a reflection of the fact that the clinical and ethical issues are acknowledged to be of such an important and personal nature. Whilst we meticulously plan care with patients for interventions at the beginning of life, all too often we fail to have equally important discussions relating to a patient's wishes at the end of life. Frequently it seems that there is too little discussion too late.

A quick-reference document, which should be read in conjunction with this policy, is provided comprising a summary of the key elements of this policy, along with an information leaflet for patients, relatives and others closest to them.

1.1 Purpose and Scope of this Policy

This policy applies to all NHS Wales staff and the care of patients of 18 years of age and over in all care settings within the remit of NHS Wales. It specifically relates to cardio-pulmonary resuscitation (traditionally referred to as "CPR"), synonymous with cardio-respiratory resuscitation, which is the attempted restoration of circulation and breathing in someone in whom both have stopped. It does not apply to other treatments and care, including procedures that are sometimes loosely referred to as 'resuscitation' such as rehydration, blood transfusion, intra-venous antibiotics etc.

Workshop Comment:

"It should become more of a routine to ask of a patient's wishes about resuscitation"

"This policy hopes to start a more open dialogue in relation to patients' wishes at the very end of life"

NHS Wales is responding to the need to introduce substantial improvements with regard to DNACPR decisions involving adults in order to achieve more appropriate patient-centred care. The focus is on respect for the wishes of individuals in order to facilitate the provision of appropriate care at the very end of life and the need for discussions to take place in a shared and planned way, at an earlier stage, across all settings including the home and community.

The purpose of this policy is to provide a framework for professionals and NHS bodies in Wales to facilitate a consistent approach to decisions about the provision of CPR. This policy is compatible with Welsh policies on organ donation and consent. While death is inevitable, achieving a dignified, sensitive and shared approach to reaching a decision relating to CPR is vital for patients, their families and their close friends. DNACPR decisions should always involve senior professionals. DNACPR discussions can be challenging and they should be conducted in a calm, professional and reflective manner.

NHS Wales

Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

The decision not to attempt CPR on a patient is a **major clinical decision**. The clinical course leading up to this point may be of short duration for some patients. For others it may follow a more gradual decline in health.

The decision as to whether a patient would want physical attempts (CPR) to maintain their circulation and breathing in the event of a cardiac arrest is also a **serious personal decision**. In most cases a DNACPR decision will be made after a careful, planned discussion in partnership with the patient and involve those closest to them. Decisions relating to DNACPR must be accorded a high level of prominence to ensure that discussions are allocated sufficient time.

It is possible to identify those patients in whom cardio-respiratory arrest represents the natural end to their illness. A **“clinical concept” of a Natural Anticipated and Accepted Death (NAAD)** is introduced in this policy in order to offer guidance to clinicians as to when to consider a discussion in those cases where CPR would represent an unsatisfactory, undignified and clinically inappropriate intervention – or possibly where the burden of CPR in clinical context clearly outweighs realistic benefit. An individual patient-centred approach is vital. The patient's fully informed personal perspective on CPR is of great importance, viewed in the wider clinical context. It is also very important to identify those patients who adamantly refuse CPR, following informed discussion.

Workshop comments:

“All too often - DNACPR discussion seems to be “too little - too late”.

“The complications of CPR and also the concept of natural anticipated accepted death should be more openly discussed”

This policy has been developed in partnership with key clinical and non-clinical stakeholders in order to develop a consistent approach to DNACPR across the NHS in Wales and to ensure that the decisions reached are based on an individual patient's needs. It outlines an open, personal approach to DNACPR decision-making in Wales, an approach understood by clinicians, patients and their families - acknowledging the particular circumstances of every patient.

Objectives of this policy

The overriding principles of this policy are:

1. To ensure an individual's life is respected and valued.
2. To ensure early senior clinical involvement and accountability in the decision making process.
3. To make clear that a DNACPR decision must not prejudice any other aspect of care.

The primary objectives of this DNACPR policy are:

- To ensure that this important discussion is accorded the highest level of significance.
- To develop across NHS Wales the approach of consistent planning with regard to CPR as an intervention being based on an individual plan for every patient.
- To ensure an integrated approach to making DNACPR decisions.
- To ensure that an individual patient plan is in place across all relevant care settings.
- To ensure correct and effective communication to all those involved in the patient's care.
- To ensure that decisions regarding CPR are made taking into account:
 - Whether CPR is likely to succeed
 - The clinical needs of the patient
 - The patient's wishes
 - Sound ethical principles
 - All relevant legislation (for example the Human Rights Act (1988) and the Mental Capacity Act (MCA) 2005 and the duties and obligations set by professional regulators.

Policy Status: 3rd Edition
 Approved by: All Wales DNACPR
 Implementation Group
 Owner: Dr Paul Buss
 Page 5

Policy reviewed: July 2017
 Policy review due: February 2019

Policy expires:

NHS Wales

Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

- To make DNACPR decisions in a transparent way that is open to examination.
- To avoid inappropriate CPR attempts in all care settings.
- To ensure staff, patients, their trusted friends and family have appropriate information on making advance decisions relating to CPR and that they are able to discuss resuscitation issues when they wish to do so and that they understand the process.
- To clarify that patients will not be asked to decide on CPR when it would be highly likely to fail - although they should be informed.
- To ensure that clinical staff who are caring for people with communication difficulties or who may be vulnerable will provide a decision making process that is clear and appropriate for their needs.

Audit Point 1 – The ‘nature’ of a DNACPR decision and the importance of good communication

Clinical staff must understand the personal implications of a DNACPR decision. Achieving this requires clinical reflection, excellent communication and informed decision making. If personal discussion with the patient is not possible (including for reasons of mental capacity) the same principles must apply.

2. Definitions

Throughout this policy “DNACPR” refers solely to the provision of Cardio-pulmonary resuscitation and not to any other aspect of the individual’s care or treatment options.

2.1 Cardiac Arrest

This is the sudden cessation of a clinically detectable cardiac output.

2.2 Cardio-Pulmonary Resuscitation (CPR)

CPR is an intervention delivered with the specific intention of restoring and maintaining circulation and breathing. CPR is a physical and relatively invasive process. It usually comprises chest compressions with the mechanical ventilation of the lungs, possibly defibrillation by electric shocks and the injection of medication. It is increasingly referred to in the literature as cardio-respiratory resuscitation.

2.3 Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)

This refers to a specific advance decision NOT to initiate CPR in the event of a cardiac arrest. It must be made clear to the patient, those close to the patient and also to the health care team that a DNACPR decision does not have repercussions on any other element of care.

2.4 Joint Statement (see section 11)

The joint statement refers to the BMA, Resuscitation Council (UK), and RCN’s report - “Decisions Relating to Cardio-pulmonary resuscitation” (2014). This update of earlier guidance represents a very important UK document in this clinical arena.

2.5 Mental Capacity

The Mental Capacity Act 2005 Section 1(2) recognises the basic principle that an adult must be presumed to have the capacity to make their own decisions unless it can be established that they are not able to understand, use or weigh up the information needed to make the DNACPR decision and/or communicate their wishes. A person must be assumed to possess the mental capacity to make a particular decision unless the reverse can be positively demonstrated for that *specific* decision. Identifying early on in the course of an illness the possibility that the patient may, at some time in the future, lose the capacity to decide for themselves will ensure that, wherever possible, a well-informed DNACPR decision can be reached or, where appropriate, achieved in the patient’s best interests.

Policy Status: 3rd Edition
 Approved by: All Wales DNACPR
 Implementation Group
 Owner: Dr Paul Buss
 Page 6

Policy reviewed: July 2017
 Policy review due: February 2019

Policy expires:

NHS Wales
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

2.6 Independent Mental Capacity Advocate (IMCA)

If the patient who lacks the mental capacity to take the specific decision does not have family or friends who are willing, and able, to be consulted an IMCA should be instructed. Please refer to your MCA lead when required.

2.7 Advance Decision to Refuse Treatment. (ADRT)

This refers to a decision by an individual to refuse a particular treatment in certain circumstances. A valid and applicable ADRT is legally binding. Note that neither the patient, nor anyone on their behalf can insist on treatment that the clinical staff do not feel is in their best interests *even* if such insistence is included in a written document. Refer to the Mental Capacity Act and the Code for further details and in the event of uncertainty with regard to the validity of the document seek legal advice.

2.8 Lasting Power of Attorney for Health and Welfare or Court Appointed Deputy

Both of the above may have legal powers to assist with the decision making process where the patient lacks capacity. However, care should be taken to check the validity of any held documentation and the scope of their powers. Where such persons are considered not to be acting in the patient's best interests it is important to seek legal advice.

3. Policy development and implementation

3.1 Process of policy development

This policy was developed following a series of meetings to evaluate current local policy positions across Wales, and through meetings with health professionals, patient groups and key national stakeholders. The process of development included clinical workshops in North Wales, West Wales and South-East Wales testing and adjusting the discussion framework and the All Wales DNACPR form. Members from a wide range of clinical communities were represented and a broad range of non-clinical stakeholders were engaged through stakeholder events. A consistent theme received at events was that a policy **must reflect a culture of "openness and candour" when a clinician broaches the subject of DNACPR** – a culture which also affords the opportunity for patients and those closest to them to raise the subject of DNACPR themselves.

The approach to developing this policy has been grounded in the public sector equality duty principles of evidence, transparency; engagement and leadership in order to ensure that it impacts in a fair and positive way. Engagement with a range of third sector organisations has raised awareness of issues relating to DNACPR and this policy is a product of this wide engagement.

3.2 Principles of policy implementation

Health professionals across NHS Wales must be made aware of this policy and also of their responsibilities to patients and those closest to them in order to meet the standards required. Staff should be made aware of this clinical policy through training measures (see Section 10) employing Local Health Board mechanisms in accordance with the local management of policies and procedures. This requires Health Boards to work closely in partnership with the other key organisations including the Welsh Ambulance Service. Staff must operate this policy within NHS systems of information governance, with the clinical information relating to DNACPR being accessible to those teams providing clinical care for the patient. It is recognised that there may be exceptional clinical circumstances when a first responder has to make an immediate decision that favours the right to life with no time to evaluate DNACPR status, hence providing CPR as the clinical situation demands.

4. DNACPR in practice – key principles

4.1 When DNACPR status is unknown

Unless a valid DNACPR decision is in operation with either a completed All Wales DNACPR form or a valid Advance Decision to Refuse Treatment (ADRT) specifically relevant to the CPR decision exists all patients must be presumed to be “for CPR”. If a significant possibility of a cardiac arrest or death cannot be envisaged, then there is no medical decision to make.

4.2 Circumstances when CPR would not restore circulation and breathing

If the senior clinician in charge of the patient, in liaison with the clinical team, are as certain as they can be that CPR will not re-establish effective circulation and breathing in the patient then CPR should not be offered or attempted. When this is the case, discussion with the patient should take place in the spirit of good practice and openness. For some patients there may be individual clinical circumstances where such discussion might lead to harm and not provide relief; in such circumstances the clinical reasons for avoiding discussion with the patient must be clearly documented.

4.3 DNACPR Discussion – openness, with confidentiality and in partnership

All patients faced with this discussion require support from those providing care. Whenever possible, with patient consent, the person(s) they have chosen to be involved in discussions about their care and treatment should be invited to be present during the discussion. The clinician must be aware of the current clinical status and the benefits and risk of harm from CPR. A discussion can ensue and a shared decision can then be reached in partnership. Patient confidentiality must be respected at all times.

Workshop comment:

“Discussing DNACPR in the community setting means that a clear plan is understood by all”

All competent patients have the right to refuse to participate in DNACPR discussions. They can also refuse permission to share the outcome of the discussion with any third party. Such decisions must always be respected and documented in the patient's records. A clinician should not force information on a patient which is likely to cause harm. A risk of harm in this context, or an indication from the patient that they do not wish to be informed about CPR, must be justified in the clinical record.

4.4 DNACPR Discussion – communication with those close to the patient

Whenever clinically possible, all patients should be offered the opportunity of support from a close individual for the DNACPR discussion. A decision to refuse such an offer of support must be respected and recorded. Individuals close to the patient will naturally be anxious about them and whenever possible should be kept informed of the clinical progress of the patient. Whilst such discussion between the patient and those closest to them are to be encouraged, if a private DNACPR discussion is requested by the patient, it is sensible at its conclusion to confirm with the patient whether they wish the conversation to remain in confidence. You must respect the position and record that decision in the clinical record.

“Staff should bear in mind that those most close to the patient may not always be immediate family members” (Transgender Wales)

Before making and recording a DNACPR decision for a patient who lacks capacity to decide about CPR, those close to the patient, who can help inform a best interests decision should be consulted, so long as it is practicable to do so, unless the clinician can see any reason why this would not be right. If the decision is urgent it is usually possible to consult them even if it is inconvenient. If a DNACPR decision is not urgent, consider deferring it until relevant people close to the patient are available. If the decision is to be ‘made on a balance of benefits and risks’, those close to the patient may have

NHS Wales
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

information about 'previously expressed wishes and about what (outcomes) the patient would have been likely to consider acceptable'. Such information will inform a decision one way or the other. If the decision is to be made because 'CPR would not be successful', discussion with those close to the patient will involve information and explanation about CPR and about a DNACPR decision [refer to the 3rd edition (1st revision) Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing June 2016].

Further information and guidance is available at:

<http://talkcpr.wales/>

And in the patient information leaflet at:

<http://www.wales.nhs.uk/researchandresources/publications/informationforpatientsandcarers>

4.5 Documentation of the DNACPR discussion:

The standard All-Wales documentation for adult DNACPR decisions must be used in the NHS Wales in order to reduce risk and to aid clear communication about the decision.

4.6 Wider communication of DNACPR decisions:

Immediate and effective communication of a DNACPR decision must take place so that all those involved with current and future care are made aware. It is the responsibility of the senior responsible clinician when countersigning the DNACPR form, to ensure appropriate communication. The original document must be prominently placed in the patient's current medical record. For all settings this may include raising awareness outside the immediate place of care (see section 6.4).

5. Making a DNACPR Decision

5.1 When should a DNACPR discussion be contemplated?

Recognising the right time to consider DNACPR may not be easy but an anticipated cardiac arrest or death in light of the current illness forms its basis. Understanding wishes expressed by the patient represents a fundamental element of good care and making DNACPR decisions **before** a patient becomes too unwell or loses the capacity to make the decision should be the aim. This requires the establishment of a bond of trust with the patient, family and others close to them.

The discussion should usually be conducted by an experienced team-member. If no DNACPR decision is in place and no specific Advance Decision on CPR exists (i.e. the wishes of the patient are not known) the presumption is that CPR will be provided. This applies unless at the time of an arrest the clinician is certain that they possess sufficient information about the patient to judge that CPR cannot be successful.

Audit point 2 – Clinical teams require time to discuss DNACPR issues

An anticipated cardiac arrest or death should instigate team discussions to identify those patients with whom a DNACPR discussion is warranted. This should become part of clinical routine – so that DNACPR is usually discussed before the need for an urgent response.

Workshop comment:

"The "appropriateness" of a "CPR call" is not usually one for the resuscitation team".

Clinical presentations can be highly variable. In some cases the level of physiological compromise at presentation indicates a likely imminent decline to a cardio-respiratory arrest. For others a more gradual deterioration may be the anticipated course. Sometimes a decline in health may be first suspected by carers and those closest to the patient

and occasionally by the patient themselves. These represent common general clinical scenarios when a DNACPR position might initially be considered.

NHS Wales
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

Audit point 3 - Team discussion relating to DNACPR

The possibility of a cardiac arrest should lead to a team discussion relating to DNACPR - with an additional community perspective whenever possible. The clinical decision framework (section 5.2) may be a helpful guide. The decision to move to a DNACPR discussion should be recorded. The DNACPR discussion itself should take place as soon as possible thereafter (within 12 hours).

5.1.1 If CPR will not restart the patient's heart and maintain breathing

If the clinical team is **as clinically certain as possible** that attempting CPR would not re-establish effective circulation and maintain breathing then CPR need not be attempted. A patient cannot demand a treatment that is not clinically indicated. To provide CPR in such circumstances would be futile. The decision is a clinical one centred on the clinical picture at the time. The position should be communicated to the patient (see section 4.3) and, with consent, to those close to them.

5.1.2 If the potential "adverse effects" of CPR outweigh any potential benefits

Even if CPR might possibly restore circulation and breathing, the benefits of prolonging life must be balanced against the risk of harm, pain and discomfort to the patient. The patient's recently expressed wishes are very important to ascertain. Teams, in this case, should also consider whether a natural death free from the invasive intervention of CPR may be in the patient's best interests which could, with agreement, result in a Natural Anticipated and Accepted Death (NAAD).

Audit point 4 – Consider the possibility of "NAAD / DNACPR"

All salient clinical aspects must be considered and discussed in order to help reach a clinically informed and a shared decision. It may be possible to conclude that the situation should be managed as a Natural Anticipated and Accepted Death (NAAD). NAAD is a "clinical concept" which may help clinicians and patients in partnership reach a shared position from which a DNACPR follows.

5.1.3 When a valid and applicable Advance Decision to Refuse Treatment (ADRT) by CPR exists

Patients should be asked at an early stage of contact if they have made an ADRT in relation to CPR. There is an expectation that patients and/or their families will endeavour to ensure that healthcare teams are made aware of the existence and content of any specific Advance Decision. If there are reasons why the attending clinicians believe an Advance Decision to be invalid or inapplicable this must be carefully documented within the patient's record. When a patient is known to have a valid and applicable ADRT, at an appropriate time a DNACPR form should be completed. Where the existence of an Advance Decision is unknown with no time to investigate - the presumption is for attempting CPR, if this is considered to have a realistic chance of benefit.

Audit point 5 – CPR-specific Advance Decisions – identification at point of contact

It is important to ascertain the existence of a specific ADRT for CPR at an early stage. This will ensure continuity of knowledge throughout the patient's journey and prevent inappropriate arrest calls.

5.1.4 Status of a DNACPR decision in a high risk clinical intervention

Any person over 18 years, who has the requisite mental capacity, can refuse treatment. If a patient with capacity refuses CPR, even when it may result in benefit, this must be carefully and clearly recorded in the patient's record. If a patient wishes a DNACPR decision to remain valid during a procedure or treatment that by its nature increases the risk of cardio-respiratory arrest (e.g. cardiac surgery), this will possibly impact on the risks of the procedure. If the clinician undertaking the

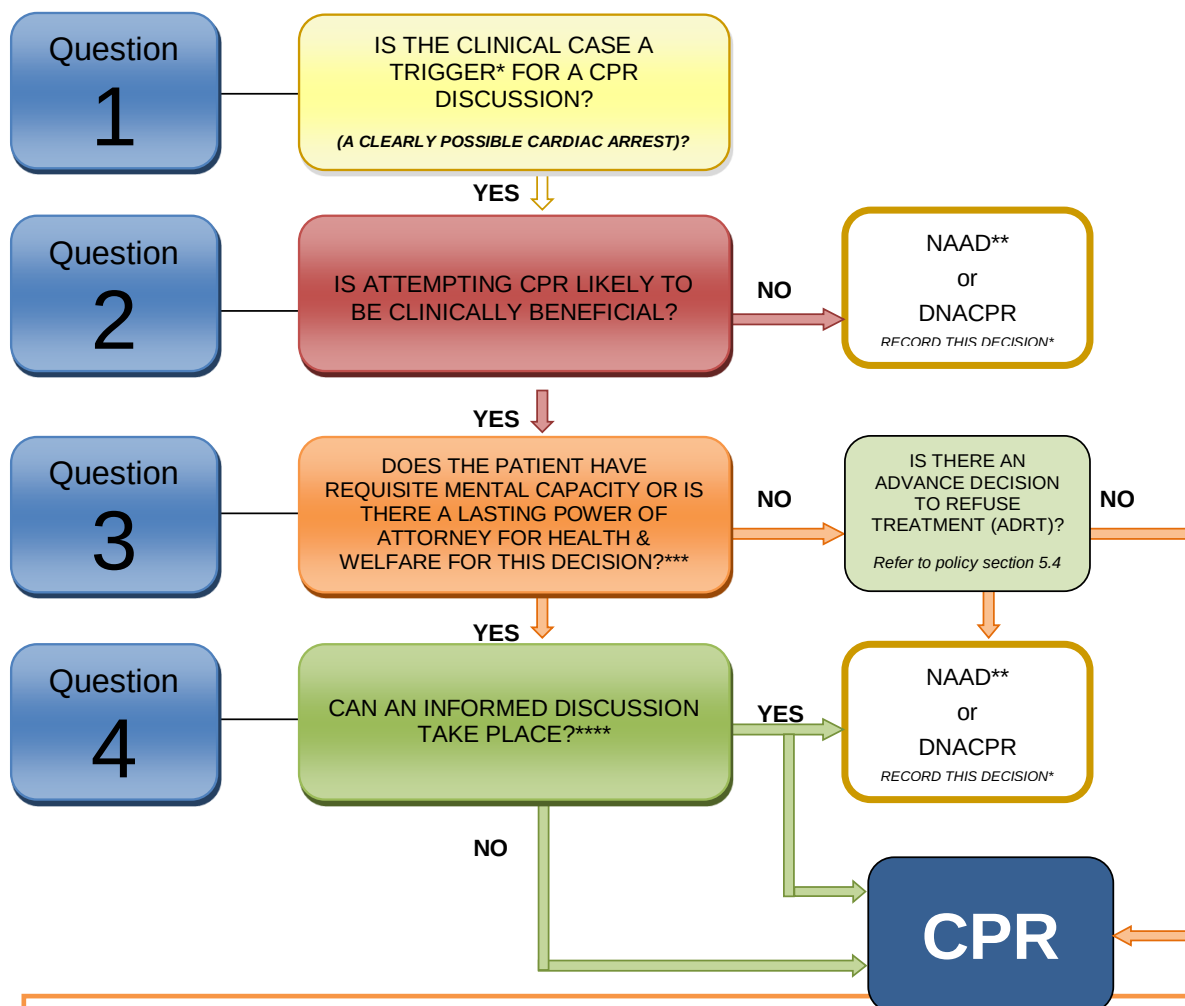
NHS Wales

Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

procedure believes that the procedure or treatment will be too high risk with the DNACPR decision still in place then detailed discussion must take place. In some cases the higher risk will mean that it might be clinically reasonable not to proceed (see section 8.2).

5.2 Framework for a DNACPR Decision

SCHEMATIC FRAMEWORK FOR DNACPR DECISION-MAKING



Note for clinicians - For details related to each box you MUST consult the accompanying complete All Wales DNACPR Policy

***TRIGGER** – may represent a traditional ‘clinical trigger’ where the clinician envisages a possible cardiac arrest as a natural consequence of the condition – or when the harm or risks of CPR clearly exceed the benefit.

****NAAD** - See Policy Section 5.5.2.

*****See Mental Capacity Act (2005) guidance paragraph 7.30– Health and Welfare Attorney must be designated to cover life-prolonging treatment decisions and be registered with the Office of the Public Guardian. If no ADRT is in place consider Section 5.4 relating to Mental Capacity Act.**

******Note that the patient may change his/her mind at any time. Also for interventions with significant risk of cardiac arrest, a CPR discussion must occur when obtaining informed consent for the procedure.**

Policy Status: 3rd Edition
 Approved by: All Wales DNACPR
 Implementation Group
 Owner: Dr Paul Buss
 Page 11

Policy reviewed: July 2017
 Policy review due: February 2019

Policy expires:

NHS Wales
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

5.3 How a DNACPR discussion should be conducted

Workshop comment:

“Approaching DNACPR sensitively can help alleviate a patient’s anxiety and a provide the family with comfort”

The patient is *the priority* and must be at the centre of the discussion. For this reason, the initial approach made concerning DNACPR, must be with great tact, with sensitivity, and always with forethought to any communication and language needs. DNACPR discussions must be based on a spirit of candour, openness and trust armed with clear clinical knowledge of the patient. The approach to the discussion should always bear in mind the emotional needs of the patient and those most close to

them. **A DNACPR discussion should never be rushed and should be approached with recognition of the individual’s particular circumstances, values and beliefs.**

Audit point 6 – A named individual for “close support”

Those closest to the patient (not always immediate family members) can provide valuable personal insight. It is essential for all patients to be asked to provide the name of someone they wish staff to deal with in the event of significant change in their condition and for this to be recorded.

Audit point 7 – The DNACPR discussion (preparation, time and privacy)

Senior clinicians must allow adequate time for DNACPR discussions. They should possess knowledge of the patient’s history and the clinical evidence-base/rationale for the discussion. The conversation should be as private as circumstances allow. The conclusion should be understood by the patient. A nominated team-member should offer further contact with the patient to enquire if clarification is necessary.

5.4 DNACPR and mental capacity

The Mental Capacity Act (2005) defines the rights of patients and describes the responsibilities of those who provide care. It reinforces the understanding that people who lack the capacity to make their own decision about the specific issue at hand must remain at the centre of decisions that affects their lives.

“It is vital to make every effort to hear the voice of those with reduced capacity” (Mencap Wales)

Impaired function of the mind or brain is common in many medical conditions and care must be taken to ensure that those who assess decision making capacity have the appropriate level of skill.

Cases where capacity may be impaired demand a reflective approach from the senior responsible clinician. The first step in the process must be to perform a robust assessment of mental capacity. Whilst this can be performed by any clinician with the appropriate skill, in complex cases liaison psychiatry can sometimes be very helpful. Where the patient is found to lack capacity the current views of the patient should still, if possible, be taken into account as well as the views expressed

Workshop Comment:

“For DNACPR – staff must be aware of, and address, any communication needs the patient might have”.

before capacity was lost. Decision makers should also consult those closest to the patient. Where this is not possible and where there is no Lasting Power of Attorney (LPA) an independent mental capacity advocate (IMCA) should usually be appointed. This will help ensure that personally appropriate decisions are made and ensure independent safeguarding of the process (refer to the Mental Capacity Act and the Code for more detail).

A DNACPR decision must never be implemented purely on the basis that the patient lacks capacity. All NHS staff must take responsibility for applying the same standard in relation to DNACPR to all patients.

NHS Wales

Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

If a patient lacks capacity and a decision is made in his or her best interests in accordance with the MCA then the clinical rationale and justification for the best interest decision should be clearly recorded in the notes by way of a best interest's balance sheet if at all possible.

Audit point 8: Raised awareness of the possibility of impaired mental capacity

A patient with altered capacity might display behaviour(s) not necessarily correlated with the usual clinical "reference points". In such cases, where DNACPR is being contemplated, input from those closest to the patient, carers and trusted friends is essential for understanding.

Audit point 9: Mental capacity and mental health

Clinical staff should also be aware of the effect that concurrent mental health conditions might impact on a patient's capacity. If it is felt that a significant psychological co-morbidity exists, specialist psychological assessment prior to DNACPR discussion should be considered.

5.5 Deciding that a case warrants a DNACPR decision

The DNACPR discussion framework is illustrated on page 11. This includes clinical events that might act as a "trigger" for a team-based DNACPR discussion. It also outlines questions clinicians should ask themselves in order to decide whether a clinical situation is one which might lead to a DNACPR discussion with the patient.

5.5.1 DNACPR

In some cases it will be clear that the clinical position is irreversible and that a cardiac arrest is inevitable. Such circumstances for example could occur in the urgent acute setting or following the rapid irreversible decline of a known previously stable condition. The conclusion of the clinical team might be that it would not be in the best interests of the patient to attempt CPR. A DNACPR decision can then be made. Unless there is very good reason to the contrary, the clinical basis should be discussed with the patient and, with consent, also the individual chosen by the patient to be involved and a DNACPR decision with clinical reasoning clearly documented. Discussion with regard to organ and/or tissue donation should be considered in line with the current All Wales policy.

5.5.2 NAAD (Natural, Anticipated and Accepted Death)

In less acute situations, a gradual decline in clinical well-being may be noted and ultimately death as a result of the current disease process may be envisaged. Accordingly, in the context of the patient's condition death might be considered to be clinically inevitable. The patient may or may not be receiving some care from palliative specialists. The team's reflection might be that death is the consequence of the disease process itself (natural) and is reasonably envisaged (anticipated) to occur in the near future.

Workshop Comment:

"NAAD represents a tripartite system – recognising the natural course, one that is clinically envisaged and where there is an agreed, shared, position"

When such a patient has capacity a discussion with the patient should take place, and if there is consent, with the person they have chosen to be involved in their care and treatment. A joint position on a Natural, Anticipated and Accepted Death (NAAD) may be the agreed shared position. NAAD is not a conclusion in itself. It would however represent a clinical position from which a DNACPR position follows. It is NOT a decision for the alteration of any other aspect of care and it should lead to further discussions as to how appropriate care can be achieved. **If a NAAD is reached, it is vital that it is conveyed to the patient and those closest to them that this would usually lead to a DNACPR decision, together with a clear explanation that "all clinically appropriate care will be provided".**

Policy Status: 3rd Edition
Approved by: All Wales DNACPR
Implementation Group
Owner: Dr Paul Buss
Page 13

Policy reviewed: July 2017
Policy review due: February 2019

Policy expires:

NHS Wales
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

Many DNACPR decisions take place against a clinical context of chronic illness with gradual deterioration and multiple co-existing illnesses. In these circumstances, a planned fully informed discussion can take place. In all care settings the discussion must cover the risks and the burdens as well as the likely outcome from CPR. A mutual understanding of matters by the patient, those individuals close to them and the clinician is essential. A position of a Natural Anticipated and Accepted Death might be reached leading to a DNACPR decision.

5.5.3 DNACPR – for a patient with an ADRT

A patient aged 18 or over, may have a specific Advance Decision (ADRT) in place with previously expressed wishes withholding permission to attempt CPR in the event of cardiac arrest (see 5.2.3). Where known this information must be shared with the clinical teams caring for the patient. (An ADRT will come into force when a person lacks capacity. Otherwise they must be consulted normally)

A copy of the Advance Decision should be attached to the back of a completed DNACPR form. Where the patient lacks mental capacity and where no specific Advance Decision exists the default position is to provide CPR.

Audit point 10 – Involving relatives and those closest to the patient

Teams must respect the knowledge and concerns expressed by those closest to the patient. Before discussing DNACPR patients should be asked if they want the support of a named person. If the patient declines this should be clearly recorded and a desire for confidentiality must be fully respected.

5.6 Who should have the DNACPR discussion with the patient?

A senior team member should be nominated for the role. The professional undertaking the discussion should immediately record the discussion on the All Wales DNACPR form and ensure (if they are not the senior responsible clinician) that this is countersigned by the senior responsible clinician at the earliest possible opportunity/next ward round. **When the senior team member is a medically qualified professional the DNACPR will become active when signed, timed, dated and following entry of the GMC number (Section 5 - All Wales form). In all other circumstances sign off (with GMC number) by the senior responsible clinician is necessary for the DNACPR to be active (Section 6 - All Wales form).**

Audit point 11 – The All-Wales DNACPR form

For DNACPR to be recognised in Wales (outside of a valid and applicable ADRT) the All Wales DNACPR form (see Section 6) must be completed. It forms the record of the DNACPR discussion. The clinician completing the form (when not the senior responsible clinician) must sign the form (Section 5 of form) and ensure countersignature by a senior responsible clinician as soon as possible (Section 6). A GMC number is essential for the form to be active.

5.7 Requirements of the senior responsible clinician

A senior responsible clinician, in relation to this policy, must be available for all settings and will usually be a consultant or general practitioner. In some circumstances, senior nursing staff in secondary care and also in community settings may adopt some functions of this role in relation to this policy (but always with agreement and additional oversight by a senior responsible clinician).

They MUST:

- **Be clinically registered** and familiar with this policy.
- **Ensure appropriate involvement** has taken place both with the patient and those close to them.

NHS Wales

Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

- **Ensure proper documentation** is in place.
- **Verify** a decision made on their behalf at the earliest possible opportunity by medical countersignature with GMC number.
- **Ensure communication of the decision** to the relevant clinical teams.

5.8 Senior oversight for every DNACPR decision

The senior responsible clinician will usually be the patient's GP in the community or a consultant caring for the patient in secondary care. The senior responsible clinician is responsible for overseeing the documentation and communicating decisions. An agreed DNACPR position must be relayed to the senior responsible clinician in a timely manner, with information that a DNACPR discussion has taken place and an All Wales form completed.

If this clinician is not physically present at the time of the discussion the fact they have been informed must be clearly recorded on the form. The process of countersignature is not necessary if the senior responsible clinician has had the original discussion and completed the form. This process ensures senior clinical overview.

Audit point 12 – The DNACPR decision and oversight by a senior clinician

A senior responsible clinician should be made aware of, and countersign, the completed DNACPR form. Out-of-hours a senior clinician must be available and informed as soon as appropriate that a DNACPR discussion has taken place. In the acute situation the DNACPR discussion will often be undertaken (and the form completed) by the senior responsible clinician.

5.9 Responsibilities of the senior responsible clinician

The senior responsible clinician who countersigns the form is clinically responsible for the agreed position. This senior clinician has additional responsibilities: to ensure the correct communication of a DNACPR decision, and to help ensure (with other team members) that the needs of those closest to the patient are being met. The senior responsible clinician should also be the reference point for any significant clinical questions or difficulties that might arise relating to a DNACPR decision.

Workshop Comment:

“Primary care must be made aware of all DNACPR decisions on their patients”

6. The All-Wales DNACPR Form

6.1 Documentation of DNACPR decisions

The All Wales DNACPR Form is the only agreed form for recording new DNACPR decisions across NHS Wales after 1 October 2015.

All relevant sections of the form must contain entries. It specifically relates to DNACPR decisions and must form an integral part of the medical record. Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) forms must be adequately completed and contain up to date information. The form should be filled out in black ball-point, with legible handwriting and also signed, dated and timed.

“The proper recording of discussions related to DNACPR is vital and engenders confidence in the system” (Older People’s Commissioner Wales)

6.2 Whole-system recognition of the All Wales DNACPR form

The All Wales DNACPR form is recognised across all NHS sectors in Wales. When a DNACPR decision has been reached **a signed and dated copy of the All Wales DNACPR form must be**

Policy Status: 3rd Edition
Approved by: All Wales DNACPR
Implementation Group
Owner: Dr Paul Buss
Page 15

Policy reviewed: July 2017
Policy review due: February 2019

Policy expires:

NHS Wales
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

handed to the patient, or the person important to the patient / their advocate at the time and the original must be prominently placed in the patient's health record with copies relayed to other parties (see section 6.4).

6.3 The completed DNACPR Decision

A DNACPR decision is a specific clinical position that requires correct communication.

Audit point 13 – Completing the All Wales DNACPR form

All sections of the form must have a clear entry. Senior responsible clinicians must check this is the case when initially informed and always prior to countersignature.

6.4 Data capture and communicating the DNACPR Decision

Local Health Boards should ensure that the out-of-hours services, emergency departments and general practices have systems that can store, coordinate, manage and respond to DNACPR data. This should include a protocol for alerting the Welsh Ambulance Service when patient transport is requested for a patient with a current DNACPR decision.

“The correct communication of DNACPR decisions is vital to meeting the patient's needs” –Welsh Ambulance Service Trust

When a DNACPR decision has been reached in the hospital setting:

1. The **original form** should be prominently placed in the **patient's medical record**.
2. A marked **copy** should be **handed to the patient, the person important to the patient or their advocate at the time** for personal ownership prior to discharge.
3. A marked **copy** should be **forwarded to the patient's GP who should retain the paper copy and ensure that the DNACPR decision is recorded electronically on the patient notes. The GP must also inform the out-of-hours provider/the nursing/care home.**
4. A photocopy should be handed to ambulance personnel when transported from a hospital setting.

When a DNACPR form has been completed in the home or community setting:

1. The **original form** should be **retained by the patient's GP, who should place it in the medical record, record it electronically and inform the out-of-hours provider.**
2. A **marked copy** should be **handed to the patient or the person important to the patient or their advocate at the time for personal ownership.**
3. When relevant a **marked copy** should be retained in the records of the nursing/care home.
4. A **copy** should accompany the patient whenever care transfers to secondary care to be entered into their case record.

Ambulance control should also be verbally informed of the existence of a DNACPR order at the time of booking an ambulance. Whenever possible a photocopy should be handed to ambulance staff when being transported.

Audit point 14 – Communicating a DNACPR decision

DNACPR decisions must be shared with clinical teams that are likely to be involved in a patient's on-going clinical care. Correct communication is essential. Processes for sharing DNACPR information must satisfy best information governance practice.

Communication with those closest to the patient must be unhurried, undertaken with patience, tact and with sensitivity for the situation.

NHS Wales
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

7. Review of a DNACPR decision

7.1 Review of a DNACPR decision

When necessary a review should normally be undertaken by a senior responsible clinician. When a review has taken place this should be recorded on the All Wales form.

A DNACPR decision review should always take place if one is requested by the patient. A review of the DNACPR decision should also be clinically considered when a patient's overall condition significantly improves warranting further discussion. The details of the review should be recorded in the patient's clinical record and the date recorded on the All Wales form. If the clinical circumstances **clearly** change a decision may need to be cancelled (see section 7.3) or a new form may need to be completed. This decision will be subject to the same information sharing as the initial decision ensuring the updating of all records with the new copy of the DNACPR form and, again, a copy of the new form must be handed to the patient or the person important to the patient or their advocate at the time.

7.2 Urgent DNACPR reviews

All patients must feel able to request a review of a DNACPR decision at any time. This includes those patients with reduced mental capacity, where either those close to them or named family members can request a review. **All such requests must have "urgent" status.** In some cases an unforeseen, sudden and *sustained* improvement in clinical status can occur and a review of the position may become necessary. In such circumstances, once clinically recognised, a review should take place.

Audit point 15 – DNACPR review

All patients with an agreed DNACPR decision will be subject to a clinical review as part of the normal course of events. Efforts should be made to ensure that patients are aware that a request for review of a DNACPR decision can be made at anytime.

7.3 Cancellation of a DNACPR decision

In some circumstances it may be appropriate to cancel a DNACPR decision. If this is necessary then the original form should be clearly crossed through with 2 diagonal lines in black ink with **"CANCELLED"** written between them. **The relevant section (section 7) of the form must also be completed and signed by a senior responsible clinician. All recipients of the DNACPR decision form (listed on the back of the original form) must be notified immediately that the decision has been as cancelled.** The communication must be in writing and logged in all relevant records and where possible contain a copy of the overwritten cancelled original document. The patient's copy of the original form should be returned and filed in an envelope in the case record to reduce risk. If destroyed (usually by shredding) this must also be recorded.

8. Special circumstances related to DNACPR

8.1 DNACPR decisions and high-risk invasive procedures

When individual patients are very unwell some pre-planned invasive procedures may substantially increase the risk of a cardio-pulmonary arrest (examples include: general anaesthesia, a pacemaker insertion, cardiac catheterisation, or surgical procedures). When such interventions are being contemplated for patients with an agreed DNACPR in place, the "current DNACPR position" must be reviewed with the patient in advance of the procedure. A decision to suspend the decision temporarily must be communicated with the patient or the patient's representative (if the patient has reduced mental capacity) and the wider clinical team and recorded.

NHS Wales

Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

Some patients may want an agreed DNACPR decision to remain valid despite the increased risk of a cardio-pulmonary arrest and despite foreseen potentially reversible causes; others may agree that the DNACPR decision should be suspended temporarily. A decision as to how to proceed with the procedure in such cases is a matter for professional judgement and must follow informed discussion.

Audit point 16 – DNACPR case for automatic review - Example 1:

An agreed “DNACPR position” must be considered by the clinician undertaking an intervention that could impact on the risk of a cardiac arrest.

An agreed temporary change to the DNACPR status (covering the intervention and the immediate post-intervention period) must be clearly communicated to all relevant teams. Any new “temporary” position must also be included in “peri-operative checklists” and be communicated clearly to recovery teams.

The post-intervention clinical course must dictate when the original DNACPR position is re-established with all necessary teams appropriately informed.

8.2 Unpredictable, unforeseen and reversible clinical events

A DNACPR decision relates specifically to wishes expressed in the event of an *anticipated* cardio-pulmonary arrest. The decision applies only to CPR and not to any other aspect of treatment.

In clinical practice however unpredictable emergency situations can occur in patients who have a current DNACPR in place. These include for example, acute, unforeseen and immediately life threatening situations such as reversible anaphylaxis, choking or a completely blocked tracheostomy tube. In such instances the underlying cause requires maximal treatment and temporary CPR might become necessary whilst any reversible cause is correctly managed.

Audit point – 16: DNACPR case for automatic review – Example 2:

When clinical circumstances are NOT those envisaged during the original DNACPR discussion and in the event of an unpredictable acute and reversible cause of deterioration followed by cardiac arrest, the DNACPR decision does not override clinical judgement. Judicious senior clinical intervention is vital in such cases - with the clinical response subject to professional justification and review.

8.3 A clear request for CPR – when CPR is not clinically in the patient’s best-interest

A patient might insist that CPR is provided - even when (for clear clinical reasons) the clinical team feel it to be an intervention which cannot provide clinical benefit. When a patient requests CPR following a discussion that clearly outlines very significant risks and burdens, the senior clinician must record fully the patient’s expressed wishes alongside their own clinical views. **When conflict exists and whilst further advice is sought the interim position should normally be to provide CPR.** Efforts should quickly be made to reconcile the position if at all possible. In some cases a “team review” might resolve to respect the patient’s wishes in an individual case, and to provide CPR. In others however it might conclude that attempting CPR in the circumstances would be clearly contrary to best clinical judgement and good practice. In such cases, a second opinion must always be offered and legal advice may become necessary with further discussion with the patient. When there is serious challenge to a DNACPR position, from whatever quarter, the legal position must be considered. Healthcare professionals, who take a fully-considered ethical and clinical position, should immediately share and document their concerns and receive support from their organisation.

A close relative, named supporter or main carer might also openly express disagreement with a decision not to provide CPR. In such circumstances, you must respect and listen to the concerns. A review by the team should take place. If the original position of the team is upheld, then a second

Policy Status: 3rd Edition
 Approved by: All Wales DNACPR
 Implementation Group
 Owner: Dr Paul Buss
 Page 18

Policy reviewed: July 2017
 Policy review due: February 2019

Policy expires:

NHS Wales

Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

senior clinical opinion may occasionally be advisable depending on individual circumstances but with the knowledge and consent of the patient. However a relative's wishes cannot override the agreed position of the patient and the clinical team.

Audit point – 16: DNACPR case for automatic review –Example 3

It should be considered an “exceptional clinical event” to pursue a DNACPR position that is contrary to the expressed wishes of the patient.

When a patient makes a request for “full CPR” that is clearly contrary to the unanimous judgment of the clinical team, this should be urgently re-considered by the clinical team and an attempt made to reconcile the position. A second senior clinical opinion should be considered. In exceptional circumstances legal advice may be necessary. All such cases should be subject to reflection at a later audit to facilitate team and organisational learning.

8.4 Patients with Implantable Cardioverter Defibrillator Devices (ICDs)

Patients with a DNACPR decision in place who also have an Implantable Cardioverter Defibrillator device (used to treat life threatening arrhythmias) require particular consideration. The decision as to when to deactivate the device requires careful planning and discussion between senior clinical colleagues (with expertise in ICD usage), the patient and those closest to them. In emergency situations teams must consult local policies or discuss with on call experts as to how to temporarily deactivate a device. All processes of informed consent and consultation with patient and close relatives apply to this element of care.

8.5 When clinical care extends between health sectors or across borders

Holistic care spans health and social care sectors with teams working in partnership with patients. Clinical staff from different sectors ideally should, whenever possible, be involved at the beginning of the DNACPR process. Such input and team-working can prove helpful in deciding whether a DNACPR discussion is warranted and can assist future care across boundaries. The General Practitioner and wider primary care team can play a key role in this.

It is recognised that patients may be repatriated from cross-border providers. When a patient transfers to Wales with an active DNACPR decision, the All Wales DNACPR Form should be completed within 7 days. During that period the cross-border decision remains active.

When a patient is receiving out-patient or short-term (day) care across national borders then Local Health Boards in Wales must notify the other providers of the current local DNACPR status of a patient. If outpatient care is delivered outside Wales then teams initiating the clinical referral also have a clinical duty to inform providers of the position in advance of the outpatient or day-care appointment.

For in-patient stays, when patients are cared for outside NHS Wales, patients should have their DNACPR arrangements immediately reviewed in the new health-setting, subject to that provider's existing arrangements. Such patients will require support from their GP to instigate a review on discharge. For those in non-NHS settings they should be managed within the clinical governance arrangements of their long term placements which should be cognisant of, and ideally aligned to, the principles of this policy.

9. Training on DNACPR and community awareness

A DNACPR training application, **emphasising the importance of good communication with patients and those closest to them**, should be placed on Local Health Board and Trust intranet systems. It should clearly outline this policy and facilitate access to further DNACPR information. Local Health Board junior doctor and nurse induction programmes across Wales must raise awareness of this policy. Primary care professionals must be offered access to training provided by Local Health Boards. It is vital that evidence is provided that this policy straddles the “whole system

Policy Status: 3rd Edition
 Approved by: All Wales DNACPR
 Implementation Group
 Owner: Dr Paul Buss
 Page 19

Policy reviewed: July 2017
 Policy review due: February 2019

Policy expires:

NHS Wales
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

of care” and hence all relevant NHS staff therefore should have easy access to knowledge bases, senior clinical support and to the training necessary in order to deliver an effective system for DNACPR. **The training needs to ensure awareness of the personal and specific nature of these decisions with awareness of the needs of patients.** It is also recommended that those clinicians undertaking senior responsible clinical roles across the NHS in Wales should undertake education on this DNACPR policy as part of their professional appraisal/revalidation cycle.

It is essential that those undertaking roles related to this policy in all community settings have access to practical work based training and education (provided ideally by Resuscitation Officers based within Local Health Boards). Training in such arenas should place some importance on the evidence and basis of knowing when NOT to provide CPR, as well as providing practical training on the performance of CPR. This training relates also to all ambulance staff with responsibility for the provision of CPR. A register should be developed and maintained of those individuals who have received training in DNACPR. Regulatory authorities for Wales should be made aware of this and might consider this as part of their monitoring of standards in community settings.

10. Measurement and Clinical Audit in NHS Wales

10.1 Audit of DNACPR in Wales

This All Wales DNACPR policy may have impact in a number of areas in relation to:

10.1.1 Processes and NHS administration

- Access to (and deployment of) All Wales DNACPR Forms - across all sites
- Communication systems for DNACPR in place across the whole system of care
- Systems for collation of Serious Incidents and/or complaints and/or special reviews related to DNACPR issues (e.g. local mortality reviews, Coroner's cases) – accessible, with documented learning and with links to professional appraisal
- Staff awareness of the DNACPR policy and access to DNACPR education and training

***“An effort must be made to cross reference incidents with complaints and investigations on DNACPR”
(Dignity revolution)***

10.1.2 Clinical and Professional aspects (Audit points 1-16)

- Decision making and appropriate use of NAAD/DNACPR
- Evidence of a correct assessment of mental capacity - when indicated
- Evidence for intention to consider advocacy and a health and welfare attorney in relation to DNACPR.
- Clinical aspects – appropriately completed and detailed DNACPR form
- Review of clinical communication (with learning events) about DNACPR involving all clinical teams (WAST, Emergency Department, Primary Care, Nursing Home etc.).
- Complex cases logged for shared learning and ongoing policy adjustment at annual national learning event.

11.2

NHS Wales
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

10.1.3 Communication and Teamwork

- Understanding responsibilities re: DNACPR roles within clinical teams
- Evidence of appropriate oversight by the Senior Responsible Clinician
- Evidence of MDT team decision making in the DNACPR process
- Evidence of correct communication across sectors including Primary Care, Out-of-Hours and emergency care systems

“Whenever possible a DNACPR audit should include patient input” (Dignity revolution).

10.1.4 Privacy, dignity and respect for patients and families

- Evidence of “spot check reviews” that decisions have been approached and reached with due regard for the patient's dignity and in privacy
- Evidence of processes for special case DNACPR review
- Internal tests of communication, coordination and responsiveness re: DNACPR decision-making

These elements should form the basis of a local DNACPR audit template. Local Health Boards following DNACPR implementation are expected to assess performance against these headings.

11. References

Nolan J Cardio-respiratory resuscitation BMJ 2012 345: e6122

Death by Indifference - 74 deaths and counting a progress report: Men cap - 2012

Dignified Care - One Year On - The experiences of older people in hospitals in Wales – 2012 – The Older Peoples Commissioner for Wales.

Human Rights Act (1998) London. Crown Copyright.

Equality Act (2010)

Mental Capacity Act (2005) London. Crown Copyright.

NHS End of Life Care Programme & the National Council for Palliative Care (2008)

Decisions relating to cardio-respiratory resuscitation: Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing 3rd edition (1st revision) June 2016

Treatment and Care Towards the End of Life: good practice in decision making. General Medical Council. (2010)

Last Days of Life Care Pathway: <http://wales.pallcare.info/>

Time to Intervene: A review of patients who underwent cardio-respiratory resuscitation as a result of in hospital cardiac arrest NCEPOD (2012)

Policy Status: 3rd Edition
Approved by: All Wales DNACPR
Implementation Group
Owner: Dr Paul Buss
Page 21

Policy reviewed: July 2017
Policy review due: February 2019

Policy expires:

NHS Wales
Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) Policy

11.2

DNACPR Form (Adult) DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION (DNACPR) DISCUSSION

Date of DNACPR Discussion:	/ /
Date Reviewed	/ /
Reviewed by	
(Signature/GMC No)	

Surname: _____
 First Name: _____
 NHS/Hospital No: _____
 Date of Birth: _____
 Home Address: _____

WHILST ACTIVE, THIS FORM **MUST** BE FILED AT THE FRONT OF THE PATIENT'S HEALTHCARE RECORD

1. Does the patient have capacity to make and communicate decisions about CPR? YES / NO

If "NO"

Are you aware of a valid Advance Decision to Refuse Treatment refusing CPR which is relevant to the current condition?

YES / NO

Has the patient appointed a Health & Welfare Attorney to make decisions on their behalf?

YES / NO

If "YES" they must be consulted.

2. Summary of the main clinical conditions and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests: Tick all reasons that apply.

Clinical Summary:

Reasons:

Not in the best interest/harm from CPR > benefit ☐

This is a natural anticipated and accepted death ☐

Patient refused CPR ☐

Other (please elaborate in patient's healthcare record) ☐

3. Has a discussion taken place with the patient? YES / NO

If CPR has NOT been discussed please clearly record reasons in the box below:

4. Has appropriate discussion taken place with those close to the patient, a Health and Welfare Attorney or an IMCA? YES / NO

Name of person:

Relationship to patient:

5. Healthcare Professional completing this form:
 (Document is **ONLY** active when signed, timed and dated with GMC No.)

Name (PRINT):

Position:

Contact Details:

GMC No: or NMC No:

(Nurse – form NOT active unless countersigned in box 6)

Signature:

Date:/...../..... Time:

6. Senior Responsible Clinician with oversight to sign below:
 (Must inform MDT/others involved in the care of the patient of the decision – record the communication below)

Name (PRINT):

Position:

Contact Details:

GMC No:

Signature:

Date:/...../..... Time:

7. CANCELLATION of decision: NB: Cross form **CLEARLY** and write "CANCELLED" across form – notify ALL copy holders (see details below)

Name (PRINT):

Position:

Contact Details:

GMC No:

Signature:

Date:/...../..... Time:

8. COPIES of this DNACPR decision form have been sent to:

1. ☐ Patient /Carer
 2. ☐ GP
 3. ☐ Nursing or Care Home

ALL BOXES MUST BE COMPLETED

In the event of a cardiac or respiratory arrest no attempts at cardio-pulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

- The patient's full name, date of birth and address must be **written clearly with ballpoint pen** or an addressograph must be attached to each copy of the form
- The date of completing the form must be entered.
- The decision must be communicated to all parties involved in the active care of the patient.
- The patient's clinical and DNACPR status should undergo routine review of circumstances. If reviewed please record at top of the form.

1. Capacity/Advance decisions

If the patient does not have capacity please ensure that an **Assessment of Mental Capacity and Best Interests** is completed. Ensure that any Advance Decision (only valid for adults aged 18 or over) is specific and valid and applicable to the patient's current circumstances. Legal advice can be considered in the event of disagreements, as recommended in the All Wales policy. All other decisions must be made in the patient's best interests and comply with current law.

2. Summary of main clinical conditions and reasons why CPR would be inappropriate, likely to be unsuccessful or not in the patient's best interests.

Please be as specific as possible. More detailed information can be recorded in the patient's healthcare record.

3. Summary of communication with patient

State clearly what was discussed and agreed. If the decision was NOT discussed with the patient clearly state the reason why. If an interpreter is used they must be approved by the organisation.

4. Summary of discussion with those close to the patient (e.g. spouse/partner, family and trusted friends, carer, or advocate)

If the patient does not have mental capacity those close to the patient must be consulted and may be able to help by indicating the patient's recent wishes. They **cannot** make the decision to withhold cardio-pulmonary resuscitation - this is a medical decision. If the patient has made a Lasting Power of Attorney for Health & Welfare, ensure that it is registered. If the patient has appointed a Health & Welfare Attorney to make decisions on their behalf, that person must be consulted. A Health & Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original Lasting Power of Attorney.

If the patient has capacity - ensure that discussion with others is with their consent and does not breach confidentiality. State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes.

5. Healthcare professional completing this DNACPR form

This will vary according to circumstances and local arrangements. This should be a senior member of the clinical team. **The form becomes active when a medical professional signs, times and dates the form and provides their GMC number.**

The decision must be overseen by the senior responsible clinician (usually the patient's Consultant or General Practitioner) at the earliest opportunity. If the senior responsible clinician is NOT the doctor initially completing the form, they must be informed as soon as reasonably possible. If a review of circumstances around the DNACPR form is necessary, this should be undertaken in line with the all Wales policy. **Any review of the decision is subject to communication requirements as outlined in All Wales policy.**

6. Details of the senior responsible clinician involved in the decision

Ensure all details (name and position) are completed (see All Wales policy) and that the DNACPR decision is communicated to all those involved in the patient's care as in All Wales policy.

7. Cancellation of the decision

Ensure all details are completed. The form should be crossed through diagonally using 2 lines and **"CANCELLED"** should be written clearly between them, and signed and dated by the doctor cancelling the decision. The cancelled form must be filed within the current clinical record and this should be communicated to all copy holders below - as per All Wales policy.

8. Communication of the Decision

Ensure communication of the DNACPR decision. Wherever possible the patient (or person closest to the patient) should receive a copy of the completed form ideally in Welsh and English. If completed in a hospital setting a copy of the form must be sent to the GP on discharge. If completed in the community setting you must communicate the decision to OOHs and/or nursing/care home if relevant.

Key contributors to this revision of this policy:

Dr Paul Buss, Medical Director/Deputy Chief Executive, Aneurin Bevan University Local
Health Board
Dr Idris Baker, Consultant Palliative Care Medicine, Abertawe Bro Morgannwg University Local
Health Board
All Wales DNACPR Implementation Group members



Quick Reference Guide

“Sharing and Involving”

A Clinical Policy For DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) FOR ADULTS IN WALES

Version 2 – July 2017

11.2

Introduction to DNACPR

This document is a summary of the key elements contained within the policy. A patient information leaflet is provided for patients and those close to them to explain the reasons for the policy.

One **aim** of the DNACPR policy is to help **raise awareness** of the importance of discussions that relate to wishes at the end of life. It will help us develop the correct, personal approach, with respect to DNACPR.

The **purpose** of the policy is to **provide a unified framework for professionals** in Wales - helping to ensure a uniform approach to decisions relating to the provision of CPR at the end of life.

DNACPR discussions can be difficult and should be conducted in a calm, professional and reflective manner. DNACPR decisions should always involve senior professionals. DNACPR decisions should be recorded on the All Wales form that will be recognised across health sectors in Wales

Throughout the policy “DNACPR” refers solely to the provision of Cardio-Pulmonary Resuscitation and not to any other aspect of the individual’s care or treatment options.

CPR – Cardiopulmonary Resuscitation

CPR is a technique used to maintain the body’s circulation and breathing. It usually means “pressing the chest” and providing ventilation to the lungs. In some cases “defibrillation” using electric shocks and also intravenous injections of medication may be used.

DNACPR

This refers to a specific decision NOT to provide CPR in the event of a cardiac arrest. It must be made clear to all that a **DNACPR decision does NOT impact on any other element of care.**

Having the discussion and reaching a decision

For professionals - recognising when to “consider DNACPR” may not always be straightforward. Quite often “envisaging the possibility of a cardiac arrest or death” in light of the current illness forms its basis. Knowing the wishes of the patient is very important and making DNACPR decisions **before** a patient becomes too unwell is good practice. This requires members of the medical and nursing team to establish a bond of trust reaching a shared position with the patient and involving those closest to them.

If CPR will not restart the patient’s heart or maintain breathing

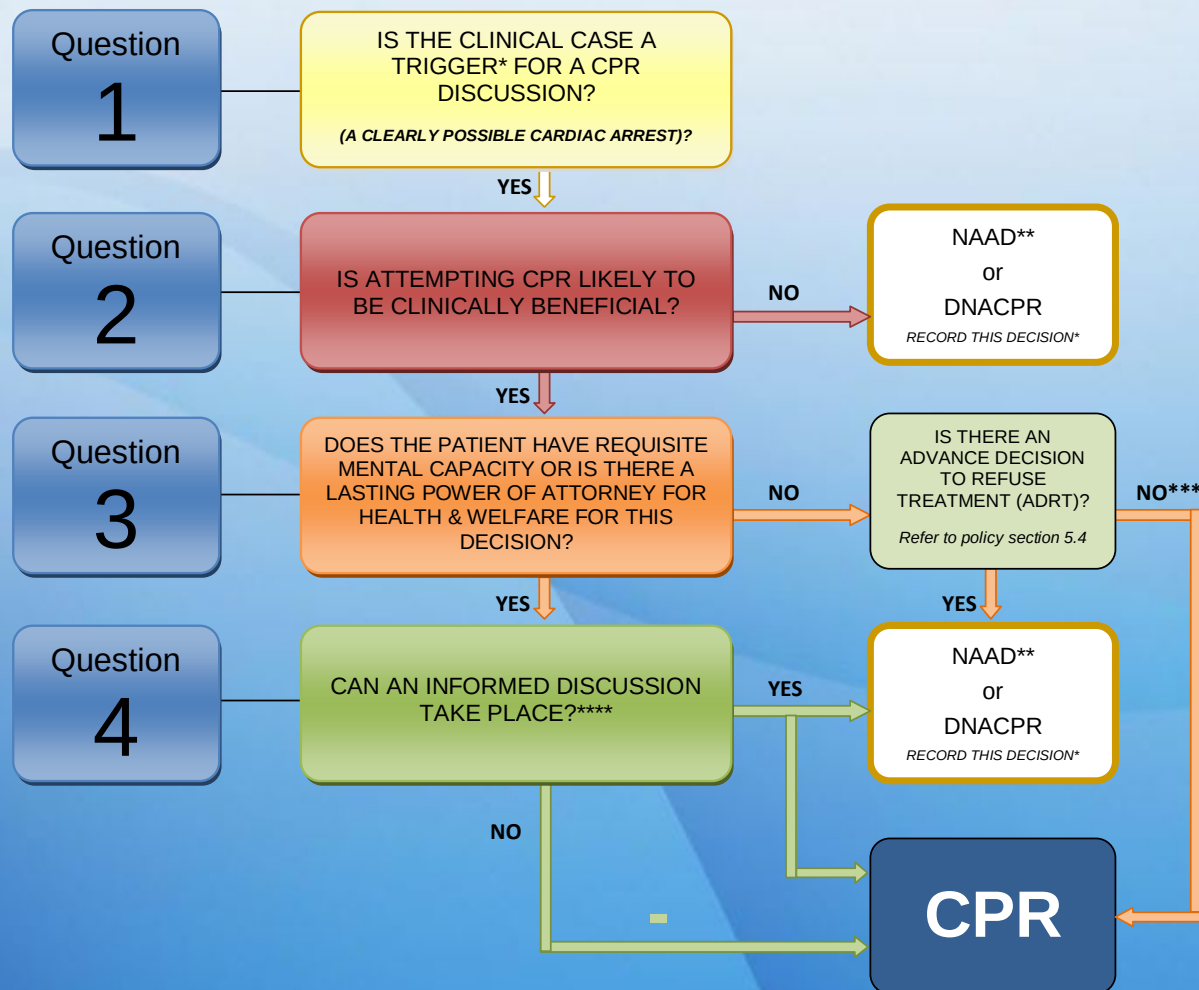
If the clinical team is as **clinically certain as it can be that attempting CPR would not re-establish effective circulation** (and maintain breathing) then CPR need not be attempted. To provide CPR in such circumstances would not be in the patient’s interest. This is always an individual clinical decision that must be based on up-to-date knowledge of the patient’s condition. **It is expected that in most situations that this will be discussed with the patient and with those closest to them.**

If the potential “harmful effects” of CPR is greater than potential benefits

Any potential benefit from CPR must be balanced against “risk of harm”. The patient’s recently expressed wishes are hence very important. If for example, a patient is in the final stages of an incurable illness and death is expected within a few days, CPR is unlikely to be successful and could prolong suffering. Best interest decisions in general are most easily reached in those circumstances where there is a clinical consensus that benefit is very low or risk of harm from CPR likely to be very high (See joint statement).

Deciding that a case warrants a DNACPR decision

The All-Wales DNACPR decision-making framework schematic is illustrated below. This includes clinical events that might act as a “trigger” for a team-based DNACPR discussion. It also outlines the key questions clinicians that should ask themselves in order to decide if a DNACPR discussion is warranted.

SCHEMATIC FRAMEWORK FOR DNACPR DECISION-MAKING

Note for clinicians - For details related to each box you MUST consult the accompanying complete All Wales DNACPR Policy

***TRIGGER** – may represent a traditional ‘clinical trigger’ where the clinician envisages a possible cardiac arrest as a natural consequence of the condition – or when the harm or risks of CPR clearly exceed the benefit.

****NAAD** - See Policy Section 5.5.2.

*******See Mental Capacity Act (2005) guidance paragraph 7.30– Health and Welfare Attorney must be designated to cover life-prolonging treatment decisions and be registered with the Office of the Public Guardian. If no ADRT is in place consider Section 5.4 relating to Mental Capacity Act.

********Note that the patient may change his/her mind at any time. Also for interventions with significant risk of cardiac arrest, a CPR discussion must occur when obtaining informed consent for the procedure.

Documenting and communicating the DNACPR decision

Documentation of DNACPR decisions

The All Wales DNACPR form is the agreed form for recording DNACPR decisions in Wales. **All** relevant sections of the form must contain entries. It relates only to DNACPR decisions and the original copy forms part of the medical record. **A DNACPR form is ONLY active when dated, timed, and signed with the GMC No. entered by a doctor.**

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms must be correctly completed and contain up to date information. The form must be completed in legible handwriting and also signed and dated. Further details on copies and communication can be found within the All Wales policy.

Senior clinical responsibility for every DNACPR decision

A senior clinician is responsible for overseeing DNACPR decisions. Agreed DNACPR decisions must be relayed to the senior responsible clinician in a timely manner. They must be informed if an All Wales DNACPR form has been completed. **If this clinician is not physically present at the time of the discussion and decision then it must be clearly recorded in the clinical notes/record.**

Communication of a DNACPR decision

Correct communication of a DNACPR decision is vital and should follow guidance within the All Wales policy.

Further key issues

When DNACPR status is unknown:

Unless a valid DNACPR decision is in operation with either an All Wales DNACPR form completed or a valid applicable Advance Decision to Refuse Treatment (ADRT) exists **patients should be presumed to be "For CPR".**

When a valid Advance Decision Refusing CPR exists

If a valid applicable Advance Decision to Refuse Treatment is in place that was made when the patient had mental capacity and when the circumstance has arisen as envisaged (Mental Capacity Act 2005) then CPR should NOT be attempted.

Refusal of CPR by patients with capacity

Any person with capacity can personally refuse CPR. If a patient with capacity refuses CPR (even when it may be of benefit), this wish (and the discussions related to this) must be carefully and clearly recorded in the patient's record and the DNACPR decision should be recorded on the All Wales DNACPR Form

Review of a DNACPR decision

A new DNACPR form would only be required/needed if the decision has changed.

A review of the DNACPR decision might, for example, be considered:

- When a patient's overall clinical condition significantly and sustainably improves warranting further discussion.
- On the request of patient or individual(s) the patient has chosen to be present for the decision making process.

Cancellation of a DNACPR Decision

In some circumstances it may be right to cancel a DNACPR decision. The original form should be clearly diagonally marked with 2 lines in black ink with "CANCELLED" written between the lines.

All parties who received copies of the original decision (see All Wales DNACPR form) must be contacted and informed that the DNACPR has been cancelled.

The communication must be in writing and logged and contain a copy of the overwritten cancelled original document. The patient's original copy should be returned and destroyed - in order to avoid future error.

Clinical Note

- A DNACPR decision relates specifically to wishes expressed in the event of a **predictable** cardiopulmonary arrest – applying only to CPR and it does not apply to any other aspects of treatment.
- In clinical practice unpredictable situations can occur in patients whilst a current DNACPR is in place (please see Section 8.2 of the All Wales policy). In such instances the underlying cause requires maximal treatment and temporary CPR might become necessary whilst any reversible cause is correctly managed.

For More Information

Please refer to "Sharing and Involving" a Clinical Policy for Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) for Adults in Wales and the Patient Information Leaflet accompanying this document.

For help with discussions about DNACPR visit the TalkCPR website at <http://talkcpr.wales/>



11.2

A Clinical Policy for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for Adults in Wales

Equality Impact Assessment

1. Introduction

The Equality Act 2010 places a positive duty on public authorities to promote equality for nine protected characteristics* and requires Welsh public bodies to demonstrate how they pay 'due regard' to equality when carrying out their functions and activities. In the context of this work, health boards and NHS Trusts are required to assess the impact of policies and services on equality and human rights. The purpose of this is to ensure that as far as practicably possible, the opportunities for promoting equality and human rights for people with protected characteristics are maximised and any actual or potential negative impact is eliminated or minimised.

2. Policy Aims and Context

Cardiopulmonary resuscitation (CPR) of patients can be an important, life-sustaining intervention. 'It was originally developed to save the lives of younger people dying unexpectedly, mostly from primary cardiac disease. However, CPR has come to be seen as a procedure that should be used for patients as a therapy to restore cardiopulmonary function and prolong life, irrespective of the underlying cause of cardiac arrest'. ⁽¹⁾

The purpose of this policy is to provide a policy framework for professionals and NHS bodies in Wales in order to enable a consistent approach to decisions relating to the provision of CPR. Whilst for every individual, death is inevitable, achieving a dignified, sensitive and shared approach to reaching a decision relating to CPR is vital for patients and those who are close to them.

* Race; Sex; Gender Re-assignment; Disability; Religion, belief/non belief; Sexual orientation; Age; Pregnancy and maternity and Marriage and civil partnerships

The decision not to attempt CPR on a patient is a major clinical decision. The aim of this policy is to help achieve a position where a discussion about CPR is accorded the highest level of significance. This should help develop across NHS Wales the correct approach of consistent planning of care with regard to CPR as a treatment option and an approach that is centred on an individual plan for each patient where any decision not to attempt CPR is based on an informed and proper discussion with the patient and those who are close to them.

A core group was established in January 2012 to develop a unified policy framework that would promote high standards of decision making in all care settings and a person centred approach that ensures the highest standards of clinical care and treatment.

The approach to developing the DNA (Do Not Attempt) CPR Policy has been grounded in the public sector equality duty principles of evidence; transparency; engagement and leadership to ensure that it impacts in a fair and positive way. Members of the core group are drawn from clinicians involved in palliative, intensive and emergency care, resuscitation officers, quality and patient safety managers, representatives from primary care and the independent care sector, community health councils, the General Practitioner Committee, Wales, ethics and equality and human rights. The design of the framework has taken account of best practice from other parts of the UK including the learning from South Central England and Scotland. A leading expert from Guy's Hospital in London has supported the work in an advisory capacity.

Early engagement with a wide range of clinical stakeholders was undertaken with three regional clinical workshops held between October and December 2012. These workshops considered key principles and case studies to test different patient scenarios in a range of clinical and non clinical settings.

Non clinical stakeholders have been key partners in this work and two engagement events were held on 13th September 2012 and 29th January 2013. Separate and focused engagement has also taken place with Mencap Cymru and the Older People's Commission to gain a better understanding of the issues for people with learning disabilities and older people.

Key principles and issues raised by DNACPR have been explored from a broad range of clinical perspectives and also, from the individual patient and family/carer's perspectives. Participation from a range of third sector organisations has raised awareness and understanding of the different and diverse needs of people living in Wales. The draft Policy is the product of this wide engagement.

3. Available Research Evidence: Literature Review

A literature review was carried out as the first stage of the process of gathering evidence to inform this equality impact assessment. The results of the literature review are provided below against each of the protected characteristics. There is some research evidence that has specifically highlighted the particular issue of DNACPR in relation to people with protected characteristics. Broader and more extensive research concerned with understanding the needs and experiences of patients when they require end of life care has also been considered, where relevant to DNACPR.

Age

Demographic evidence demonstrates that people are living longer. By 2005-09 life expectancy in Wales had increased to 77.0 years for males and 81.4 for females. Population projections published by Public Health Wales suggest that the number of persons aged 15-24 will decrease by 4% in 2031 whereas an increase of 79% is forecast for the 75+ age group.

Population age structures in rural areas are older and often this is compounded by outward migration of younger people and inward migration of older people. Current projections indicate that the increase in the proportion of older people will be greater in rural areas. As well as having an older age structure, the population in rural areas is by definition more dispersed leading to difficulties in respect of access to, or the provision of, services. (2)

The Public Health Wales Observatory has reported that although life expectancy overall has increased, inequalities in both life expectancy and quality of life in Wales have persisted if not slightly increased. Life expectancy has increased more slowly in the most deprived areas compared to the least deprived in Wales. The gap between the most and least deprived areas is 18.9 years for males and 17.8 years for females. This contrasts with the national inequality gap in life expectancy overall of 9.2 years for males and 7.1 years for females. ⁽³⁾

Older persons are disproportionately affected by chronic conditions. The Welsh Health Survey reported that 82% of respondents aged 65 years and over suffered from a chronic condition, of whom 54% suffered from two or more. If current trends continue the number of people living with chronic conditions will continue to increase in the future, with people living longer and developing more than one chronic condition. ⁽²⁾

Research undertaken by the National Confidential Enquiry into Patient Outcome and Death (2102) ⁽¹⁾ assessed the case notes of 586 adult patients who had a cardiac arrest, triggering either a call to the resuscitation team that led to the delivery of chest compressions or defibrillation during a 14 day study period in 2010. The median age for the sample included was 77 years.

With an increasingly ageing population it will be important to ensure that DNACPR decisions are not adversely affected by negative attitudes towards older people and negative assumptions about their quality of life.

Research published by the Older People's Commissioner for Wales in 2011 ⁽⁴⁾ highlighted the findings of Dignity and Essential Care Inspections carried out by Healthcare Inspectorate Wales. Do Not Attempt Resuscitation (DNAR) forms not always being fully completed and up to date was reported as a constant theme and challenge. The Research refers to 'clear, effective communication (as) essential to help older people exercise choice and control in a healthcare setting.

A lack of information and advice about health conditions, medical treatment, or the quality of care an older person should expect can cause fear and uncertainty and make a stay in hospital more difficult' (4).

The 'Together for Health – Delivering End of Life Care' Delivery Plan sets out the Welsh Government's expectations of NHS Wales, 'working with its partners, in particular the hospice and social care sector, to reduce inequalities in end of life care up to 2016. It sets out how patients and their families will be supported at the end of life, providing high quality care in all settings for people of all ages'. (5)

Disability

People with Learning Disabilities

Research by the former Disability Rights Commission (DRC) in 2006 (6) found that people with learning disabilities are more likely to die young and to live with physical ill health than other citizens. The research found that people with learning disabilities are more likely to be obese, and to experience chronic and long term health conditions, such as respiratory disease and Diabetes. They are also more likely to be diagnosed with these conditions at a younger age than the general population.

The research identified a range of causes to explain the physical health inequalities including poverty, difficulties recognising symptoms, lack of access to healthy lifestyles, inequalities in access to screening and treatment and the side effects of medication. One of the most significant barriers to healthcare was identified as the perceived negative or discriminatory attitudes of healthcare staff.

Many respondents in the research felt that their physical health or other health needs were neglected, or more readily dismissed, due to their learning disability. This was referred to in the research as 'diagnostic overshadowing', attributing any physical symptom to an underlying mental health problem or learning disability.

Research published by Mencap in 2012 ⁽⁷⁾ highlights how discriminatory and negative attitudes towards people with learning disabilities and their quality of life have adversely influenced DNACPR decisions; ‘the doctor took one look at my son and said that he was not for resuscitation’. In another example, healthcare professionals are criticized for making ‘discriminatory and incorrect assumptions’ about people with learning disabilities following a ‘do not resuscitate order. In this instance the reasons given on the CPR form were listed as ‘Down’s syndrome, unable to swallow ... bed bound, learning difficulties’.

Mencap’s research ⁽⁷⁾ highlights that ‘the inappropriate use of DNR orders has remained a constant feature of many Mencap cases. There have been circumstances where DNR notices have been applied without the knowledge or agreement of families and applied hastily in inappropriate situations, solely on the basis of the person’s learning disability’.

Mencap’s research ⁽⁷⁾ also suggests that healthcare professionals are often unaware of issues around capacity and consent to the extent that patients are often denied treatment or treatment is delayed. This is referred to as ‘flawed best interest decision-making’ when, despite the process being technically followed, the medical advice given in the best interest decision meeting has been weighted in favour of a decision not to proceed with active treatment and the application of DNR orders. This has led to families sometimes agreeing with the decision, only later to find that there was a better prospect of recovery with treatment than they had been told.

Mencap refer to many accounts from families of treatment not being given under the guise of concern about consent. This raises the important need to properly apply the law on consent which is clear that if a person lacks capacity to consent to treatment, a decision must be made on their behalf in their best interests, and the family should be involved in this decision.

People with Sensory Loss

There is a plethora of research published by sensory loss organisations to evidence the barriers to communication experienced by people with sensory loss when they need to access healthcare. These experiences extend to family and carers with different communication needs who should be involved in the DNR decision making process.

Recent research into the experiences of Deaf people ⁽⁸⁾ when they need primary and secondary healthcare highlighted that 27 out of 36 people who had recently experienced staying in hospital, were not provided with the services of a British Sign Language interpreter when being asked to sign a consent form. Respondents in this research stated that they often missed information and did not fully understand what the doctor was saying.

There could be a potential negative impact for people with sensory loss if their different communication needs are not recognised and met.

People with chronic and long term health conditions

The Welsh Government has quantified the extent of chronic conditions on the population in Wales. ⁽²⁾ One third of adults in Wales (an estimated 800,000) reported having at least one chronic condition; of people aged over 65 in Wales, two thirds reported having at least one chronic condition, and one third had multiple chronic conditions; and over three-quarters of people aged over 85 in Wales reported having a limiting long-term illness. If current trends continue, the number of people living with chronic conditions will increase with people living longer and developing more than one chronic condition.

A study looking at the palliative care needs of people with chronic obstructive pulmonary disease (COPD) ⁽⁹⁾, concluded that few people with end-stage COPD are given an opportunity to make decisions about their end of life care and despite the majority saying that they would wish to die at home, the majority are still dying in hospital.

People with Mental Health Conditions

Research in 2006 ⁽⁶⁾ found that people with mental health conditions experience poorer physical health than the general population. It highlighted that people with mental health conditions are more likely to experience chronic and long term conditions, for example, respiratory illnesses, Diabetes, heart disease and cancer.

Informed consent is an important issue for patients with mental health conditions. The statutory framework on capacity and consent issues is set out within the Mental Health Capacity Act (2005). This must be fully taken into account in any DNACPR decision making process.

Race

Census data shows that in 2011 more than nine out of ten (93.2%) residents in Wales were White British while 6.8% of the population (208,006) were from Black Minority Ethnic (BME) groups. A comparison of census data from 2001 and 2011 demonstrates that the population in Wales has increased across all BME groups with the exception of White Irish.

In the context of age, most of the population aged 65+ is White British. Data also shows that most ethnic groups have been ageing since mid 2001 (exceptions are Mixed White and Black Caribbean and Other Black). Amongst the BME groups, Indian (over one thousand people), Pakistani (almost one thousand people) and Black Caribbean (around 700 people) populations have the highest number of people aged 65+. Recent UK wide population projections identify that ageing trends are expected to continue. By 2026 it is estimated that there will be over 1.3 million people in the UK from BME groups aged 65+, many of whom may experience life limiting illnesses.

In the context of languages spoken, in 2011 97.1% of the population in Wales spoke English or Welsh as their first language. The second most spoken language was Polish (0.6% or 17,001). This was followed by Arabic (6,800), Bengali (5,207) and Tagalog/Filipino (2,749).

The majority of people who do not speak English as a first language could either speak it well or very well, whereas 19,305 people whose main language was not English, could not speak English well or at all.

A number of studies in England have looked at the needs of both Black and Minority Ethnic patients and carers in end of life care and have found that there are factors associated with culture and language which need to be considered to fully meet their needs ⁽¹⁰⁾.

Religion and belief

More than half of the population in Wales (57.6%) described themselves as Christian in 2011 whilst almost a third reported having no religion. The second most reported religion was Muslim, which represented 1.5% (45,950) of the population.

There is evidence from research undertaken in England ⁽¹¹⁾ that ethnic and cultural differences can influence patterns of advanced diseases, illness experiences, healthcare seeking behaviour and the use of healthcare services. The values and beliefs that underpin religious traditions and family roles might also be seen as incompatible with palliative/hospice care. Some groups might avoid disclosing prognosis and diagnosis in order to protect the patient or avoid distress. ⁽¹¹⁾.

Most of the evidence on disparities and unmet needs for BME populations when in receipt of palliative and end of life care refers to poor communication between healthcare professionals and the patient/family. 'Moreover, these interactions rely heavily on high quality communication between health and social care professionals and patients and their families. The inability to engage in communication not only affects access to palliative care services but has been shown to be a source of serious problems in clinical consultations and the cause of misunderstandings amongst patients, family members and healthcare providers'.⁽¹¹⁾

Poor communication has been identified as a serious problem when providing care to BME groups. 'This is associated with a lack of sensitivity to cultural and religious issues (and consequent poor understanding of needs) and lack of translation resources. It is also highlighted that poor communication can 'impede a doctor's ability to assess the patient's mental competence to make informed decisions' (11).

The evidence has also highlighted differences regarding end of life decisions (such as a lower use of advance care planning documents and more choices of aggressive treatment (13). Substantial evidence reports that minority ethnic groups are less likely to complete advance directives than the majority White. 'They are more likely to desire life-sustaining treatment and aggressive treatments such as artificial nutrition and cardiopulmonary resuscitation even where there is no hope for recovery'.

Reasons for these differences are complex and sometimes contradictory. The most commonly discussed issues were mistrust regarding the healthcare system, the importance of religion and difficulties in trying to apply the Western model of autonomy to different cultures. It seems to affect both decisions to undertake aggressive treatments and decisions not to use advance care planning. (11)

Religion has a fundamental influence in shaping treatment decisions at the end of life. ...The idea of autonomy, right to self determination and control over dying is not a universal value and it is not shared in all parts of the world. Many patients might prefer involvement in decision making by families and health professionals. The concept of advance care planning documents is not universally accepted and might be seen as an 'intrusive legal mechanism' interfering with the family responsibility to care for their loved ones, a violation of one's self identity and family. (11)

In some cultures where the patient is protected from hearing their diagnosis while the family receives the information, discussing advance care planning might actually harm patients and their families' (11).

The research evidence highlights that religion has a fundamental influence in shaping treatment decisions and this must be understood and respected by healthcare professionals when they need to consider advanced care planning and the application of CPR.

Sex

There is evidence to demonstrate that there is a gender difference in life expectancy and women in Wales can expect to live 4.4 years longer than men. Females are, however, estimated to spend only around two years longer than males in good health or free from limiting long-term illness or disability. ⁽³⁾

There is no research evidence to suggest that there are particular issues that need highlighting in relation to DNACPR.

Sexual Orientation

Research identifies a number of key issues for LGB people: professional staff attitudes towards sexual identities influences the quality of care offered and received and that heterosexual assumptions may exist throughout care ⁽¹²⁾.

Consultation for the English End of Life Care Strategy Equality Impact Assessment noted that in terms of quality of end of life care, Lesbian, Gay and Bisexual (LGB) people were most at risk of discrimination ⁽¹²⁾.

Guidance produced by the Royal College of Nursing and UNISON (Not 'just' a friend: best practice guidance on healthcare for lesbian, gay and bisexual service users and their families) suggests that it can be a concern for LGB people that someone close to them will be denied visiting rights and information because they are not seen as the 'next of kin'. Guidance was published by the Welsh Assembly Government in 2008 to raise awareness of the needs and rights of lesbian, gay and bisexual people when accessing healthcare services in Wales ⁽¹³⁾.

The guidance highlights that recognition of next of kin/nominated contact when one partner is in hospital or needs medical treatment is an issue of great concern to same-sex partners.

Although there is no legal definition of 'next of kin' in this context, and nothing to prevent same-sex partners acting as 'next of kin'/nominated contact in these circumstances, there are still misconceptions about this among the general public and among medical and other staff. Confusion arises over who is 'next of kin' because the general understanding of the term is that it is a blood relative or married or civil partner. However, this is not the case and lesbian and gay couples who have not registered a civil partnership and unmarried heterosexual couples can, if they so wish, nominate their partner as 'next of kin'. (13)

The DNACPR Framework will need to ensure that it is inclusive of and recognises the rights of same-sex families. Medical and other staff should be supported to challenge prejudiced attitudes and behaviour in staff and other service users and need to be aware of the impact on privacy and confidentiality. The important need to recognise the diverse identities of patients and to be sensitive to their choice of 'next of kin' was raised throughout the engagement work.

Older lesbian, gay or bisexual people represent a generation who lived in times when same sex relationships were pathologised and, for gay and bisexual men, illegal. This group may have experienced incidences of prejudice and therefore be less open than younger generations. (12)

Research suggests that it is likely that older LGB people will anticipate or have had experience of negative reactions relating to their sexual orientation or gender identity. This can impact on the person's ability to have discussions about end of life care and access to local community support.

Previous disclosure of sexual orientation may have been traumatic. For some it could also lead to a distancing from families of origin such that the individual may rely on and prefer alternative networks of support. However, there is a risk that the significance of 'friend' relationships is not recognised before and after death. This could result in a person or group, their relationship with the dying person and their grief going unrecognised. (12)

Gender Re-assignment

The above research considered in the context of Lesbian, Gay and Bisexual people also included the experiences of Transgendered people. Many of the issues highlighted above will be as relevant to Transgendered people.

Welsh Language

Public services have a responsibility to comply with the new Welsh Language (Wales) Measure. This will create standards regarding Welsh which will result in rights being established that will ensure Welsh speakers can receive services in Welsh. Meeting the information and communication needs of patients who speak Welsh will need to be taken into account in the DNACPR decision making process.

‘Language is at the core of establishing and expressing identity. Responding sensitively to language, whilst focusing on the individual, is an essential principle of maintaining dignity and respect in care within a bilingual setting’. ⁽¹⁴⁾

Language provision is particularly important for older people who may only be able to communicate using their first language when they become unwell. The Strategic Framework for Welsh Language Services in Health, Social Services and Social Care, ‘More than just words ...’ refers to older people in residential care settings discovering ‘that their ‘sense of self’ and ‘social recognition’ diminishes because their body and mind is deteriorating. Some will have already suffered losses such as bereavement, their home, and some physical and mental skills. It’s essential therefore to provide care that reflects a person’s language and cultural background in order to respect their identity and maintain their dignity’. ⁽¹⁴⁾ In addition to older people, the Welsh Government has identified three other priority groups where Welsh language services are especially important, these are: children and young people; people with learning disabilities and people with mental health problems. These groups are particularly vulnerable because their care and treatment suffers when they are not treated in their own language.

Human Rights

A CPR decision is highly relevant to the Human Rights Act 1998 and in particular, the right to life (Article 2), the right not to be tortured or treated in an inhuman or degrading way (Article 3) and the right to respect for private and family life, home and correspondence (Article 8).

Clinical decisions about whether or not to attempt CPR often arise in difficult circumstances. Rates of survival and complete physiological recovery following in-hospital cardiac arrest are poor. A high proportion of in-hospital deaths now involve CPR attempts, even when the underlying condition and general health of the patient makes success very unlikely. This can mean that patients may undergo futile attempts at CPR during their dying process. Effective Do Not Attempt (DNA) CPR decision making should improve patient care and prevent futile and undignified procedures at the end of life.

Research published by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD 2012) ⁽¹⁾ revealed the need for a closer definition of the aims of the treatment of sick people in hospitals and raises many issues including the disparity between the public and professional perception of the outcome of CPR, effective communication and informed consent and ensuring a dignified death.

There are times when cardiopulmonary resuscitation (CPR) is inappropriate. It may be futile because a patient is dying from a terminal illness or it may be against the wishes of the patient. A decision making process that allows healthcare professionals to be informed when CPR should not be initiated, is central to person centred care and enabling a dignified death for patients and compassion for their families and carers who would want their loved one's wishes to be fulfilled.

Placing DNR notices on a patient's record without their knowledge or consent or that of their family members is likely to constitute a breach of human rights and in particular, Article 8 which safeguards respect for patients' private lives.

The Equality and Human Rights Commission intervened in a Court of Appeal case which revolved around whether seriously ill patients and their loved ones have the right to be consulted about the use of DNR Notices. The Court of Appeal has ruled that doctors have a legal duty to consult with and inform patients if they want to place a DNR order on medical notes.

Historically, blanket policies that are based on subjective factors such as age and quality of life may also have a discriminatory impact and could be subject to a human rights challenge.

4. Themes from Engagement

The third sector organisations that have been involved in the DNACPR engagement work are listed on Appendix 1. The key themes that were highlighted through engagement are:

- The important need to ensure that patients and carers/families are fully involved in the DNACPR decision making process.
- The need to ensure that the appropriate next of kin is recognised in the care and treatment of an individual.
- The need for effective, accessible and kind and sensitive communication and information to ensure that DNACPR is explained and understood. Good communication is at the heart of this. It is about communication between families and not just professionals. People knowing what their loved one would want.
- The need to ensure that DNACPR decisions are recorded and transferred across and between primary, community, secondary and independent care sector organisations.
- The need to promote a non judgemental and positive attitude towards disabled and older people to ensure that DNACPR decisions are not based on unlawful discriminatory attitudes and stereotypes.
- The need to inform and change public perceptions of CPR and the limits of its effectiveness.

- The need to address the risk of creating negative perceptions of DNACPR decisions as a withdrawal of any further treatment and care.
- Mental health is not the same as mental capacity. It is important to recognise symptoms and their impact on mental capacity. The timing of conversations to explore an individual's wishes is important in this respect. A decision may reflect the way the person is feeling at that particular time.
- Part of the Policy should be about who has the conversation – senior medical staff, the person who knows the patient, their illness and prognosis.
- Faith, culture and end of life.
- Welsh Language and other language provision.
- This is not just about older people. It is about everyone.
- The role and involvement of carers and people without carers/family or estranged families and homeless people – the role of independent advocacy.
- People receiving healthcare outside of Wales, for example, prisoners in England and people with severe mental illness – cross border issues.
- Family/carer support and the issue of guilt.
- The need for simple information for all ages.
- The application of electronic record systems and processes for information travelling with patient. How will the Policy work in emergency situations and how will information transfer between primary, secondary, community and independent care settings.
- How will accountability be addressed within the Policy Framework, including how you ensure that everyone is

responsible for implementing the Framework, that staff are familiar with and have been trained in the process and the standards expected as well as receiving training in communication skills, plus the need to understand that they will be held to account for their actions.

- How will the Policy Framework be monitored and will the process be self assessment. If this is the proposed tool for the framework, it might be helpful to acknowledge that this might not give a true assessment of the situation. Self assessment can be successful where there is a genuine desire to improve but it can also have the potential to mask poor performance when there is denial that improvement is needed. An example of this is the Mid Staffs Healthcare Commission report which showed that the hospital was functioning well, whilst in actual fact it was failing.

There could be cross referencing the results with complaints received/concerns raised in relation to DNR decisions, HIW and Ombudsman complaints/investigations, etc. It might be useful to look at other all Wales Frameworks that have been introduced, eg nutrition/medicines, to assess the effectiveness of the monitoring tool and any improvements to enhance it.

It might be useful to consider whether an external assessment could help with raising the credibility of the audit process. Patient stories could be used in conjunction with other methods, for example, inviting people who have used the service to work alongside professionals. This could include involving people in staff interviews and induction, audit meetings, research, resolving complaints, concerns, etc

The main themes highlighted are that communication has to be at the core of the policy and practice; that DNR decisions must be grounded in person centred care that acknowledges and responds to the diverse needs and identities of patients and that robust and transparent monitoring arrangements are developed and implemented that are capable of evidencing that the Policy is being delivered effectively.

5. Outcomes

Equality impact assessment is a continuous process. The assessment has so far demonstrated that DNACPR is relevant to all of the protected characteristics and that there are particular issues to consider with regard to age, disability, race, sexual orientation and human rights. Research has evidenced that there is the potential for DNACPR decisions to impact adversely on disabled and older people. This will need to be monitored as part of the implementation of the policy at a local level to ensure that there is no negative impact.

There is a lack of research specific to Wales to highlight the issues and/or experiences of Lesbian, Gay, Bisexual and Transgendered people, older Black Minority Ethnic (BME) groups and different faith groups. Focused engagement with these groups at a national and local level should be explored as the Policy is further developed and monitored.

The important need to involve carers and people who are close to the patient in the DNACPR decision making process is recognised within the policy framework. Developing awareness of the Policy with carers and organisations that represent them should help to ensure that the aims of the Policy in this respect are achieved.

11.2

April 2014

References

1. Time to Intervene? A review of patients who underwent cardiopulmonary resuscitation as a result of an in-hospital cardio respiratory arrest. National Confidential Enquiry into Patient Outcome and Death (2012)
2. Public Health Wales Observatory: GP Cluster Profiles (2013)
3. Public Health Wales Observatory: Measuring inequalities: Trends in mortality and life expectancy in Wales (2011)
4. Dignified Care: One Year On: The experiences of older people in hospital in Wales. Older People's Commissioner for Wales (2012)
5. Together for Health – Delivering End of Life Care: A Delivery Plan up to 2016 for NHS Wales and its Partners – The highest standard of care for everyone at the end of life. (2013)
6. Equal Treatment – Closing the Gap: A Formal Inquiry into the physical health inequalities experienced by people with learning disabilities and people with mental health problems. Disability Rights Commission (2006)
7. Death by Indifference: 74 deaths and counting. A progress report 5 years on. Mencap (2012)
8. Access to Local Health Board (LHB) Services for Deaf People. South Wales. British Deaf Association. (2013)
9. Murray S: Palliative Care for People with COPD: we need to meet the challenge; Primary Care Respiratory Journal. (2006)
10. Department of Health End of Life Care Strategy – Equality Impact Assessment (July 2008)

11. Palliative and end of life care for Black, Asian and Minority Ethnic groups in the UK. Demographic profile and the current state of palliative and end of life care provision. Public Health England; King's College London; Marie Cure Cancer Care. (2013)
12. The route to success in end of life care – achieving quality for lesbian, gay, bisexual and transgender people. NHS National End of Life Programme. Improving end of life care. (2012)
13. Raising awareness of the needs and rights of lesbian, gay and bisexual (LGB) people when accessing healthcare services in Wales. WHC (2008)031
14. More than just words ... Strategic Framework for Welsh Language Services in Health, Social Services and Social Care (2012)

Appendix 1

A Dignified Revolution

Age Cymru

Diverse Cymru

Gofal Cymru

Marie Curie

Mencap Cymru

Older People's Commission

Transgendered Wales

APPROVAL OF THE MEDICINES CODE	
Name of Meeting	Quality, Safety and Experience Committee
Date of Meeting	December 6 th 2017
Executive Lead: Executive Medical Director	
Authors: Nurse Advisor Medicines Management. Lead Pharmacist Quality and Safety. Pharmacy Department UHW 029 2074 2995	
Caring for People, Keeping People Well: The Medicines Code Underpins the Health Boards commitment to Avoid Waste, Minimise Harm and Avoid Variation.	
Financial impact: N/A	
Quality, Safety, Patient Experience impact: The Medicines Code will provide practice guidance that is applicable to all members of the multidisciplinary team involved in all or part of the medicines management process. Aligning practice to the code will reduce variation in practice and minimise risks associated within medicines management processes.	
Health and Care Standard Number: 2.6 Medicines Management – people receive medication for the correct reason and receive the right medication, at the right dose and the right time.	
CRAF Reference Number: 5.1 Deliver safe, effective and efficient care - Patient harm resulting from inadequate management of medication	
Equality and Health Impact Assessment Completed No (in development)	

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Aligning UHB Practice to the All Wales Policy for Medicines Administration Recording Review and Storage (MARRS 2015).
- Annual Medicines Audit completed by Clinical Boards and reported to UHB Medicines Management Group.

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** The Medicines Code
- **APPROVAL** of the withdrawal of 13 policies/procedures on page 3.
- **APPROVE** the full publication of the Medicines Code in accordance with the UHB Publication Scheme.

11.3

SITUATION

Currently in Cardiff and Vale UHB, there are a significant number of medicines and/or medicines related policies and procedures. They are often difficult to find, most have a section on responsibilities and governance which can be repetitive and some have passed their revalidation dates. In order to improve the availability of up to date evidence based medicines management policy and procedural guidance and ensure alignment to Welsh Government advice, Pharmacy who have responsibility for most policy and procedural guidance relating to medicines have reviewed and updated all current guidance available and drafted The UHB Medicines Code.

The document supports the UHB Strategy to avoid waste, minimise harm and reduce variation. It also supports Health Care Standard 2.6 Medicines Management ensuring people are given medication for the correct reason and receive the right medication, at the right dose and the right time.

BACKGROUND

Following the publication of the Trusted to Care Report (2014), subsequent Welsh Government spot checks of hospitals throughout Wales and the introduction of the Medicines Administration, Recording, Review, Storage and Disposal (MARRS) work stream, Cardiff and Vale University Health Board has conducted a full review of its medicines related policy and procedures. Trusted to Care and the MARRS work demonstrated a lack of knowledge of medicines policy and procedure within health care staff groups. Welsh Government produced the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (MARRS Policy), this policy was ratified in November 2015. Welsh Health Boards were subsequently required to review all their medicines related policies and procedures and align to the all Wales document. Following this review and after conducting a benchmarking exercise with other Welsh Health Boards, Cardiff and Vale has developed The UHB Medicines Code.

ASSESSMENT

Wide consultation has taken place to ensure that the policy/procedure meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was shared with all the Clinical Boards, Members of the UHB Nursing and Midwifery Board and Members of the UHB Medicines Management Group
- Comments were invited via individual e-mails from all groups these were fed back via Nurse Advisor Medicines Management.

11.3

Where appropriate comments were taken on board and incorporated within the draft document.

The monitoring and review of the document will be undertaken by the UHB Medicines Management Group.

The primary source for dissemination of this document, The Medicines Code, within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site

Supporting Information

All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal is available on the following link:

<http://www.awmsg.org/docs/awmsg/medman/All%20Wales%20Policy%20for%20Medicines%20Administration,%20Recording,%20Review,%20Storage%20and%20Disposal.pdf>

QSE is asked to approve the Medicines Code in place of the following out of date medicines related policies and procedures and those requiring revision. These will be removed from publication on approval of the Medicines Code:-

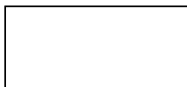
- Policy for Safe and Secure Handling of Medicines
- Ordering Storage, Disposal, Safe Prescribing and Administration of Controlled Drugs.
- Prescribing for Staff Procedure.
- Medicines reconciliation Procedure.
- Covert Administration of Medicines Policy
- Access to Medicines When Pharmacy is Closed procedure
- Disposal of Medicines Procedure
- Management of Staff involved in Medication Errors Procedure
- Patient Orientated Medicines Procedure.
- Potassium Injection Prescribing, Ordering, Storage and Administration
- Procedure for Safe Administration of Medicines to patients with Swallowing Difficulties.
- Provision of Discharge Prescriptions When Pharmacy is Closed.
- Safe Administration of Medicines in Secondary Care.

A Primary Care Supplement is also being developed.

An Equality and Health Impact Assessment is being completed for the Medicines Code.

11.3

Medicines Code Version 1



THE MEDICINES CODE

Date to be reviewed:	August 2019	No of pages:	116
Author(s) title: Medicines Management Group. Pharmacy.	Director Pharmacy and Medicines Management. Lead Pharmacist Quality and Safety. Nurse Advisor Medicines Management.		
Responsible dept / director:	Pharmacy		
Approved by:	C&V UHB Medicines Management Group		
Date approved:			
Endorsement by:	C&V UHB Medicines Safety Executive C&V UHB Nursing and Midwifery Board.		
Date endorsed:			
Date activated (live):			

Date EQIA completed:	Infection prevention and control
Documents to be read alongside this policy:	Infection Prevention and control All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal. Cardiff and Vale Good Prescribing Guide. Management of Parenteral Cytotoxic Chemotherapy. Extravasation Policy NMC Standards for Medicines Management. Patient ID Policy

First operational:					
Previously reviewed:					
Changes made yes/no:					

PROPRIETARY INFORMATION

This document contains proprietary information belonging to the Cardiff and Vale University Health Board. Do not produce all or any part of this document without permission from the C&V UHB

Index:

Any questions or enquiries relating to the Medicines Code should be emailed to welshmedicines.information@wales.nhs.uk under the subject heading Medicines Code

Chapter 1 Introduction to the Hospital's Medicines Code	8
Introduction	8
Purpose of the Medicines Code	8
Scope	8
Standard Operating Procedures (SOP).....	9
1.1 Classification of medicines.....	9
1.2 Corporate Health Board Responsibilities	11
Chapter 2 Operational Responsibilities for All Professional Staff.....	12
2.1 Responsibility of the Director of Pharmacy and Medicines Management.....	12
2.2 Responsibility of the Executive Nurse Director and Clinical Board Nurse Director	13
2.3 Responsibility of the ward sister/charge nurse/clinical lead.....	14
2.4 Responsibility of Individual Health Care professionals involved in the Medicines	14
2.5 Responsibility of Prescribers.....	14
Chapter 3 Medicines Audit, Suspected Fraud and Suspected Theft	15
3.1 Monitoring and audit	15
3.2 Risk management and patient safety initiatives	15
3.3 Anti theft and fraud culture	16
3.4.2 Suspected fraud in respect of medicines.....	16
Chapter 4 - Prescribing Medicines	18
4.1 Prescribing medicines	18
4.2 Persons authorised to prescribe medicines	18
4.2.1 Dietetic products	19
4.3 Prescribing guidance	19
4.3.1 Formulary and non-formulary medicines.....	19
4.3.2 Unlicensed medicines	19
4.3.3 Off License / Off Label medicines	19
4.3.4 Anti cancer medicines	19
4.3.5 Controlled Drugs	19
4.3.6 Intravenous (IV) and parenteral medication.....	20
4.4 Prescription writing.....	20
4.4.1 Handwritten one word prescriptions.....	20
4.4.2 Computer generated prescriptions.....	20
4.5 Prescribing competence.....	20

Cardiff and Vale
University Health Board

4.6 Prescription documentation	20
4.6.1 In-patient medication administration record (prescription chart).....	21
4.6.2 Variable routes	22
4.6.3 Approved abbreviations for routes of administration.....	23
4.6.4 Further guidance	23
4.6.5 Dose frequency	23
4.6.6 When required medicines (<i>pro re nata/ p.r.n.</i>).....	23
4.6.7 Discontinued medicines	24
4.6.8 Care pathways and the use of pre printed prescriptions and/or pre printed labels	24
4.7 Medicines Reconciliation	24
4.8 Prescribing for patients with swallowing difficulties or patients with naso-gastric or gastrostomy tubing	28
4.9 Out-Patient prescribing.....	28
4.10 Prescription amendment in order to correct individual in-patient prescriptions.....	29
4.11 Validity of an in-patient prescription	29
4.12 Validity of out-patient prescriptions	30
4.13 Prescribing for discharge (To Take Home).....	30
4.14 MTeD	30
4.15 Leave medication	31
4.16 Discharge of patients from community hospitals.....	31
4.17 Faxed prescriptions for discharge (TTHs).....	31
4.18 Prescribing for relatives and visitors of in-patients	31
4.19 Verbal prescriptions to nursing staff - prescribing by telephone.....	32
4.20 Verbal prescriptions to pharmacists – corrections by telephone	34
4.21 Controlled Drug prescribing.....	34
4.22 Prescribing for Controlled Drug Dependency	34
4.27 Prescribing medicines which carry a black triangle symbol in the BNF	34
4.28 Prescribing medicines for which the Patient Safety Wales (and former NPSA) has issued safety concerns.....	35
4.29 Prescribing for patients detained under 'The Mental Health Act'	35
4.30 Patient Group Directions (PGDs)	35
4.31 Prescribing for staff who are unwell at work	35
Chapter 5 - Ordering of Medicines.....	37
5.1 Ordering ward stocks of medicines	37
5.1.1 Stock control	37
5.1.2 Ordering ward stock (WOREQ)	37

Cardiff and Vale
University Health Board

5.1.3 Documentation	38
5.1.4 Order assembly and transfer.....	38
5.2 Receipt of medicines on the ward or unit	38
Chapter 6 - Control and Storage of Medicines.....	39
6.1 Storage of medicines	39
6.1.2 Stock medicines in clinical areas.....	39
6.1.3 Patient's Own Drugs	39
6.1.3.1 Storage of Patient's Own Drugs	39
6.1.4 Suspicious substances or suspected illicit materials.....	40
6.1.5 Medicines cupboards and trolleys	40
6.1.6 Medicines refrigerators.....	41
6.1.7 Storage of medicines in intensive care, high dependency and coronary care units and recovery rooms.....	41
6.1.8 Epidural levobupivacaine bags	41
6.1.9 Emergency boxes, anaphylaxis kits and hypo (hypoglycaemia) boxes	41
6.1.10 Medicines and Health and Safety	42
6.1.11 Storage of Controlled Drugs.....	42
6.1.12 Storage of medicines by community nurses.....	43
6.2 Security of medicines.....	43
6.2.1 Custody of keys controlling access to medicines.....	43
6.2.1.1 Pharmacy	43
6.2.1.2 Wards	43
6.2.2 Custody of Controlled Drugs	43
6.2.3 Discrepancy or misappropriation of medicines.....	44
6.2.4 Apparent loss of medicines in clinical area	44
6.2.5 Apparent loss within the pharmacy	44
6.2.6 Dispensing errors discovered on a ward	44
6.2.7 Samples of medicines left by pharmaceutical representatives	45
6.3 Transport of medicines	45
6.3.1 Storage conditions in transport	43
6.3.2 Packaging for transportation	45
6.3.3 Transport documentation	46
Chapter 7 - Administration of Medicines	47
7.1 Persons who are authorised to administer medicines	48
7.1.1 Nurses and Midwives authorised to administer medicines	48
7.1.2 Non-nursing staff authorised to administer medicines	48

Cardiff and Vale
University Health Board

7.1.3 Administration requiring two registrants	49
7.1.4 In the absence of a registered second checker	49
7.1.5 Selection and administration	50
7.1.5.1 Selection of medicines	50
7.1.5.2 Safe Administration of medicines	50
7.1.5.3 Non administration of medicines.swallowing difficulties	51
7.1.6 Administering cytotoxic medication.....	57
7.2 Administration via the route	57
Covert administration.....	58
7.3 Self administration – Patient Orientated Medicines System (POMS)	60
Non Availability	
7.6.1 Non availability during pharmacy department opening hours.....	66
7.6.2 Non availability when pharmacy is closed.....	67
7.6.3 Administration error	68
Chapter 8 - Administration of Intravenous Medicines.....	69
8.1 Professional responsibilities and accountability	69
8.2 Training and competency for IV and other routes of parenteral administration.....	70
8.3 Prescribing intravenous medication	71
8.4 Storage of intravenous medication	72
8.5 Preparation of intravenous medication	72
8.6 Labelling of intravenous medication.....	73
8.7 Infusion devices for Intravenous medication.....	74
8.8 Administration of intravenous medication.....	74
8.9 Patient monitoring with intravenous medication	75
8.10 Infection control and personal protective equipment.....	75
8.11 Disposal of waste material.....	76
8.12 Responsibilities of the pharmacist and the pharmacy department.....	76
8.13 Identifiable risks with intravenous medication	76
Chapter 9 - Controlled Drugs	78
9.1 Accountability.....	78
9.2 Roles and responsibilities	78
9.3. CONTROLLED DRUG STATIONERY.....	79
9.4. STORAGE OF CONTROLLED DRUGS	80
9.5. ORDERING AND DELIVERY of CONTROLLED DRUGS	81
9.6. EMERGENCY SUPPLY OF CONTROLLED DRUGS	82
9.7. RETURN OF CONTROLLED DRUGS TO PHARMACY	83

Cardiff and Vale
University Health Board

9.8. PRESCRIBING CONTROLLED DRUGS	85
9.9 ADMINISTRATION of CONTROLLED DRUGS	87
9.10. DISPOSAL/DESTRUCTION OF CONTROLLED DRUGS	88
9.11. CONTROLLED DRUG REGISTERS AND RECONCILIATION OF	89
9.12 USE OF A PATIENT'S OWN CONTROLLED DRUG ON THE WARD	90
9.13. CONTROLLED DRUG DISCHARGE MEDICINES (TTHs) AND RECEIPT OF CONTROLLED DRUGS BY OUTPATIENTS	91
9.14. TRANSFERS BETWEEN CLINICAL AREAS	92
9.15. CONTROLLED DRUGS FOR MIDWIVES	93
9.16. RECEIPT AND HANDLING OF CONTROLLED DRUGS BY PHARMACY	93
9.17. TRANSFER OF CONTROLLED DRUGS USING MESSENGERS	94
9.18. CONTROLLED DRUGS WITHIN ANAESTHETIC ROOMS	95
Chapter 10 – Return, Disposal and Destruction of Medicines	96
10.1 Return of excess or unwanted medicines	96
10.1.1 Acute and community hospitals	96
10.1.2 Community nurses	96
10.1.3 Medicines brought into hospital by patients	96
10.2 Disposal of cytotoxic medicines	96
10.3 Disposal of Controlled Drugs	97
10.4 Disposal of part used syringes and injections	97
10.5 Disposal of medicines by the pharmacy	97
Chapter 11 - Defects, Hazards, Adverse Reactions and Incidents Involving Medicines	98
11.1 Losses and discrepancies	98
11.2 Management of medication errors	98
11.2.1 Action to be taken in event of medication error	98
11.2.2 Reporting a medication error	99
11.2.3 Serious medication errors	99
11.3 Near misses	100
11.4 Medicines Safety Executive a sub group of the Corporate Medicines Management Group	100
11.5 Management of staff involved in medication errors	101
11.6 Reporting and recording adverse drug reactions and defective medicinal products	102
11.6.1 Defective medicinal products	102
Chapter 12 - Unlicensed Medicines and Unlicensed Indications	103
12.1 What is a product licence?	103
12.2 Healthcare professionals' responsibilities in prescribing, supplying and administering medicines	104
12.3 Monitoring and Recording	106

Cardiff and Vale
University Health Board

12.4 Unlicensed Medicines Risk Assessment Form 106

12.5 Non-Medical Prescribing 106

12.6 Packaging 106

12.7 Prescribing interface with GPs for unlicensed medicines and medicines outside of license 106

Chapter 13 - Medicines in Clinical Trials 108

13.1 Cardiff and Vale Research Review Service (CaRRS) 108

13.2 Clinical trial storage, prescribing and supply 108

13.3 Unblinding a clinical trial medication 109

13.4 Disposal or return of clinical trial medicines 109

Chapter 14 Strong Potassium Injections, Ordering, Storing, Prescribing and Administration 110

Chapter 15 Storage of Records Relating to Medicines 111

Resources 113

Glossary 114

Chapter 1 Introduction to the Hospitals Medicines Code

Introduction

Cardiff and Vale University Health Board (C&V UHB) is committed to the safe and secure handling of medicines to protect its patients, staff and visitors, and its financial resources. This Medicines Code updates and replaces previous Medicines Policies and Procedures used in Cardiff and Vale Hospitals. Cardiff and Vale's Pharmacy Directorate prepared the Medicines Code which was then approved by the C&V UHB Medicines Management Group and the Nursing and Midwifery Group, and ratified by the C&V UHB Quality, Safety and Experience Committee.

Purpose of the Medicines Code

The purpose of this Medicines Code is to set out a clinical and corporate governance framework to promote safe and secure systems for the controlling and handling of medicinal products in the hospitals and clinics operated by the C&V UHB as part of an overall medicines management process.

Guidance on safe and appropriate prescribing has been considered and disseminated through the Medicines Code by the C&V UHB Medicines Management Group. In general, medicines need to satisfy tests of clinical and cost effectiveness and use should be justifiable on grounds of safety, given the alternative therapies available and the circumstances of the patient.

In addition to this Medicines Code, healthcare professionals must abide with the current version of their relevant professional bodies' Policies, Standards and Codes of Practice. If extreme circumstances arise such that this Code cannot be applied then the prime consideration will be the safe and effective treatment of any patient concerned. However, if any deviation from the Code occurs, those staff involved must document all alternative measures taken in the appropriate records and inform senior professional staff.

Scope

This Medicines Code with the underpinning principles of legal, quality and safe practice, applies to all doctors, nurses, pharmacists and other health care professionals across C&V UHB involved in the ordering, supply, storage, prescribing, administration and disposal of medicines. The medicines include Prescription Only Medicines (POMs),

Cardiff and Vale
University Health Board

Pharmacy Medicines (P), General Sales List Medicines (GSL) and Controlled Drugs (CDs). The Code also includes complementary medicines, pharmaceuticals (non-therapeutic items) which include certain medical devices traditionally supplied through hospital pharmacy departments.

Standard Operating Procedures (SOP)

Each Clinical Board may develop and implement SOPs describing safe working practice for aspects of work conducted within their Clinical Board. If an SOP involves medicines, or aspects of medicine usage, across a multi-professional area Doctors/Nurses Pharmacists, the SOP must be approved first by the Clinical Board and then by the C&V UHB Medicines Management Group.

1.1 Classification of medicines

Medicines are considered as two main sub-groups, Controlled Drugs and Medicines.

a) Controlled Drugs

Controlled Drugs are those drugs classified under the 'Misuse of Drugs Act 1971', and its associated regulations.

b) Medicines

Medicines will be taken to be all substances defined under the Medicines Act as being medicinal products. These include those restricted to supply on prescription (POM), those that can only be sold from a Pharmacy (P), and those that can be sold at any establishment, General Sales List medicines (GSL). Unlicensed medicines do not have a United Kingdom Product License.

c) Complementary medicines

The principles adopted for the use of medicines will also be followed for complementary medicines.

d) Pharmaceuticals

The term "pharmaceuticals" will be used to describe those non-therapeutic items covered by the policy (e.g. disinfecting and sterilizing agents). It will also include certain devices carrying a CE mark traditionally supplied by pharmacy.

e) Black triangle medicines are newly introduced medicines, subject to intensive monitoring for potential side effects by the European Medicines Agency (BNF) and Medicines and Healthcare Products Regulatory Agency (MHRA) (identified by ▼ in the British National Formulary).

f) Medicines used outside product license are medicines used in a manner,

Cardiff and Vale
University Health Board

indications, which are outside the as defined in the Summary of Product Characteristics (SPC). Eg different dose, indication, administratin route.

- g) Specials** are unlicensed medicines that do not have a product license and are usually commissioned from a licensed manufacturing unit at the request of a prescriber, or by a pharmacist acting on behalf of that prescriber.
- h) Medicines which do not have a UK product license (unlicensed medicines).** Usually obtained on a named patient basis.

Fgh – see ch 12

1.2 corp resp

1.2 Corporate Health Board responsibilities

a) Chief Executive

The Chief Executive has overall responsibility for medicines management in C&V UHB.

b) Medical Director

The above responsibility is delegated to the Health Board's Medical Director, supported by the C&V UHB Medicines Management Group.

c) Director of Pharmacy and Medicines Management

The Director of Pharmacy and Medicines Management is responsible for organising, monitoring and reporting on medicines' management, its systems and procedures.

Chapter 2 Operational Responsibilities for All Professional Staff

2.1 Responsibility of the Director of Pharmacy and Medicines Management

The Director of Pharmacy and Medicines Management is responsible for ensuring that there are sufficient systems in place for the following:

- Providing a safe, effective, efficient and secure system for medicine stocks held within pharmacy. The Health Boards Pharmacies.
- Providing a safe, effective, efficient and secure system for medicine distribution.
- Providing a system for monitoring ward medicine usage and advising on appropriate stock range and stock holding levels.
- Providing advice on medicines and controlled drug security.
- Providing advice on appropriate environmental storage conditions.
- Providing advice on safe and proper means of disposal of unused/unwanted medicines.
- Providing advice on safe and effective systems and arrangements for medicine administration. This includes commenting and advising on medicine administration errors and near misses reported via the DATIX Incident Reporting system.
- Providing advice on transport of medicines and other pharmaceuticals.
- Providing a system, when the pharmacy is closed, of access to emergency medicine stocks and the availability of a pharmacist for emergency duties.
- Where a pharmacy led stock control service is provided there is a shared responsibility between the ward/unit ward manager/clinical lead and the clinical board of pharmacist
- Providing advice on clinical pharmacy services and ensuring that there is consistency of approach such that prescriptions are monitored and appropriate action taken to ensure effective use of resources.
- Ensuring that there are adequate mechanisms in place to monitor and report on the usage on medicines throughout the Health Board and to devise strategies to promote cost effective prescribing.
- Ensuring that there are systems in place with the use of medicines throughout the Health Board.
- Ensuring medicines are held to meet the need of hospitalized patients and immediate response to civilian emergency.

Each Clinical Board will have an assigned Clinical Board Pharmacist who has a delegated responsibility for implementation of the above.

The Director of Pharmacy and Medicines Management is charged with the responsibility for medicines management throughout C&V UHB. This includes ensuring pharmacy representation on local medical devices committees to ensure safe usage of infusion systems and devices within C&V UHB

2.2 Responsibility of the Executive Nurse Director and Clinical Board Nurse Director

The Executive Nurse Director and Clinical Board Nurse Directors are responsible for ensuring that systems are in place within wards and departmental clinics to facilitate the processes within the medicines code and that information guidance within this medicines code is available to staff and adhered to.

- The ordering of medicines and pharmaceuticals.
- The appropriate storage (physical and environmental conditions of medicines and pharmaceuticals).
- The administration of medicines including patients' own medicines other than those administered by a doctor
- The recording of administration of medicines.
- The security of medicines and prescription forms.
- The supply of medicines to patients in accordance with Patient Group Directions (PGDs)/ Patient Specific Directions (PSDs).
- The reporting of medicines related incidents and errors via the DATIX Incident Reporting System.
- The safe and proper disposal of unused/unwanted medicines and pharmaceuticals.
- The retention of documents relating to the ordering, storage and administration and supply of medicines.
- The induction of new staff with respect to informing them of the Health Boards' Medicines Code
- The education and training required to enable nurses to comply with this Medicines Code and for ensuring that a copy is readily available to staff.

2.3 Responsibility of the ward manager /clinical lead.

- The ward manager/clinical lead, will have joint responsibility with the pharmacy directorate for the ordering system where there is a pharmacy provided led stock control service.
- The ward sister/charge nurse/clinical lead is responsible for the secure storage of medicines in their area.

2.4 Responsibility of Individual health care professionals involved in the medicines management process

Each individual health care professional is responsible for:

- Reading and understanding this Medicines Code.
- Complying with this Medicines Code and their own regulatory bodies, guidance, standards policies etc. of their own
- Ensuring they have the required qualifications, competence and/or authority to complete the tasks.
- Maintaining the security of medicines within their practice area.

2.5 Responsibility of prescribers

Medical and non medical prescribers will practice in accordance with local procedures and guidance and will comply with their respective professional Code of Practice.

Chapter 3 Medicines Audit, Suspected Fraud and Suspected Theft

3.1 Monitoring and audit

As part of the responsibility for delivery of the medicines' management process, the Director of Pharmacy and Medicines Management will ensure that the following explicit, written, quality standards are prepared and regularly audited as part of the C&V UHB audit cycle:

- The process of prescribing of medicines in C&V UHB hospitals
- The appropriateness of medicines prescribed for individual patients including license status and adherence to agreed therapeutic guidelines.
- The preparation of parenteral medicines. This will include all C&V UHB hospital clinical areas as well as the main pharmacy department.
- The clinical pharmacy review of prescriptions and dispensing of medicines.
- The administration of medicines to patients.
- The supply of medicines to take home and the counseling of patients about those medicines.
- The reporting of medication errors.
- Medicines administered for clinical research and drug trials.

3.2 Risk management and patient safety initiatives

The Director of Pharmacy and Medicines Management and/or the Medicines Safety Officer will lead on safe medicines practice within the Health Board. This will be via The Medicines Safety Executive (MSE) a multi professional sub group of the UHB's Corporate Medicines Management Group. The MSE will maintain clear and identified links with the UHB Patient Safety Team

The Director of Pharmacy and Medicines Management, MSE and Pharmacy Management Team will actively participate in patient safety initiatives e.g.

1,000 Lives Plus

The Director of Pharmacy and Medicines Management or a senior member of the Pharmacy Management Team) will hold responsibility for communication and liaison with the Welsh Risk Pool and Patient Safety Wales on medicines safety

Cardiff and Vale
University Health Board

and risk issues

The risks inherent in medicines management and the effectiveness of risk control measures must be monitored and reviewed on a continual basis.

Senior Management, both within Pharmacy and C&V UHB, must be informed of any significant risks and risk control measures.

Medication incidents should be regularly monitored and issues of significance reported to the C&V UHB Safety and Standards Committee via the Medicines Safety Executive (MSE).

3.3 Anti theft and fraud culture

C&V UHB has a zero tolerance anti fraud and theft culture and is committed to the principle that the NHS resource of medicines is always put towards the patient in need of that prescribed medicine. C&V UHB will seek to reduce medicine losses from theft and fraud to an absolute minimum by sanctions against those determined to steal or defraud the NHS. Possible sanctions may include criminal, civil or disciplinary proceedings, and C&V UHB will seek to recover the cost of stolen or defrauded medicines. Incidents involving members of staff, patients or visitors that are suspected to have stolen C&V UHB medicines or prescription forms pads, must be reported through a clinical incident entry completed by the senior nurse or senior pharmacist on duty. The local security manager must be notified – how to access this person.

The directorate lead nurse and/or directorate pharmacist may conduct initial enquiries and then, should matters proceed to an investigation, the local security manager will then take responsibility for any subsequent investigation of alleged theft. The security manager will liaise with South Wales Police and the human resources manager as appropriate.

11.3

3.4.2 Suspected fraud in respect of medicines

Some examples of NHS medicine and prescription frauds are as follows:

- Falsified medicine stock records
- Falsified orders for medicines
- Prescription fraud e.g. forged signatures and/or false representation by the patient for medicine not prescribed by an authorised NHS prescriber
- Self prescribing
- Prescribing for family members or friends

Cardiff and Vale
University Health Board

- Prescribing for those who are not entitled to be prescribed NHS medicines e.g. foreign nationals who are not entitled to NHS treatment

This list is not exhaustive and those determined to commit fraud may develop new and sophisticated methods to avoid detection.

If an alleged theft involves suspected fraud, the Medicines Safety Executive and/or the Security Manager will refer the incident to the Local Counter Fraud Specialist of C&V UHB.

Chapter 4 - Prescribing Medicines

4.1 Prescribing medicines

All prescribing must be on C&V UHB approved prescription stationery before supply or administration to patient may occur. In strictly defined situations e.g. via a Patient Group Direction, homely remedy guidance/discretionary medicine, a verbal order, in role as a midwife, or the use of specified parenteral medicines for the purpose of saving life in an emergency a prescription it is not necessary to authorise administration (see chapter 16 for list of medicines).

Each prescriber has a duty of care when issuing prescriptions to patients, to ensure that they are issued appropriately to patients under their care.

Prescription forms and pads are controlled stationery and therefore must be stored in accordance to the C&V UHB guidance.

Each prescriber is responsible for the safe storage of any blank prescription forms and pads issued to them. Should blank forms or pads be lost, they must inform their line manager must be immediately informed and an investigation be instigated

4.2 Persons authorised to prescribe medicines

Only those employed by C&V UHB or working under a service level agreement (or contractual arrangement) and legally authorized to prescribe e.g. doctor, dentist, registered non-medical prescribers (NMPs), may prescribe medicinal products.. Non-medical prescribers must have gained sign off from their appropriate line manager and in the case of a nurse or midwife NMP sign off from the appropriate Clinical Board Nurse Director. NMP's must also be registered on the C&V UHB NMP database before prescribing within their area of competence. Provisionally registered doctors (FY1s) may only prescribe in connection with their employment with C&V UHB and cannot prescribe for out-patients. Medical students cannot prescribe, but may write prescriptions to acquire and demonstrate competency. This must be under direct supervision, with the prescription being countersigned immediately by an approved prescriber.

Dentists are required by their registration to restrict their prescribing to their areas of competence.

4.2.1 Dietetic products

Whilst Dietetic products are not medicines, however dietitians can initiate formulary dietetic products by writing them on the patient's in-patient meds admin prescription chart or a C&V UHB approved nutrition chart. They should endorse any item not to be continued at discharge as 'For in-patient use only'. This avoids inadvertent long term continuation.

4.3 Prescribing guidance

4.3.1 Formulary and non-formulary medicines

All newly initiated medicines for both in and out-patients should be prescribed from the approved formulary list.

Patients admitted on most non-formulary medicines will be continued on these medicines, but in certain situations pharmacy will agree substitution with an alternative formulary item in accordance with a local procedure approved by the C&V UHB Medicines Management Group.

If a non formulary medicine is needed for treatment of an in-patient the patient's own medicine supply should be used as a first option. If/when a further supply is needed a medicines review should be undertaken and medicines swapped to formulary items where appropriate.

4.3.2 Unlicensed medicines

See Medicines Code: Chapter 12.

4.3.3 Off License / Off Label medicines

See Medicines Code: Chapter 12

4.3.4 Anti cancer medicines

The prescribing of cancer medication is limited to authorised prescribers in C&V UHB. Full Guidance can be found in the Management of Parental Cytotoxic Chemotherapy Policy.

4.3.5 Controlled Drugs

See Medicines Code Chapter 9

4.3.6 Intravenous (IV) and parenteral medication

See Medicines Code Chapter 8

4.4 Prescription writing

4.4.1 Handwritten prescriptions

Each prescription must be legal, legible, unambiguous and written or printed in indelible ink that can be photocopied. Upper or lower case may be consistently used.

A simple test for legibility is for another person who is unfamiliar with the prescriber's handwriting to read it without difficulty.

4.4.2 Computer generated prescriptions

The planning, development and implementation of any electronic prescribing system must be approved by the C&V UHB Medicines Management Group.

Different electronic prescribing systems may exist within C&V UHB. Electronic prescribing will be limited to prescribers trained in use of the particular system. Once a prescriber is enabled as a user, access will be via individual Nadex log on. Prescribers must adhere to the C&V UHB IT information technology policies.

4.5 Prescribing competence

All authorized prescribers must ensure they have appropriate knowledge and experience to prescribe competently in their area of practice. Knowledge of the "Guidance on Prescribing" sections in the current British National Formulary and the UHB Good Prescribing Guide is essential. Completion of the e-prescribing training package for the All Wales In-Patient Medication Administration Record is mandatory

4.6 Prescription documentation

Permanent changes to prescribed medicines must be noted within the patient record along with the indication for treatment or reason for stopping treatment (e.g. ineffective / side effects).

4.6.1 In-patient medication administration record (prescription chart)

The All Wales In-Patient Medication Administration Record is to be completed in accordance with the instructions for this task. (See prescribing e-learning package on Learning@nhs.wales).

The following patient details must be entered:

- Name
- Address
- Unit number and NHS number when practicable
- Date of birth
- Name of consultant
- Weight (as soon as practical)
- Medicine sensitivity (allergies)

Cardiff and Vale
University Health Board

A pre-printed addressograph label should be used whenever possible and attached to the prescription chart or form before other details are added.

If more than one chart is in use "1 of 2" etc. must be written.

The clerking doctor must complete the drug/allergen section on admission, even if no allergies are known; this must be signed and dated. An allergy record in medical clerking notes is not sufficient. The medicine(s) in question must be specified and the type of allergy noted or the 'none known' box signed and dated. Medication must not be administered until this section is completed.

A doctor, nurse, pharmacist or a pharmacy medicines management technician can complete the allergy section at a later stage if an allergy is subsequently discovered or the detail is initially incomplete.

The weight of the patient must be entered for all paediatric patients and for patients where medicine dose adjustments by weight will be made.

If an additional specialist chart is in use e.g. warfarin, insulin or other options, as shown on the front of the All Wales In-Patient Medication Administration Record, it must be indicated on the main chart.

The following medication details must be entered:

- Route of administration
- The recommended International Non-Proprietary Name (rINN) (i.e. the approved / generic name) of the medicine should be written legibly using either upper or lower case.
- Proprietary names (i.e. brand names) may only be used for multi-ingredient preparations with no approved name, for products whose proprietary name defines a specific formulation (e.g. slow release theophylline preparations, certain creams and ointments) or for safety reasons to avoid miss selection of product (e.g. OxyNorm^(R) and OxyContin^(R)) or bioavailability (e.g. Neoral^(P) and Sandimmun^(R)).

Medicine names must not be abbreviated e.g. [MTX, MMT, ISMN, GTN, FeSO₄ are not acceptable].

The date on which the treatment is to commence must be entered on the prescription chart. If rewritten, the *original* start date, not the rewrite date is used.

4.6.2 Variable routes

Medicines for administration by variable routes in certain circumstance can be

Cardiff and Vale
University Health Board

prescribed once on the prescription chart indicating the routes e.g. PO/IV but only where the doses by each route are the same e.g. metoclopramide. When the doses by each route are different e.g. prochlorperazine, each route required must be prescribed individually.

4.6.3 Approved abbreviations for routes of administration

IM intramuscular
INH inhalation
IV intravenous
NEB nebulisation
PO /O oral
PR rectal
PV vaginal
SC sub-cutaneous
S/L sub-lingual
Top topical.

Other routes of administration should be written in full.

Intrathecal must always be written in full ref to IT policy).

4.6.4 Further guidance

Further guidance on prescribing, how doses should be expressed, permitted terminology and the use of multiple charts, refer to the C&V UHB can be found within Good Prescribing Guide and the British National Formulary section on prescribing.

11.3

4.6.5 Dose frequency

For regular medication the prescriber should preferentially use the pre-set medicine round times to indicate administration time, The 24-hour clock must be used when specific timings are needed e.g. for antibiotics to space doses evenly through 24 hours, or for frequent dosage regimen used in Parkinsonism.

4.6.6 When required medicines (*pro re nata/ p.r.n.*)

For “when/as required” medicines. Full details of the directions for administration in Medicine Code November 2017

Version: 1

Page 23

Cardiff and Vale
University Health Board

frequency of a for when 1 as required meds must be recorded. The time or frequency of administration and maximum dose in 24 hours must be stated e.g. cyclizine 50mg p.r.n. is not acceptable. This should be written "cyclizine 50mg every 6 – 8 hours p.r.n., MAX 150mg in 24hours

Temazepam 10mg p.r.n. is not acceptable. Likewise "Temazepam 10mg p.r.n. at night for sleeping" is acceptable.

4.6.7 Discontinued medicines

A diagonal line must be drawn through the prescription so that cancellation is obvious, but the prescription is not obliterated. This should be signed and dated. In some cases a large 'Z' or a can be used as an alternative to a diagonal line and this should be signed and dated.

4.6.8 Care pathways and the use of pre printed prescriptions and/or pre printed labels

Certain patient pathways include pre-printed prescription details and/or pre printed labels that are used where there is a need for clarity when prescribing complex regimens, or to provide a safe and complete package of care. Examples are insulin regimens where there is dosage titration dependant upon blood glucose results, and in post operative pain relief for parenteral or epidural opioid analgesia. Before use in C&V UHB, all pre-printed prescriptions or labels must be approved by the C&V UHB Medicines Management Group.

The prescriber is responsible for placing the prescription label on the patient's chart and must sign and date the prescription in order to authorise its use. The signed chart becomes a Patient Specific Direction (PSD). Medication must not be administered until there is an authorised prescriber's signature present.

4.7 Medicines Reconciliation

To assist in the medicines reconciliation process it is requested that all patients are admitted from primary care with sufficient information about their medication and medical history. This information is referred to as the minimum data set.

It is understood that patients presenting directly to the Emergency Unit may not bring this information with them, but it should be obtained from their relative, carer or GP's surgery at the earliest opportunity.

The doctor's responsibilities on admission:

On admission to hospital it is the admitting doctor's responsibility to:

- Take a medication history from the patient, and/or carer to the best of their ability and using the information sources available to them at that time, including the ambulance handover sheet.
- Document this on the medicines assessment form and include this with the admission documentation in the patient's medical notes.

Use the medicines assessment form to document any intentional changes to regular medication made on admission and during the patient's hospital stay i.e. stopped (with reason), held (with intended review date) or amended (with reason).

- Annotate the medicines assessment form indicating the sources used to find the medication history, the name, signature and bleep number of the admitting doctor.

Write a inpatient medicines administration record prescription chart for the patient's hospital stay.

- Respond promptly (within 24 hours) to any amendments or discrepancies highlighted by the pharmacy team on the medicines assessment form; update the patient's prescription chart as necessary.

It is understood that the quality and accuracy of the initial medication history may be limited, particularly outside of normal working hours, owing to lack of access to key information sources e.g. GP records. Every effort should be made to obtain this information e.g. using the patient's individual health record (IHR). Any inaccuracies and incomplete information must be rectified as soon as possible.

The pharmacy team's responsibilities on admission:

- On admission to hospital it is the pharmacy team's responsibility to:
- Check the medication history documented on the medicines assessment form by the doctor using at least one reliable source (preferably two). This can include sources previously accessed by the doctor.
- Reconcile the patient's medications by comparing the medication prescribed on the drug chart to the medication history, ensuring that any omissions or changes are intentional by referring to the medicines assessment form.
- If changes and omissions have been made without reference to them on the medicines assessment form then an explanation and rationale will be requested from the doctor in charge of the patient's care and documented on the medicines assessment form for future reference.

Cardiff and Vale
University Health Board

- Any medication found to be required but not documented in the medication history obtained by the doctor will be documented on the medicines assessment form so that it is accurate and complete. These discrepancies will be communicated to the doctors in an appropriate and timely manner for their attention and appropriate action.
- Document which doctor the information has been relayed to and their bleep number.
- The pharmacist will sign and annotate the form with their name and contact/bleep number against the entries they have made.
- When the medicines assessment form is accurate and complete, and prescribers have made any changes as appropriate to the drug chart then a full medicines reconciliation has been completed.

This should normally be carried out within 24 hours of admission except at weekends when there may be a delay of up to 72 hours. This would normally fit with likely access to GP records.

On confirming the drug history, the drug history section on the front of the drug chart must be signed and dated documenting the sources used.

When all medications have been successfully reconciled, the medicines reconciliation section on the front of the drug chart must be signed and dated by the pharmacist.

Any further changes to medication during a patient's hospital stay must be documented in the medical notes with a clear explanation of the reasons for change.

If a pharmacy technician finds any discrepancies when completing a POMS check then these should be highlighted to the pharmacist for action.

Where appropriate, discrepancies and action to be taken should be communicated to the nurse looking after the patient.

11.3**The nurses' responsibilities:**

Ensure all medicines supplied for a patient are held securely, are accessible, and are transferred with the patient. Medicines brought into hospital are the patient's personal property and should be dealt with accordingly.

Medicines reconciliation issues may be picked up whilst administering the patient's medication. Any discrepancies should be discussed with the doctor and/or pharmacist.

Any outstanding issues on the medicines assessment form should be prompted for review.

Cardiff and Vale
University Health Board

As part of the discharge process nursing staff should go through the discharge medication with the patient and/ or carer to make sure they are aware of any changes made during admission.

Any concerns or questions raised by the patient/carers must be confirmed by reference to the medicines assessment form or referred to the doctor.

On Discharge:

When the patient is discharged it is important to communicate information about medication changes to the patient's GP. This should be done on **both** the discharge prescription ("To Take Home" or TTH form, e-discharge letter or MTeD communication) and the discharge summary by the doctor. This is because there is sometimes a delay in the discharge summary being written or reaching the GP's practice and the TTH form generally reaches the practice sooner.

4.8 Prescribing for patients with swallowing difficulties or patients with naso-gastric or gastrostomy tubing

Some patients are unable to take medication in solid oral dosage forms. A stepwise approach is suggested to choose a suitable alternative:

- If possible, use a licensed medicine in a suitable formulation to meet the patient's needs (e.g. a dispersible tablet or licensed liquid medicine)
- If there is no suitable licensed formulation, consider using a licensed medicine in an unlicensed manner, for example by crushing tablets or opening capsules
- In order to use a licensed medicine, consider switching to a different therapeutic agent in the same class, or to a different route of administration. In most cases a suitable licensed preparation will be available to meet the patient's needs.
- In the few situations where the patient's needs cannot be met by licensed medicines, the use of special-order "unlicensed" products ('specials') may be considered.

Prescribers should be aware that many medicines are not available in a form that can be administered via naso-gastric or gastrostomy tubing. The crushing of a tablet or opening of a capsule changes its licensed status. If a tablet requires crushing or a capsule requires opening to facilitate their administration, the pharmacist should indicate this on the patient's inpatient drug administration chart. In the absence of such directions a pharmacist should be consulted for advice. Alterations that change the licensed status of a medicine must be brought to the prescriber's attention and recorded in writing.

4.9 Out-Patient prescribing

Out-patient prescribing and supply should be minimal, limited to hospital only products or when an urgent clinical need exists. The internal hospital out-patient prescription form HMR 112 (W) can only be dispensed from the hospital pharmacy. Routine and non urgent amendments to medication should be made by the use of a GP prescribing referral form. An 'Outpatient Department GP Medication review' form is available to facilitate this process.

Cardiff and Vale
University Health Board

The WP10 (HP) (or non-medical prescriber {NMP} equivalent) prescription form may only be used in exceptional pre agreed circumstances e.g. clinic held remotely to a hospital pharmacy. This form can be dispensed from community pharmacies. Prescribing quantities should be for short duration of therapy, and regular supply of medicines will be obtained from the patient's GP. The maximum quantity prescribed will usually be not more than one original pack. The WP 10 (HP) or NMP equivalent form must not be used to circumvent any hospital prescribing procedure e.g. non formulary medicine and prescribers need to be aware that data from WP 10 (HP) s or NMP equivalents is audited for compliance. The prescriber must clearly print their name and contact number when using a WP 10 (HP) or NMP equivalent, to enable contact should a query arise from the dispensing community pharmacy.

When medicines are to be prescribed for administration in out-patients they should be written within the patient notes or written on a prescription chart to allow the details of administration to be recorded and signed, include detail of COPPS etc.

4.10 Prescription amendment in order to correct individual in-patient prescriptions

Under an agreed enabling protocol pharmacists may amend in-patient medication records and transcribe GP treatments onto prescription charts for elective and emergency admissions in order to correct and/or clarify prescriber's intentions.

Any pharmacy alteration must be legible, dated, and identify the amending pharmacist by their initials and bleep number for contact. It will specify when appropriate which clinician agreed the amendment.

Where amendments would decrease readability, the prescription will be rewritten and signed by the pharmacist. The nurse is permitted to administer the medicine without a medical countersignature. Where actual or potential clinical reasons exist for omitted items, the item will not be added to chart. If the reason for omission is not documented a note will be left on the in-patient medication record or contact made with the prescriber, depending on the urgency. The pharmacist will not amend anything beyond their experience or competence. Communication with the prescriber is essential to maintain safety and ensure correct treatment.

4.11 Validity of an in-patient prescription

The prescription is valid until stopped by prescriber, administration section is full or patient is discharged. A new medicines record must be written if patient is readmitted.

Cardiff and Vale
University Health Board

The use of a continuation sheet is not allowed when the administration section is full.
Only charts originating within the C&V UHB are valid.

4.12 Validity of out-patient prescriptions

The prescription is valid for 6 months.

Schedule 2, 3 and 4 Controlled Drug scripts are valid for 28 days.

4.13 Prescribing for discharge (To Take Home)

TTH prescriptions or MTED Discharge advice letter should ideally be written 24 hours prior to discharge to avoid delays in dispensing. They may be written by an authorised prescriber from the responsible consultant team, by other medical prescribers covering shifts or by a non medical independent prescriber.

4.14 MTED

The Medicines Transcription and electronic Discharge (MTED) system is a module of the Welsh Clinical Portal which has been implemented across all inpatient wards across Cardiff and Vale UHB. MTED allows for the electronic transcription of a list of patient's medication which contributes to a final discharge advice letter (DAL). The DAL is sent electronically to a patient's GP in any area of Wales automatically when a patient is discharged and is stored on Cardiff Clinical Portal and the Welsh Clinical Portal.

A patient's medication can be transcribed from the chart onto the MTED system by a pharmacy technician, pharmacist or prescriber at any stage during the inpatient stay, inpatient drug administration, depending on the agreed procedure for each ward. On many wards the transcribed medication list is kept up to date by pharmacy during the inpatient stay and must be reviewed by the doctor at discharge when the DAL is prepared. Here, MTED provides a comprehensive list to the GP of all medication continued, started, stopped or withheld while in hospital. It is used during the inpatient stay for ordering of medication both on site and remotely, and any additional information regarding supply in the community can be recorded. On other wards all medication is transcribed at the time of discharge by the prescriber. The final DAL is printed and signed by the prescriber ready for assembly by pharmacy in during opening hours, or ward staff out of hours according to the protocol.

4.15 Leave medication

Leave medication should be ordered as set out above in 4.13 'Prescribing for Discharge'. Where a local procedure exists, and it has been approved by the Clinical Board and if appropriate the C&V UHB Medicines Management Group, medication dispensed and labeled by pharmacy for leave can be supplied to cover the period of time until the patient is readmitted to hospital in accordance with the procedure. Nurses must not dispense medication from ward stock to facilitate supply of leave medication as this is a contravention of Regulations under the Medicines Act.

4.16 Discharge of patients from community hospitals

Community Hospitals will arrange prescriptions for discharge medication as for acute hospitals in

4.13 above. This will ensure a safe process for prescription writing, dispensing and supply of discharge medicines for patients to take home. Supply of discharge medication may be obtained from the local hospital pharmacy or by use of the patients own drugs (PODs) or from a local community pharmacy if a C&V UHB approved procedure is in place.

4.17 Faxed prescriptions for discharge (TTHs)

Faxed discharge prescriptions are not permitted within acute hospitals. In community hospitals, where a POMs system of medicines management is not in operation, discharge prescription supply is usually obtained by sending the original discharge prescription to the local hospital pharmacy for dispensing. In certain circumstances, the use of faxed prescriptions to the local hospital pharmacy may be used to facilitate efficient discharge. Each faxed discharge prescription must be accompanied by a copy of the in-patient medication record. Controlled Drugs cannot be issued from faxed prescriptions, but may be dispensed and supplied only when the original prescription is received and checked against facsimile copy.

4.18 Prescribing for relatives and visitors of in-patients

Relatives and visitors of in-patients may occasionally stay overnight locally or within the hospital. They are responsible for supplying their own medication. When they have not brought their own medication to the hospital and their health may suffer as a consequence they should obtain an emergency supply from a community pharmacy, or if not local to the area, a local GP practice may be willing to prescribe as a temporary resident. The GP Out

Cardiff and Vale
University Health Board

of Hours Service can issue a prescription to a temporary resident, and in certain circumstances attendance for treatment at the Accident and Emergency Department is appropriate.

If relatives cannot leave the hospital, and the consultant team treating the patient agree to take prescribing responsibility, the hospital pharmacy may agree to dispense a prescription written by the hospital team treating the inpatient.

4.19 Verbal prescriptions to nursing staff - prescribing by telephone

Telephoned prescriptions are permitted only in exceptional circumstances when in the nurses' professional judgment, patient safety or care would otherwise be compromised. It is emphasised that verbal orders are only appropriate in exceptional circumstances and are expected to be minimal in number. Exceptional circumstances will mainly be for areas where there are no doctors on site, e.g. Community Hospitals, Minor Injuries Units, and when treatment is needed to urgently relieve symptoms.

Verbal prescriptions can amend, delete or add a prescription item. They cannot be used for controlled drugs. Any refusal by a nurse to accept a verbal prescription must be documented by the nurse.

The following principles for confirmation of prescription should apply:

- The prescriber must be informed of other medicines currently prescribed for that patient
- A verbal order must be received by a nurse and confirmed ideally by a second nurse (except in circumstances detailed in paragraph below).

The prescriber must state:

- The identity of the patient
- The prescriber's identity
- The name of the medicine to be administered (spelt to avoid confusion)
- The dose to be administered
- The route and time to be administered

This information must be given to the first nurse, entered on the in-patient medication record or casualty card and then repeated back to the prescriber by the second nurse.

The nurse taking the verbal message should be familiar with the medicinal product.

When it is not possible for two nurses to be present to receive the verbal order, a second member of staff who may be qualified or non-qualified should be present. Both members of staff involved must sign and date the entry.

Cardiff and Vale
University Health Board

In exceptional circumstances, when a community health professional is working alone and is unable to receive a fax or electronically transferred instruction, the health professional may accept a verbal order from a prescriber to administer an urgent single dose of a medicine until such time as a fax or electronically transferred instruction can be made.

The prescriber must sign the form as soon as possible after giving the verbal order. Where doctors are on site, this must be signed as soon as possible and within the prescriber's shift.

In areas where doctors are not on site, the order must be signed within 72 hours.

Where an Out of Hours service is in operation, the prescriber giving verbal instructions can arrange for a second prescriber to countersign the verbal order

In areas where doctors are not on site doses may be administered for up to 72 hours without the doctor's signature until the verbal instructions are signed by a prescriber.

4.20 Verbal prescriptions to pharmacists – corrections by telephone

Verbal orders can be given by a prescriber to a pharmacist to amend delete or add a prescription item. This need often results from a pharmacist initiated query.

Having confirmed the identity and name of the patient with the prescriber, the pharmacist must confirm the following details:

- The patient hospital number
- Date of birth
- Address
- The medicine name, form and dose
- The name of the prescriber.

The pharmacist must also have access to sufficient information to assure themselves of the appropriateness of the medicine and dose. The pharmacist must read the alteration or addition back to the prescriber who must then affirm the original instructions.

The pharmacist will then amend the in-patient medication record or out-patient prescription recording the name of the prescriber, who has been contacted, then sign and date the amendment.

If the alteration is to formulation, frequency or timings of dose, then that part of the prescription may be crossed out and altered to ensure that the alteration is clear.

If the alteration involves any other changes e.g. new medicine, change in dose, then the whole prescription for that item must be written out as a new entry on the in-patient medication record or out patient prescription form.

11.3

4.21 Controlled Drug prescribing

See Chapter 9

4.22 Prescribing for Controlled Drug Dependency

See Chapter 9

4.27 Prescribing medicines which carry a black triangle symbol in the BNF

The black triangle symbol ▼ identifies those preparations in the BNF that are monitored intensively by the Medicines and Healthcare Products Regulatory Agency (MHRA). Prescribers are urged caution when prescribing these preparations and should report

adverse drug reactions to the MHRA

4.28 Prescribing medicines for which the Patient Safety Wales (and former NPSA) has issued safety concerns

Patient Safety Wales and formerly the National Patient Safety Agency (NPSA) may have identified certain medicines as having particular risks associated when they are prescribed. This risk is highlighted by the production of a Patient Safety Notice/Alert (NPSA through the issue of a Rapid Response Report (RRR)). Prescribers are urged to familiarise themselves with these.

4.29 Prescribing for patients detained under 'The Mental Health Act'

Circumstances arise where a patient is detained under The Mental Health Act and will need medication prescribed either by consent or against the patient's wishes. The prescribing team must ensure that any prescribing will be in accordance with the current legislation set out under the Mental Health Act.

4.30 Patient Group Directions (PGDs)

Each Clinical Board is responsible for gaining approval of the C&V UHB Medicines Management for their Patient Group Directions. PGDs must be prepared in accordance with WHC CMO (2000) 1 using a C&V UHB template for PGDs. Advice in the preparation of PGDs can be obtained from Pharmacy. A record of approved PGDs is displayed on the C&V UHB intranet. When the review date arrives the appropriate Clinical Board will be responsible for reviewing and updating the PGD.

4.31 Prescribing for staff who are unwell at work

In order to standardise practice for staff that are unwell at work and to ensure compliance with the Welsh counter fraud initiative and the principles of clinical governance, this protocol describes the circumstances in which it is acceptable for doctors to prescribe medicines for staff

Self-prescribing is held to be generally undesirable to many authorities, including the General Medical Council, and will not be accepted. This avoids the dangers associated with the loss of objectivity, misdiagnosis and circumvention of the normal general practitioner-patient relationship. All routine medicines for doctors, their families and other hospital staff should be obtained through the General Practitioner Services. Prescriptions are subject to routine and random audit and exceptions to this

Cardiff and Vale
University Health Board

protocol will be brought to the attention of the C&V UHB Audit department. There are, however, circumstances when it is reasonable for a doctor to prescribe limited quantities of medicines for a medical colleague:

- The prescriber must be a fully registered practitioner and hold the post of Consultant, Staff Grade Doctor, Trust Specialist or Specialist Registrar.
- The prescriber's decision to prescribe is taken to support the attendance of his/her colleague in the workplace.
- A maximum of one week's treatment (or one original pack where appropriate) will be supplied, prescribed.
- Prescribers should note that data from prescription forms WP 10(HP) dispensed by community pharmacies, are returned to C&V UHB for audit purpose and are subject to regular scrutiny.
- Prescriptions outside this guidance will be treated as a private transaction, and the full cost of the medication will be charged to the patient in accordance with the private prescription and signed order charge arrangements within the local hospital. Pharmacy will not dispense any prescription for any medicines that significantly affect performance, mood altering medicines or controlled drugs under this protocol.

Chapter 5 - Ordering of Medicines

5.1 Ordering ward stocks of medicines

The process of ordering and receiving medication from pharmacy as stock medication for a ward or unit must ensure that certain controls are in place to cover the safety and security of the medicines (to include a clear documented audit trail), ensure that only controlled stationery is used, prevent overstocking of the area, ensure safety of the staff and patients, and clearly show who has the direct responsibility for each stage of the process.

5.1.1 Stock control

Each ward or unit must have an agreed stock list of medicines which are either used regularly on that ward or unit, or are required in case of an emergency. The stock level should be agreed between the pharmacy department and the clinical lead and this should be reviewed on a regular basis (usually at least twice a year). The sister/charge nurse/clinical lead has responsibility for all medicines on that ward or unit. This overall responsibility cannot be transferred to anyone else since it covers the strategic elements of medication handling on the ward or unit which ensures that day to day practice is in line with current legislation, local and national policies/guidance. The pharmacy will arrange which system of regular top-ups/stock control is best suited for that ward or unit, and the frequency with which these will take place. Ad-hoc orders should be processed as described in the Medicines Code. Community Hospitals will order stock medicines as arranged with their local hospital pharmacy.

5.1.2 Ordering ward stock (WOREQ)

The ordering system in use on that ward or unit will determine who raises the order. Where wards or units have a pharmacy top-up/stock control, the pharmacy staff that carry out the top-up/stock control will initiate the order. Wards or units that do not have pharmacy top-up/stock control will order using an agreed medicines requisition that will be completed by a member of the ward or unit staff who has been authorized to initiate orders. Authorization of staff will be the responsibility of the ward/clinical lead and all authorized staff will have their name and signature logged with pharmacy. Ad-hoc orders may be initiated by the ward or unit staff, but they can only be made in the manner agreed with pharmacy and by a member of staff who has been authorized to initiate orders.

5.1.3 Documentation

All documentation used in the ordering of medicines will be classed as “controlled stationery” and as such should be stored safely except when in use. Access to medicines requisitions should only be to authorised staff and any electronic medicines ordering documents or system is limited to staff with authorisation attached to their individual user name and log on. All order documentation records whether paper or electronic will need to be kept for 2 years as a record of the transaction for audit purposes

5.1.4 Order assembly and transfer of Medicines

Order assembly and the transfer back to the ward or unit will be the responsibility of the pharmacy department. The pharmacy will highlight medicines needing special storage or temperature conditions, to ensure the security and stability of the medicines until they are delivered to the ward or unit.

5.2 Receipt of medicines on the ward or clinical unit

When medicines have been delivered to the ward or clinical unit the delivery must be signed for. The ward/clinical lead in charge should delegate a member of the ward staff to check the medicines received against the delivery note issued with the medication. If all the items are correct then the nurse shall sign and date the delivery note and then put away the medicines in their designated locked cupboards on that ward or unit. Any discrepancy identified must be notified to pharmacy as soon as possible.

Chapter 6 - Control and Storage of Medicines

6.1 Storage of medicines

Medicines dispensed by pharmacy and will be labeled in a manner to indicate to patients and nurses, the correct manner of storage and use of medicines. Medicines needing storage in a controlled drug cupboard will be labeled 'Store in a Controlled Drugs cupboard'. Medicines needing cold storage will be labeled 'Store in a refrigerator'. Certain medicines can carry risk of harm to those who need to handle the medicines e.g. cytotoxic medication or hormonal medication and will carry warning labels indicating this risk.

6.1.2 Stock medicines in clinical areas

The stock held in a ward or department should be the minimum for safe and effective patient treatment and efficient service provision. The ward or clinical area will agree the items to be held as ward stock with pharmacy whose staff are authorized to inspect all medicines on any C&V UHB premises at any time. Storage of medicines no longer in use can increase risk of error and they should be returned as set out in this Code. If it is found that the storage conditions are inappropriate; the nurse with continuing responsibility must be informed. In a situation of a continuing problem the Nurse Advisor for Medicines Management will notify in writing the Senior Nurse responsible for the ward or clinical area.

6.1.3 Patient's own drugs (PODs)

When a patient is in hospital, the term 'Patient's Own Drugs' (PODs) refers to medicines that have been brought into hospital by the patient, having been dispensed for that patient outside of the hospital. It also includes over the counter (OTC) medication purchased by a patient and brought into the hospital. PODs medicines are not C&V UHB property but to ensure safe use and control for an individual patient their medicines must be stored and handled as set out in 6.1.3.1

6.1.3.1 Storage of PODs

Where appropriate PODs are stored in lockable bedside medicine cupboards used exclusively for that patient. Cupboards or lockers designated for PODs storage must only be used for storage of PODs, and must not be used for patient's own property, money, food or valuables. If a ward is not utilising PODs then the PODs must be stored in a cupboard or

Cardiff and Vale
University Health Board

trolley until such time that they can be returned to the patient or relative. PODs should be assessed for suitability for use by a pharmacist or pharmacy technician or registered nurse/midwife in accordance to the local pharmacy procedure. An in-patient may be self-administering certain medication that is not practical nor is expedient to be kept in a locked cupboard. Examples of this are be patient controlled analgesia, inhaler therapy, glyceryl trinitrate spray or topical preparations e.g. creams. These need not be stored in a locked cupboard when prescribed and used by those patients capable of self administration. PODs that need cold storage must be kept in a refrigerator, and the medication record should be noted with the place of storage.

6.1.4 Suspicious substances or suspected illicit materials

If a patient is found to be in possession of a suspicious substance or illicit material then the member of staff must follow the guidance for disposal in the Medicines Code Chapter 9 and chapter 10. A Datix report should be completed.

6.1.5 Medicines cupboards and trolleys

A ward or clinical area must have sufficient and proper storage cupboards, medicines trolleys, racking and shelving to safely store medication in a dedicated room or area. Each area where medicines are stored must be kept clean, be well ordered and comply with current legislation for storage of medicines (PSN030 sets out the requirements). Internal and external medicines should be stored in separate cupboards or where this is not possible, on separate shelving within a cupboard. Testing reagents shall be stored in a separate locked cupboard. Disinfectants shall be stored in a locked cupboard, separate to internal medicines. Where a traditional ward medicines trolley is used to facilitate medicines administration it is good practice to ensure that medicines held on the trolley are restricted to individually dispensed items and the minimum stock from ward stock required to meet the needs of the medicine round. When the trolley is in use it must not be left unattended unless locked. When the trolley is not in use it must be locked and secured to the wall or floor by a chain, padlock or security system. Medicines must not be left on top of the trolley or on any exposed shelf of the trolley. CDs must not be stored in the medicines trolley. Where an automated ward or department medicine storage system is in use e.g. Omnicell, the system and its access controls must be approved by pharmacy. Infusion fluids, peritoneal solutions and large volume sterile irrigations are best stored in a locked cupboard, but where they are stored on shelving it must be in a secured area, providing clean conditions and where there is not public access.

6.1.6 Medicines refrigerators

Medicines labeled 'Store in a refrigerator' shall be stored between 2-8°C in a dedicated locked medicines refrigerator. Guidance is set out in Patient Safety Notice PSN015. Medicines refrigerators should preferably be hard wired to the electrical supply to prevent accidental switching off. The use of refrigerators with temperature recording charts is preferred. Medicines refrigerators must have the temperature monitored and recorded daily, and this should be regularly audited by a named individual.

Non medicines e.g. milk or food must not be stored in a dedicated medicines refrigerator.

6.1.7 Storage of medicines in intensive care, high dependency and coronary care units and recovery rooms

In the above clinical areas where there is continuous high level nursing/staffing, medicines may be stored in a secure or convenient location and not in a locked cupboard. However, the storage location must allow constant oversight by nursing staff. Each registered health care professional accountable for the individual patient is responsible for the safe custody of these medicines at all times. When these medicines are no longer required by the patient they must be returned to the pharmacy or the unit's medicines cupboard.

6.1.8 Epidural levobupivacaine bags

Epidural levobupivacaine bags must be stored separately from intravenous infusion bags to minimise risk of erroneous selection of levobupivacaine and inadvertent administration by an incorrect route. Compound epidural bags containing levobupivacaine and fentanyl must be stored in a CD cupboard.

6.1.9 Emergency boxes, anaphylaxis kits and hypo (hypoglycaemia) boxes

These medicines are provided to wards to provide immediate life saving treatment therefore they should not be stored in locked cupboards, but be kept in a safe location in the clinical area so as to be readily available when needed. This must be balanced against the need for medicine security, therefore wherever possible they should be stored out of direct view of the public. Some areas will have alarmed trolleys for storage of emergency boxes. Each emergency box will have a tamper evident seal and expiry date, and once the seal is broken or the box expires it should be replaced via the pharmacy as soon as possible.

6.1.10 Medicines and Health and Safety

Flammable materials must be stored away from sources of ignition and preferably locked. Medical gases are generally piped but when medical gas cylinders are used they must be secured and stored in a dedicated cradle trolley and in accordance with the supplying company's safety instructions.

6.1.11 Storage of Controlled Drugs

See Chapter 9

6.1.12 Storage of medicines by community nurses

Where community staff need to carry medicines to a patient's home or elsewhere, they must ensure that the medicine is securely stored until use or return to the originating storage cupboard at base. If the medicine requires cold storage the medicine must be carried in appropriate packaging to maintain the 'cold chain'. Medicines should be carried concealed in the boot of a vehicle and should not be left unattended,

6.2 Security of medicines

6.2.1 Custody of keys controlling access to medicines

6.2.1.1 Pharmacy

The safe custody of medicines within the pharmacy, pharmacy keys and pharmacy entry swipe cards are the responsibility of the Director of Pharmacy and Medicines Management.

6.2.1.2 Wards

In wards or clinical areas the responsibility for safe custody is that of the WRN/clinical lead of the ward or clinical area. The person with continuing responsibility can be delegated responsibility for possession of the custody of the keys to the medicine cupboards, medicine refrigerator and medicines trolleys. All ward medicines keys must be passed to the next WRN at handover. Unauthorised persons must not be permitted access to medicines within hospital premises. The ward/area should provide a copy set of medicines cupboard keys to pharmacy in order to maintain service in certain circumstances, such as the loss of keys.

A master key for PODs cupboards is held by each ward team. Lost keys must be reported in accordance with the local security procedure. A patient may hold the key to their individual bedside PODs cupboard where they have been assessed to be able to self-administer their medication according to a C&V UHB approved local procedure.

6.2.2 Custody of Controlled Drugs

See Chapter 9

6.2.3 Discrepancy or misappropriation of medicines

Each member of staff will maintain their own record of any incident and their subsequent action. The WRN lead will make initial enquiries to establish if any suspected theft or suspected fraud may have occurred. See section 3.3 and 3.4

6.2.4 Apparent loss of medicines in clinical area

The person in charge of the clinical area should assess the significance of the loss of the medicine (whether it is a CD or not) and then determine if the procedure set out for missing CDs will be followed (see Section 9.10). If theft or fraud is suspected see sections 3.3 & 3.4. All losses involving CDs must be referred as soon as possible to the senior nurse who will contact the Duty Pharmacist as necessary and the procedure set out in the Controlled Drug section of the Medicines Code must be followed.

6.2.5 Apparent loss within the pharmacy

Any apparent loss of medicines within the pharmacy must be reported immediately to the Duty Pharmacist. The senior pharmacist and the person reporting the loss should examine the records against the physical stock to confirm the apparent loss. If no satisfactory explanation is forthcoming the senior pharmacist will inform the or their deputy who will again check the stock records against physical stock. Should the apparent loss remain unexplained, the Director of Pharmacy and Medicines Management or deputy will inform the Security Manager of the loss and in consultation with him/her may report the incident to the Police and ask for an independent investigation. The relevant disciplinary and finance procedures will be applied, if appropriate.

6.2.6 Dispensing errors discovered on a ward

When an apparent dispensing error is discovered on a ward or in a department the WRN lead in charge of the ward or department will contact the pharmacy as soon as it is practical, in order to confirm the status of the medication and ensure that where necessary a new supply is made available to the patient. The ward staff should complete a Clinical Incident Repor on Datix detailing the error or provide information to the local hospital pharmacy for completion. Dispensing errors are considered 'must report incidents' within the C&V UHB policy for clinical incident reporting.

The pharmacist receiving such a report will complete a pharmacy incident report to be submitted to the local pharmacy operations manager. The pharmacy will maintain a record of such incidents for audit and clinical governance purpose. If a patient has wrongly received

Cardiff and Vale
University Health Board

any medicine, the consultant in charge of that patient will be informed of the incident so that any clinical action needed can be taken, and that the patient and/or relatives can be informed.

6.2.7 Samples of medicines left by pharmaceutical representatives

It is imperative that C&V UHB must know what products are being used within its boundaries. Samples of medicines must not be left in clinical areas, or issued to individual healthcare staff by pharmaceutical representatives for use within C&V UHB. Representatives wishing to discuss supply of samples for use for evaluation of a medicinal product must be referred to the hospital pharmacy.

6.3 Transport of medicines

When medicines are being transported from the pharmacy to ward or unit it shall be in such a manner that ensures they reach their destination safely, undamaged and have been kept under the correct storage conditions. Each hospital pharmacy will put in place a system for recording dispatch and delivery of medicines from the originating pharmacy.

6.3.1 Storage conditions in transport

Whenever medication is to be transported from one area to another, then the recommended storage conditions e.g. Safe storage for Controlled Drugs, temperature or humidity must be considered and the method of transfer must take these storage conditions into account. When sending out items with highly sensitive temperature conditions e.g. vaccines, it is good practice to notify the receiving unit of the day/date of transportation to maintain the cold chain as described in the NPSA Rapid Response directive (RRR008 Cold Storage)

6.3.2 Packaging for transportation

When transporting any medicine, due regard must be taken of the fragility of the item being dispatched. Those items known to be fragile e.g. items already packed in a glass container, or items which are known to have a COSHH hazard must be packed carefully (these may require extra padding around the container) in order to remain intact throughout the transport process. It is essential that when the item reaches its destination it is still intact and can be used for a patient.

Pharmacy must be notified immediately of any damaged receipts.

Cardiff and Vale
University Health Board**6.3.3 Transport documentation**

Medication should only be transferred from pharmacy to a ward or unit on the same site by hospital staff. In most cases this will be pharmacy/hospital porters. Other staff e.g. pharmacy, nursing or health care workers can also transport medication, but only if they can be identified by their employer identification badge. For any transfer that is going off site to another health premises, then the person carrying out the delivery must sign a pharmacy transport note on pickup within pharmacy and also ensure that the receiving staff signs for receipt of the medication to ensure a complete audit trail. The carriers in this case will be signing for the outer transport bag or box and not for the individual contents. The record of receipt will be returned to the supplying pharmacy as soon as possible. If voluntary transport arrangements are in use then a badge or similar identification system must be in place.

Chapter 7 – Administration of Medicines

The purpose of this section is to establish the principles for safe practice in the management and administration of medicines by registered nurses, midwives and other healthcare professionals. It is aligned to the Nursing and Midwifery Council Standards for Medicines Management (2010) and the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (MARRS '015).

Definition of administration: Administer is 'to give a medicine either by introduction into the body, whether by direct contact with the body or not (e.g. orally or by injection) or by external application (e.g. application of an impregnated dressing)

Definition of second checker: A staff member usually authorised to administer medication or a person on a training placement from a university course that is undergoing training for registration as a nurse or health professional. In certain defined situations the second checker may be a health care support worker who has undergone training for this task.

Remember:

In order to administer medicines safely the person administering must:

- Establish the identity of the patient in accordance with the UHB Patient Identification Policy.
- Check the prescription is clearly written, unambiguous and appropriate for the condition being treated
- Check that the patient is not allergic to medicine to be administered.
- Check the medicine against the prescription to ensure correct dosage, route and timing of the administration.
- Check the expiry date of the medicine to be administered.
- Ensure that the patient takes the medication
- Make a clear and accurate recording of initials on medicines administration chart once you are sure all medicines administered have been taken/applied. Medicines intentionally withheld or refused by patient must be annotated with the appropriate code and where necessary an entry made in the patient's notes.

Note: Medicines must never be left unattended, and must be securely stored when not in use.

Cardiff and Vale
University Health Board

7.1 Persons who are authorised to administer medicines

All health professionals set out below and deemed competent to administer medicines can administer medicines on the authorisation of a medical practitioner, dental officer, and non medical prescriber. Patient group directions only authorise those named within the PGD to administer the particular medicine. For in-patients they must be prescribed on an approved computer prescribing system or the appropriate hand-written prescription chart or stationery approved under a model of service. It is recommended that medicines to be administered orally and by injection should be prepared and given at different times.

7.1.1 Nurses and Midwives authorised to administer medicines

All nurses and midwives with a current registration with the NMC and assessed as competent within Cardiff and Vale UHB including bank nurses. Agency nurses must have received appropriate training and assessment by the agency providing the nurse and the agency must be able to demonstrate this to the UHB.

7.1.2 Non-nursing staff authorised to administer medicines

- Registered Medical Practitioners and Dentists
- Registered Operating Department Practitioners with the appropriate training and assessment of competence
- A nurse in training or student under the supervision of a registered nurse (Level 1) or registered nurse (Level 2) or midwife who remains accountable for ensuring that the correct procedure takes place
- After appropriate training and competence assessment specific medicines may be given by Pharmacy staff, Radiographers, Podiatrists, ECG Technicians, Physiotherapists and Clinical Support Workers

7.1.3 Administration requiring two registrants

It is recognized that all healthcare professionals can make human errors. For the following types of medicinal products an independent full process two person check is recommended practice to reduce the risk of adverse drug events. In C&V UHB this is required in the following processes

- All medicines administered to a child less than 16 years of age. (with the exception of Teenage Cancer Trust where oral medicines are administered with a single nurse check to patients of 14 years and upwards).
- Controlled Drugs see 9.9
- All intravenous, epidural injections and infusions.
- Where a calculation is involved

By definition the independent check must not be controlled or influenced by any other person. The independent check must include that the medicine matches the prescription, that the correct strength, dose and form has been selected, including any calculations that must be clearly documented, that the product has not expired and the patient is not allergic to the particular medicine. The process must include a check of the patients identity at the bedside and the administration or start of the administration. Accountability for the preparation and administration remains with both professionals.

The checking of medicines by a second healthcare professional does not apply in areas of anaesthesia and resuscitation where the doctor or dentist can administer medicines alone. The checking of medicines by a second healthcare professional may not apply in community practice e.g. at a patient's home. However independent checking is required for any medicine, which the primary administrator is unfamiliar with, in particular, those medicines that are to be administered parenterally regardless of the professional group.

7.1.4 In the absence of a registered second checker

In certain clinical areas, and exceptional circumstance, if a second registrant is not available to act as a second checker, the Clinical Board can approve a process for a member of staff e.g. healthcare support worker, to undergo suitable preparation and assessment for acting as a second checker. In some instances this can include student nurses/midwives or operating department practitioners who are undergoing training in medicines administration.

Cardiff and Vale
University Health Board

N.B. Student nurses/midwives or student operating department practitioners, cannot act as a second checker for IV preparation and administration of medicines. 1st year student nurses/midwives or student operating department practitioners cannot act as second checker for CD's.

7.1.5 Selection and administration

7.1.5.1 Selection of medicines

When a health practitioner is selecting a medicine for administration it is vital that the process results in the correct medicine to be given in the prescribed dose by the prescribed route and at the required time.

To support this process all medicines supplied from the pharmacy will be labeled by the original manufacturer or by the pharmacy in a manner that will allow identification of the medicine contents against the patient's prescription.

If the pharmacy repackages an original manufacturer pack, the pharmacy label will then identify the contents of the dispensed container. If the container is a box containing a strip of tablets it is good practice to confirm identity marked on the label with the tablet/capsule name and strength printed on the strip. This is necessary to ensure that a wrong strip has not been returned to another container box at a previous administration time. If the name and strength of a medicine is not clearly printed on a medicine strip, or a label seek advice from another health practitioner. If there is any ambiguity it is advisable to check with the local pharmacy to confirm identity of the medicine.

7.1.5.2 Safe Administration of medicines.

Remember in order to administer medicines safely the person administering must

- Establish the identity of the patient in accordance with the UHB Patient Identification Policy.
- Check the prescription is clearly written, unambiguous and appropriate for the condition being treated
- Check that the patient is not allergic to medicine to be administered.
- Check the medicine against the prescription to ensure correct dosage, route and timing of the administration.
- Check the expiry date of the medicine to be administered.
- Ensure that the patient takes the medication.

Cardiff and Vale
University Health Board

- Make a clear and accurate recording of initials on medicines administration chart, of all medicines administered, intentionally withheld or refused by patient. Where necessary an entry into the patient's notes must also be made

It is the responsibility of the Ward Sister / Ward Unite Manager/ Unit Lead to ensure that standards of medicines practice are adhered to and ensure that the person administering medicines has received the relevant training and education to enable them to safely administer medicines.

To ensure medicines are safely administered the administrator must-

- Know the therapeutic use of the medicine to be administered, its normal dose, side effects, precautions, contra-indications and monitoring requirements. In the event that the administrator is not aware of this information, they must be able to locate the information before administration. (Sources include BNF and Medusa).
- Be aware of the patients care plan, the patients condition, in particular with regards to their medication needs.
- Be alert to potential errors in prescribing or dispensing.
- Contact the prescriber without delay if :-
 - Contraindications to the medicine are identified
 - The patient develops a reaction to the medicine
 - Assessment of the patient indicates that the medicine may no longer be suitable for the patient

11.3

7.1.5.3 Non- administration of medicines.

In some circumstances it may be appropriate for the administrator not to administer the prescribed medicine, either because they are unable to administer (e.g. patient refuses) or because the administrator feels there is an appropriate reason to withhold (e.g. withholding anti-hypertensive medication if the patient's blood pressure is too low). In the event of the non administration of medicines the administrator must annotate the medicines administration chart with the appropriate code. i.e.

X – Prescribers request.	2- Patient not on ward.
3 – Patient unable to receive/no access.	4 – Patient refused.
5 – Medicines unavailable.	6 – See notes.

Cardiff and Vale
University Health Board

It is the administrator's responsibility to inform the patient's medical team, or the 'on call' medical team, that the medicine has not been administered, the reasons why, and to discuss the need for alternative action. The patient's condition must be taken into account to determine the urgency with which this information needs to be passed onto the medical team. Discussion with the pharmacist may facilitate this.

If for any reason it is not possible to administer the medicine, then the following guidance should generally be observed, but if the administrator has any concerns they should seek further advice, from the prescriber, pharmacy or the BNF, especially where the prescription is for four hourly administrations.

Cardiff and Vale
University Health Board

Prescription is for	Guidance.
Once a day medicines	Administer the missed dose as soon as possible, up to 12 hours after the prescribed time.
Twelve hourly medicines.	Administer the missed dose as soon as possible, up to 6 hours after the prescribed time.
Eight hourly medicines	Administer the missed dose as soon as possible, up to 4 hours after the prescribed time.
Six hourly medicines	Administer the missed dose as soon as possible, up to 3 hours after the prescribed time.
Four hourly medicines	Administer the missed dose as soon as possible, up to 2 hours after the prescribed time.

11.3

7.1.5.3.4 Administration of medicines to adult with swallowing difficulties.

This section offers guidance for safe administration of medicines to patients with swallowing difficulties, it covers oral and tube administration of medicines. If a patient has difficulty swallowing tablets/capsules the prescriber must consider the need for treatment. Consider-benefit of treatment, non-formulary request, potential long term availability and cost implications. If available an assessment by Speech and language therapist (SLT) should be completed and recommendations followed. Consideration should be given to the following:-

- Is the swallowing problem likely to be short or long term?
- Is a licensed, formulary liquid formulation available?

Cardiff and Vale
University Health Board

- Is an alternative route (rectal, parenteral) available/appropriate?
- Does an alternative drug from the same class help address any of the above?
- Is enteral access available/needed?

Contact pharmacy to discuss if crushing tablet/opening capsule or use of enteral route is appropriate. Some advice is detailed below

Standard tablets

Ordinary release tablets are usually made by one of two methods, direct compression or wet granulation. A variation in the excipients used in the tablet formulation will affect the disintegration time of the tablet when it is placed in water. Several devices are available for crushing tablets. Use one per patient and care should be exercised to minimise risk of exposure to drug powder.

Soluble Tablets

A soluble tablet dissolves completely when placed in water to give a solution of the drug.

Effervescent tablets

These tablets will effervesce and disperse when placed in water and must be fully dispersed before administration to allow gases to escape. Care must be taken with sodium content.

Dispersible tablets

Although designed to be given orally, dispersible tablets disintegrate in water to give particles that may or may not suspend in water. Not all are suitable for administration via fine bore tubes. Care with sodium content.

Buccal/Sublingual tablets

These medications are designed to be absorbed through the oral mucosa and therefore bypass the first-pass metabolism effects of the liver. These formulations are a useful alternative for patients who are nil by mouth or are unable to swallow, providing the patient is able to produce normal quantities of saliva. They are not suitable for administration via enteral feeding tubes as significantly reduced drug absorption will occur.

Modified Release Tablets

As a rule these are not suitable for crushing or administration via enteral feeding tubes as the

Cardiff and Vale
University Health Board

pharmacokinetic profile of the drug may change and result in excessive peak plasma concentrations and side –effects.

Hard Gelatin Capsules

Some capsules can be opened and the powder mixed with water. Some capsules contain granules rather than powder.

Soft Gelatin Capsules

These drugs are usually poorly soluble in water and are therefore contained in an oily solution within the capsule. These are not suitable for administration via an enteral feeding tube. It may be possible to pierce the capsule shell using a pin and squeeze out the contents, however, accurate dosing cannot be guaranteed. The volume contained in the capsule can vary depending on the brand used.

Enteric coated tablets

These tablets are given an enteric coating to protect the drug from degradation by the acidic conditions of the stomach or to reduce the incidence of gastric side-effects. Crushing these tablets and administering via enteral tubes is highly likely to cause tube blockage. Stomach irritation and a decrease in effectiveness may occur.

Cytotoxic tablets - Do not crush – avoid contact

Where the enteral route is appropriate – use the procedure below (section 3). Reassess the patient and their treatment as the patient's condition changes e.g. daily. Note- the implications of crushing tablets or opening capsules include:

- Modifying the product, rendering it unlicensed and therefore the UHB accepts liability for any adverse effects. N.B. Liability will rest with the person administering the medicine unless UHB procedures are followed.
- Change in stability of the product
- Change in drug absorption and therefore amount of drug that the patient receives
- Potential increased risk of adverse effects
- Health and safety risks to staff and/or patient handling the medicine
- Cross-contamination or infection risk if appropriate procedures are not followed.
- Administering Medicines in Soft Food

Crushed medicines or capsule contents may be administered with a small amount of cold soft

Cardiff and Vale
University Health Board

food such as a teaspoon of yoghurt (care with dairy products and drug interactions e.g. quinolones, tetracycline) or jam. A small amount should be used to ensure the full dose is taken. Crushed tablets or capsule contents may taste very bitter; it can be helpful to mask the taste for patients taking these medicines orally by using strong flavors' such as jam or blackcurrant cordial. Medicines should only be administered in food with the patients' knowledge and consent. Hiding medication in food is considered "covert administration" and is only permissible in certain circumstances following a defined process (see 7.2)

Procedure: administration of medicines by crushing tablets or opening capsules

N.B The use of an oral syringe or standard medicine pot is contraindicated for administering medicines to dysphagic patients (see below)

Obtain pharmacy advice on suitability and implications of crushing tablets/opening capsules for each medicine. Advice is available from ward pharmacist, medicines information (UHW Ext 42979) or if urgently required out-of-hours, the on-call pharmacist.

- Advice on preparation and administration must be documented on the drug chart (or supplementary chart if necessary- attached to the drug chart)
- Confirm dose (adjust if necessary) resulting from change in form.
- Where capsules are opened or an injection is to be given orally use a clean receptacle reserved for the specific patient.
- Where tablet is to be crushed use a tablet crusher reserved for the specific patient (and wash thoroughly between uses). Crush to a fine powder.
- Add 10-15ml sterile water to the crushed tablet, capsule powder or viscous injections to make an appropriate solution or slurry. Check the appropriate consistency that Speech and Language assessment advised e.g. normal/syrup/custard thickness.
- Consider whether administering medication from a medicine spoon or Kapi cup is most appropriate for the patient (obtain advice from speech and language therapist if necessary). N.B syringing medication orally is contraindicated in dysphagic patients as it can increase risk of aspiration. The standard medicine pots are also contraindicated in dysphagic patients due to increased risk of aspiration associated with tilted back head position.

Unless advised by pharmacy otherwise, administer each medication separately. Do not mix any medications prior to administration. Administer immediately after preparation and ensure the full dose has been taken.

Procedure: administration of medicines via enteral feeding tubes

Do not administer medicines via tubes that are being used for aspiration or are on free drainage.

- Where a multilumen tube is in use, ensure the medicine is administered via the lumen with the correct output position. Ensure any other ports are closed and airtight.
- Ensure the prescription chart indicates the appropriate route of administration (if not- contact the prescriber).
- Ensure the enteral feeding tube is patent.
- Stop/suspend any enteral feed which is running. Consult pharmacy for advice on appropriate timing intervals
- Flush the feeding tube with 30ml sterile water.
- Draw medicine into an oral/enteral syringe of suitable volume. A parenteral syringe must not be used.
- Ensure an airtight connection of syringe to the enteral tube.
- Administer each medicine in turn, flushing the tube with 10-20ml of water between medicines. The volume used should reflect the diameter of the lumen to prevent build up on the inner wall of the tube but take care with fluid-restricted patients.
- Flush the tube with 15-30ml of water on completion.
- Restart the enteral feed where appropriate

7.1.6 Administering cytotoxic medication

Cytotoxic chemotherapy can only be administered to patients by those specific health professionals authorised to administer cytotoxic chemotherapy by the C&V UHB.

7.2 Administration via the intravenous route

Practitioners (including doctors, dentists, nurses and other health professions) are permitted to administer intravenous medicines provided they have received UHB delivered or endorsed appropriate education, training and assessment of competence. All intravenous medicines and fluids should be prepared and administered in accordance with C&V UHB approved local procedures (See Chapter 8). Practitioners can only administer intravenous cytotoxic chemotherapy as set out in Chapter 8.

Covert administration

There may be times when a patient needs to be administered medication covertly – i.e. without the patient's knowledge.

It may be lawful to do this where –

- The patient is detained under the Mental Health Act 1983, the treatment is for mental disorder and the Consultant considers that it is necessary for the medication to be administered covertly, or
- The patient lacks mental capacity either to consent to, or to refuse, medical treatment, but will not accept it. In these circumstances, treatment can be given to the patient covertly if the decision to give it has been made in accordance with the Mental Capacity Act 2005 (MCA).

The impact on the patient of the covert administration of medicine must be considered carefully, as part of the best interests' decision making process. This is because the patient may regain capacity, understand what has been happening and lose trust in staff.

Given the risk of a breakdown in trust, the covert administration of medicines is likely to be appropriate only when the patient is unlikely to regain capacity to consent to or refuse the medicine. Covert administration of **any** medication (not just sedatives) can only be given in exceptional circumstances. This applies to all employees of the UHB who may be involved in decisions about and/or the administration of covert medicine to patients of all ages. This includes locums and staff on honorary contracts.

A recent Court of Protection case regarding Deprivation of Liberty Safeguards (DoLS) considered at length the issue of covert administration of medication. This case has implications for all Clinical Boards within the UHB, Primary Care and the Supervisory Body (DoLS). The ruling from the Judge with regards to the covert administration of medicines to a 92 year old woman in a care home included

- that covert medicines were being administered without any proper reviews or safeguards being in place, and
- the administration of covert meds contributed to the situation where the patient was being deprived of her liberty

He went on to say that –

- Covert medication can only be given after a best interests decision has been made, by involving relevant professionals and family members, and

Cardiff and Vale
University Health Board

- If the decision is made to give medication(s) covertly, a management plan to do this must be drawn up, including provision for regular reviews

The following sets out the issues to be considered/action taken when clinicians believe that covert medication may need to be given.

- 1) Covert medication can only be administered (except under Mental Health Act 1983) where
 - the patient lacks mental capacity to consent to/refuse the medication, and
 - does refuse it, and
 - it is felt to be essential for the patient's health, and
 - the circumstances are exceptional (see Nice Guidance)
- 2) Before the medication can be administered covertly (unless in an emergency), a best interests decision must be made involving the relevant healthcare professionals and the patient's family/friends. If the patient already has a DoLS authorisation, then the Relevant Person's Representative (RPR) must also be involved and the Supervisory Body informed in order to carry out a review.
- 3) If the patient (in a hospital or care home) is not already subject to a DoLS authorisation, clinicians must assess, using the DoLS Proforma whether an application for DoLS authorisation should be made, as the use of covert meds is an aspect of *continuous supervision and control*. If the patient is in their own home, Local authority legal advice must be sought.
- 4) If it is agreed that covert administration of medication is in the patient's best interests, then this decision, together **with details of the individual medication(s)**, must be clearly and fully recorded in
 - the medical and/or care home records
 - any best interests assessment (DoLS)
 - any DOLS authorisation
- 5) If there is disagreement, then legal advice must be sought.

Cardiff and Vale
University Health Board

- 6) A management plan must be agreed and drawn up, to include timeframes and review frequency. It must specify that if medication is to be changed, a further review of the use of covert medication must be held and the Supervisory Body informed.
- 7) Reviews must involve the relevant healthcare professionals, the patient's family/ friends and the RPR (if in place).
- 8) Conditions should be included in any DoLS Standard Authorisation regarding the use of covert medication and timescales of reviews.

7.3 Self administration – Patient Orientated Medicines System (POMS)

Cardiff and Vale UHB is committed to the continued improvement of patient care. The POMS is regarded as the model for best practice in medicines management for hospitals. It provides substantial benefits for patients and hospitals. The opportunity for self- and/or supervised administration of medicines allows :-

- Improved opportunity to clarify regular medication and inform the therapeutic management plan.
- Difficulties with self-administration of medicines to be identified during the hospital stay.
- Improved opportunity to educate patients on their drug treatment
- Increased patient understanding and reduced potential for re-admission due to medication error.

POMS facilitates and supports the appropriate use of patients own medicines and self administration whilst in hospital. The aims of the POM system are :-

- To ensure that the patient, where able, understands their medication plan and is involved in their medicines administration at the appropriate level whilst an inpatient.
- To ensure that the patient is fully prepared for discharge.
- To avoid duplication of prescription dispensing and reduce waste.
- To facilitate continuity of prescribed medicines between primary and secondary care settings.
- To limit unnecessary changes to long term medicines treatment.
- To improve the quality of information to the patient and all relevant parties within the medicines management process

Most of the medicines brought into hospital by patients, where POMS is not in place, are destroyed due to a lack of storage facilities or the systems to ensure they are safely returned to the patient. Utilising patients own medicines whilst in hospital can help to reduce prescribing errors as well as avoiding duplication of supply. Costs are kept to a minimum and waste reduced. People at home usually administer their own medicines. With the appropriate assessment it is logical for patients to have access to and administer their own medicines. Nurses play a major part in education of these patients to ensure the safe and effective use of the medicines, to allow self medication in hospital to develop further. For the purposes of this procedure, the word medicine describes any medication that the patient has already used or, with appropriate support would reasonably be expected to use at home.

Using Patients own medicines.

Patients should be encouraged to bring in their own medicines. All patients should be asked if they have brought any medicines with them, any medicines remaining at home should where possible be brought in. All medicines must be locked in the patient's bedside cabinet, or temporarily in another secure location e.g. in admissions areas where cabinets are not available.

Medicines brought in from home remain the patients property and consent must be sought and given for their continued use in hospital or, where appropriate, destruction.

Patients have the right to refuse consent for continued use or destruction. Where destruction is advised, due for example to medicines being no longer required or expired, patients should be advised of the associated risks.

Medicines will be assessed for continued use using the suitability criteria set out below. This can be done by a pharmacist or medicines management technician on their next routine visit.

A nurse may administer patient's own medicines prior to them being assessed formally by pharmacy if they are satisfied of their suitability using the criteria below.

- Medication must be clearly labelled with, the name of the patient, the name and strength of the medicine, the date dispensed (this should be less than 3 months ago)
- Where dosing instructions are given they should be current and correct.
- If the medication has not got a patient specific label, it should not be used unless it is a) in a blister pack with a clearly marked expiry date or b) is a clearly identifiable medicine in an original container, with an expiry date.

Cardiff and Vale
University Health Board

- If the medication has a short shelf life (eg. GTN tablets, eye drops) or if they require storage in a fridge, check their use with the patient and use individual judgment.
- Appearance of the container, label and medicine should be acceptable, ie. intact, clean, with no visible signs of deterioration.
- Check with patient that the medication has been stored properly. If in doubt do not use.
- If patient's medication is provided in a compliance aid, eg Dosette, the medicines may only be used if the patient is self administering at level 3 and there have been no changes to the medicines regime.
- Medicines should be discarded and returned to pharmacy with the patients consent if, the expiry date has been reached, medicines are in poor condition or mixed in one container.

Professional discretion should remain the overriding factor in assessing suitability of medicines.

Storage of medicines on POMS wards.

Supplies of oral medication for all patients are kept in a locked cabinet attached to their bedside locker. Each cabinet will have a lock operated by a single key, or key code. A master key/ master code system will be in place for nurse administration/ stock renewal etc.

It is the responsibility of the registered nurse to remove medicines no longer required from the patient's medicine cabinet.

Overall responsibility for the safety and security of patient medicines cabinets and medicine cupboard keys/codes, lies with the ward manager. The nurse in charge will hold the master key/be responsible for code system.

Each ward may have up to 4 master keys, for use by team nurses at the discretion of the ward manager nurse. These master keys must be on the nurse's person or locked away at all times. Ideally a shift by shift handover of keys should be done to account for the whereabouts of the keys. Procedures must be in place in order to ensure code systems remain secure, this includes identifying which staff have access to the codes, and when codes need to be changed, and who's responsible for change.

Patients assessed as self medicating (level 3 discussed in section 4) can be given the individual key/code to their patient medicines cabinet. They must be made aware of the need to keep the key/code out of sight and to return it to the nurse on discharge; however it remains the responsibility of the nurse to retrieve the key/code from the patient on discharge.

Cardiff and Vale
University Health Board

Patients at Level 1 and 2 must not be given access to the key/code to their medicines cabinet.

If keys are lost or the code system is breached, every effort must be made to ensure the system remains secure. If this is not achievable this must be reported via the clinical incident process

Ordering of replacement/duplicate keys/code systems must be made via the appropriate source, please discuss with the Nurse Advisor Medicines Management.

Supply of medicines from pharmacy will occur in the following ways:

Stock.

A technician will be assigned to top up the stock cupboards at least once a week, there will be two types of stock:-

- Labelled POMS pre-packs of medicines used frequently in the area. The nurse must complete the label with the patient's name and date and then place in the patient's medicine cabinet.
- Stock packs – frequently used medicines, these are for use in one off or PRN dose administration, (and issuing a pre-pack may be wasteful). The stock packs do not have patient's labels on them and must never be placed in the patient's medicine cabinet.

Patient's own medicines.

If a patient has brought medicines into hospital that are deemed suitable for continued use they will be placed in the cabinet and used to administer. When re-supply is indicated, if the medicine is not available as a POMS pre pack a supply will be dispensed from pharmacy with a label with patients name and dosing instructions. There will be at least 7 days supplied.

NB when individual supplies arrive from pharmacy it is the registrant's responsibility to place the item in the patient's medicines cabinet.

Staff Education.

It is the responsibility of the Ward Manager/Clinical Lead, to ensure that the registered staff working in their ward have been appropriately trained to work within POMS.

It is the responsibility of the registrant to identify to the Ward Sister/Charge Nurse/Clinical Lead if they require training or updates. A register of staff who have received training should be kept locally.

Medicines Administration on a POMS ward .

All patients admitted to an area where POMS is in place must be assessed using the identified assessment chart (in the UHB risk assessment document). A patient specific plan for appropriate re-assessment must also be identified. NMC Standards for Medicines Management, states that the responsibility for this assessment lies with the registrant. The assessment process ensures that the patient is placed at the right level and this minimises risks associated with self administration.

➤ Level 1: Registered Nurse Administration.

Registrant administers medicines giving full explanation to patient. The patient does not have access to the key. The registrant initials the drug chart as appropriate at time of administration.

➤ Level 2: Patient Administration under Supervision.

The patient administers medicines but under the supervision of the registrant. The patient does not have access to the key. The registrant initials the drug chart as appropriate at time of administration.

➤ Level 3: Patient Administration without Supervision.

The patient is happy to self administer their medicines, signs consent and continues to administer their own medicines without supervision and is given a key to their cabinet. The registrant is responsible for checking that the patient is aware of any changes to regime and is compliant and happy to continue. The registrant is required to sign the prescription chart at least once in 24 hours to demonstrate this has been done.

The registrant is responsible for acting upon a patients changing condition and move the patient to the appropriate level – NB Patients can move up or down a level.

Patient Education.

The NMC state that patient education is the professional responsibility of the nurse, in conjunction with the pharmacy and medical team. All patients must receive information regarding correct use of their medicines before commencing a self administration scheme and prior to discharge. Knowledge should be checked and reinforced throughout the process. The information can be verbal, written and where appropriate a combination of both, it should include

- The name of the medicine.
- The purpose of the medicine.

Cardiff and Vale
University Health Board

- The dose and frequency of the medicine.
- Any special instructions
- Possible side effects.
- Duration of treatment.

The Medicines Reminder Card is designed as a prompt to patients and is important when patients are self medicating and at discharge to aid compliance. It is not a prescription, and patients must be encouraged to refer to the medication label for instruction.

The Medicines Reminder Card should be completed by the registrant caring for the patient. The content of the card must be fully discussed with patients who have been assessed as Level 3 before starting self medication. The card must then be checked and, where required, updated at least once in 24hrs, and after every prescribing change. The medicines reminder card should be made available with the patients in patient medicines chart, for checking by the Pharmacist. On discharge the card should be discussed with patients as their condition allows.

At discharge wherever possible the card should be available with the TTH to be checked and signed by the Pharmacist. If the card is not present with the TTH or unavailable then a check against the TTH and drug chart must be made by the registrant responsible for discharge and signed accordingly.

Controlled Drugs

Patients assessed as being at Level 1 or 2 follow the UHB Policy for Safe Ordering, Storage and Administration of Controlled Drugs. Patients assessed as being Level 3 can self administer oral controlled drugs if their regime is stable. CD's brought in by patients can be assessed for suitability for continued use. If a hospital supply is required for self administration a TTH must be generated and a maximum of 14 days will be supplied. Whilst the CD are the patients own medicines and they are responsible for them, appropriate assessment will minimise associated risks. A dose by dose record will not be made in the ward CD register.

Transferring Patients.

Lockers with medicines cabinets attached should not be transferred to another ward as the assigned master keys for the receiving ward may be different.

When a patient is moved to another ward please follow the following steps:-

- The registrant must remove all the medicines from the patient's medicine cabinet.

Cardiff and Vale
University Health Board

- The medicines should be placed in a pharmacy bag. These are available on POMS wards and usually used when patients are going home.
- The medicines should be taken with the patient and given to the registrant receiving the patient on the new ward.
- The medicines should then be placed in the patient's medicine cabinet if a POMS ward, or in the ward medicines trolley.

Discharge Medicines.

A TTH must be written when a patient is being discharged, this must be clinically checked by a pharmacist. Pharmacy staff will then check the patient's medicines on the ward for suitability and length of supply. This process will normally be instigated by your ward pharmacist, or by bleeping the discharge pharmacist for your area.

- You may occasionally (e.g. at weekends, or for unplanned discharges) be asked to send the discharge advice letter (DAL, or TTH) with all medicines from the patient cabinet and the in-patient drug administration record and any associated supplementary charts to pharmacy, but you should only do this if specifically requested to by pharmacy staff.

NB – It is the responsibility of the discharging registrant to complete a final check of the discharge medicines against the TTH before the patient leaves. This check should be done with the patient wherever possible.

Non-availability of medicines

If the pharmacy department is advised by a supplier of the unavailability of a medicine it will communicate this information to medical and nursing staff as soon as possible. The pharmacy department will seek availability of any alternative that could be used. It is helpful to medicine users to know if the supply interruption is short or long term so that all avenues can be considered for temporary or long term therapeutic options.

Medication is an essential part of a patient's treatment and it is important that they receive their prescribed medication in a timely manner. This Code also covers those instances when the medication is not on the ward for administration at that appropriate time.

7.6.1 Non availability during pharmacy department opening hours

When medicines are newly prescribed for any patient, ward staff should consider if the medicines are on the ward stock list or not. If not, then they should bring this fact to the

Cardiff and Vale
University Health Board

attention of the pharmacy staff providing services to the ward. If the item is urgently required, and no pharmacy staff are available, then ward staff should order the medicine from the pharmacy dept by using the appropriate medicines requisition form or local hospital pharmacy ordering system.

Newly admitted patients should have their medicines reconciled by a member of the pharmacy staff, which will include an assessment of which medicines need to be supplied.

If any medicine is unavailable from the pharmacy department, then it is the responsibility of the pharmacist to inform the ward staff of that fact, and to discuss the options e.g. wait for the original patient's medication to be brought into the hospital or arrange for a prescription change to a formulary medicine.

7.6.2 Non availability when pharmacy is closed

If a medicine to be administered to a patient is unavailable, then a decision must be made by the staff looking after that patient as to the urgency and necessity of the patient having that medication. If a decision is made that the medication is required to be given before pharmacy reopens, then the ward staff must ensure that every effort is made to find an alternative way of obtaining it. Medications which are likely to be urgent are

- Intravenous Medicines
- Medicines to treat acute symptoms e.g. chest pain and agitation
- Antibiotics
- Steroid
- Anticonvulsants

Check the stock holding in the hospital's emergency room/cupboard on the intranet/printed list, then follow the local procedure for access to this supply. Take full packs from the emergency medicines room/cupboard and make a record what has been taken.

Ask the advice of the senior nurse on duty within the hospital to check about the possible availability of that medication on other wards or units within the hospital. Obtaining a supply of medication from one ward to another should only be carried out with the consent of the senior nurse on duty within the hospital. For Controlled Drugs Record (see Section 9.8.1).

If neither of the two options above enables supply of the urgent medicine, then contact the Emergency on call Duty pharmacist in accordance with local procedures, who may recommend an alternative, or make a supply.

For the community hospitals a WP10 (HP) can be written and dispensed locally, or in exceptional circumstances the Emergency Duty pharmacist may be contacted in accordance with local arrangements.

7.6.3 Administration error – see 6.2.6

If a medicine is administered in error, the person administering the medicine must report the incident to the medical team responsible for the patient's care so that the situation can be assessed and determine that any appropriate medical action is taken. The medical team will inform the patient of the incident. The person administering the medicine must report the incident to their line manager. A clinical incident entry on Datix must be completed

Chapter 8 - Administration of Intravenous Medicines

The National Patient Safety Agency (NPSA) issued guidelines to promote the safer use of injectable medicines resulting from reports made to NPSA of errors and incidents in the use of injectable medicines. Developments in intravenous medicines have introduced precise reconstitution and administration techniques to ensure maximum efficiency of the medicine and minimise harm to the patient. The essential theme of these guidelines is that all staff involved with intravenous medication should be trained and sufficiently knowledgeable and competent in dealing with intravenous medication. The staff should also have guidelines, information and support in respect of the medication to ensure the correct prescribing, preparation, administration and monitoring of injectable medication at all times.

Epidural injections are clearly not for intravenous use, but the principles applied to training, prescribing, preparation, labeling and administration of IV medicines apply.

8.1 Professional responsibilities and accountability

Practitioners holding registration with their professional regulatory body are accountable for their actions and omissions. When administering intravenous medication staff must exercise their professional judgment as to their knowledge and experience in dealing with each individual medication. Where an individual member of staff is unfamiliar with a particular medicine, and/or has little or limited experience in administration of the medicine the individual must refer back to the prescriber or the pharmacy department for more detailed information. This information is also available from the electronic source The Injectable Medicines Guide (Medusa). Practice set out within this policy will apply to all practitioners/staff who are involved in the prescribing, administration and safe handling of intravenous medication within the Health Board.

Each Clinical Board must ensure that all staff that are or may be involved in intravenous medication are :

- Able to access all policies, procedures and guidelines approved by C&V UHB for the use of intravenous medication.
- Given the appropriate level of training, retraining and competence assessment which must be recorded for their involvement with intravenous medication.
- Given information as to any medicine or device alert concerning intravenous

Cardiff and Vale
University Health Board

medication, device or consumable which may be used in administering intravenous or parenteral medication within C&V UHB.

- Staff that administer cytotoxic intravenous chemotherapy and cytotoxic medication by other routes, must demonstrate that they have undertaken approved training.

8.2 Training and competency for IV and other routes of parenteral administration

All staff involved in the use of intravenous and other routes of parenteral medication must be trained and competent in all roles that they may undertake concerning parenteral medication. Within C&V UHB training programmes are in place to ensure that all aspects of intravenous medication usage are covered to include:

- Prescribing
- Preparation (including calculations)
- Labeling
- Administration
- Checks involved throughout the process (who and when)
- Devices used for administration
- Monitoring requirements
- Disposal of waste material
- Risks of using intravenous medication and how to minimize them
- Standard information sources available to Health Board staff concerning intravenous medication.

C&V UHB, through its Learning and Education Department, has set up a scheme to ensure that all staff involved in any aspect of intravenous medication has undergone the training and is deemed competent. The names of those deemed competent can be recorded on a database, but as a minimum will be recorded in the staff members personal file. As part of the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal a review of competence will take place every three years and where there has been a practice gap of 12 months or more.

Competence for administration of adult chemotherapy will be set out in standard operational procedures of the C&V UHB. Administration of intravenous chemotherapy is limited to professionals who have completed the identified training and demonstrated competence.

8.3 Prescribing intravenous medication

Medicines should only be given by the intravenous route when the practicality and appropriateness of other routes has been excluded. The use of this route should be regularly reviewed in favour of switching to oral administration (or another route) as soon as clinically appropriate. When two or more patient medication records (prescription charts) are in use, it is essential that they are cross referenced so that practitioners are aware of all prescribed medicines. To ensure safe practice prescriptions for intravenous medication must specify the following:

- The allergy status of the patient
- Patient's name
- Prescribers signature
- The medication using approved name (in certain circumstances the brand and formulation)
- The dose and frequency
- Date of initiation and route of administration
- Concentration or total quantity of medication in the final infusion container or syringe
- Name and volume of diluents and/ or infusion fluid to be used
- Rate and duration of administration
- Stability information to determine expiry date of the final product
- Type of pump or device number being used
- For children the age and weight should be specified
- Date for treatment review
- What clinical monitoring should take place, how often and for how long, (See product characteristics and e- Injectable Medicines Guide)

The use of a normal saline flush(sodium chloride 0.9%) (only), is considered an essential part of cannula care and intravenous medication/fluid administration. It should therefore be considered as inclusive in the prescription of intravenous medication/fluid and a separate prescription is not required.

8.4 Storage of intravenous medication

The storage of intravenous and other parenteral medication (except large volume infusions) stocked on a ward or department must be in the appropriate locked pharmacy cupboard or fridge. Any medication issued for individual patients that require special storage will have this highlighted on the pharmacy label.

8.5 Preparation of intravenous medication

Whenever possible ready prepared injections, infusions or Centralised Intravenous Additive Service products (CIVAS) should be used. If any extra manipulation or medication addition is required then the staff involved must ensure that they are familiar and competent to carry out the preparation of this particular intravenous medication. Preparation and administration requires two registrants , see section 7.1.3

- Read all the prescription details carefully and confirm that they relate to the patient to be treated
- Confirm that the details on the prescription are correct e.g. dosage, diluents/s. concentration rate of administration and that the patient is not allergic to the medicine or any of its components.
- Ensure that the area to be used for the preparation is clean and clear of clutter. Ideally this should be a dedicated area just for the preparation of intravenous medication
- Assemble all the equipment and infusion devices required including flushes if they are required. Process the preparation using a non-touch technique (ANTT), i.e. avoid touching areas where bacterial contamination may be introduced e.g. syringe tips, needles and vial tops.
- Prepare the label (see below)
- Beware of confusion due to similar names and/ or packaging, by reading the labels carefully.
- Check expiry date of all the materials and medication used Check for damage to containers, vials, ampoules and packaging Confirm that the materials have been stored correctly Complete any calculations. These should be written in the patient's notes and checked by an independent practitioner who is competent in the administration of that intravenous medication.
- Hands must be cleaned according to the control of infection guidelines
- If a giving set is required it should be attached using the technique appropriate for the type of container. The line must be primed in accordance with nursing procedures.

8.6 Labelling of intravenous medication

All injections and infusion additives must be labeled after preparation. Under no circumstances should a practitioner have in their possession or vicinity two or more unlabelled syringes at the same time. If the syringe is to be administered via a pump device then it must be labeled in a manner not to conceal the syringe calibrations or as to otherwise affect the function of the pump device.

In Line with NPSA Guidance Labels for intravenous medicines should clearly state the following information

- name of the medicine;
- strength;
- route of administration;
- diluent and final volume;
- patient's name;
- expiry date and time;
- name of the practitioners preparing the medicine.

8.7 Infusion devices for intravenous medication

All infusion devices in use within C&V UHB must be of a type that has been approved. Staff who use a particular device must be familiar with the function and limitation of each device that they need to use and ensure that the device is suitable for administration of the medication or diluent that is being used. Additionally, staff must be aware of the compatible giving set/s which can be used safely with that device. All staff using infusion devices must have received appropriate training for use of that particular device and have been shown to be competent in the use of that device.

8.8 Administration of intravenous medication

Before administering any intravenous medication a practitioner should be aware of any monitoring of the patient that is necessary after the medication is administered, and then check the following:

- Patient's name and hospital/NHS number
- Prescriber's signature
- The medication using the approved name (in certain circumstances the brand and formulation)
- The dose and frequency
- Date and route of administration
- The allergy status of the patient
- Check that the medication is free of haziness, particles and discoloration.
- Concentration or total quantity of medication in the final infusion container or syringe.
- Name and volume of diluents and/ or infusion fluid to be used
- Rate and duration of administration
- Stability information to determine expiry date of the final product
- Type of pump to be used
- For children the age and weight should be specified
- Date for review of treatment
- That the medication is due at that time and has not already been administered.

The person administering the medication must record the administration as soon as possible after the event in the appropriate patient record. Ask the patient to report any soreness at the injection site or any change in their well being. When an infusion is running, it should be regularly monitored by a competent member of staff who has undertaken the appropriate competence training. Administration of intravenous medication requires two registrants, see section 7.1.3.

8.9 Patient monitoring with intravenous medication

Prior to the administration of any intravenous medication the staff that will subsequently be looking after the patient must be made aware of any specific clinical requirements as to the monitoring of the patient, preferably this should be in the form of written details. Any of the results or findings from the monitoring must be documented within the patient's notes and the prescriber informed of any deviations from the expected findings. The patient should be involved in helping staff by being made aware that they should inform staff of any changes in their well being. The nurse who is looking after the patient will make frequent checks for :

- Signs of leakage from site or infusion bag
- Signs of infection or inflammation at the infusion site.
- Remaining contents of the infusion bag
- Rate of infusion.

Where particular risks are identified, these need to be clarified with the prescriber prior to administration of any intravenous medication.

8.10 Infection control and personal protective equipment

As parenteral medication is accessing the body directly bypassing the normal infection barriers, it is imperative that the control of infection and the maintenance of the medicines sterility are made a high priority by staff that are undertaking the preparation and administration of the product.

Guidance on Personal Protective Equipment is set out in the local Infection Prevention and Control Procedures.

8.11 Disposal of waste material

All waste must be disposed of in line with the C&V UHB policy on waste which must concur with current environmental legislation. Any material that has been in contact with the patient should be classed as hazardous clinical waste and disposed of via the standard method for clinical waste. Any item deemed as 'sharps' should be disposed of by being placed in a 'sharps' bin even if they have a small amount of medication left inside them. Empty infusion sets can be placed in the yellow/orange clinical waste bags or in 'sharps' boxes.

For guidance on disposal of Controlled Drugs see chapter 9. or Guidance on disposal of Cytotoxic Chemotherapy Agents see Management of Parenteral Cytotoxic Chemotherapy Policy.

8.12 Responsibilities of the pharmacist and the pharmacy department

The Pharmacist providing clinical services to a clinical area and its patients shall

- Ensure that a risk assessment is carried out on every new intravenous medication and, whenever possible a ready to use dosage formulation of the medicine is purchased in preference to any injection that needs manipulation prior to administration.
- Provide Information and advice is provided to all health care professionals on the administration of intravenous medication.
- Assist with the training of staff.
- Ensure that staff are aware of how to access the agreed standard references for intravenous medication.
- Ensure that all guidance produced for the prescribing and administration of any intravenous medication has been approved appropriately

8.13 Identifiable risks with intravenous medication

The following list is not exhaustive but includes some common general risks:

- Incomplete and unclear prescriptions that do not contain vital information concerning the dose, preparation or administration which can lead to possible errors and increased risk to patients
- Administration of medication by the wrong parenteral route i.e. giving medication by the epidural route when the correct route should be intravenous.
- Absence of relevant and accurate information concerning intravenous medication
- Complex calculations needed for prescribing the correct dose, infusion rate or

Cardiff and Vale
University Health Board

preparation of dilution for intravenous medication. Calculations should be independently double checked by a second registrant.

- Involvement of inexperienced staff (e.g. registrant or students in training) in some parts of the process.
- Selection of wrong medication or diluent.
- Use of expired items.
- Unsafe handling of toxic medication or non aseptic technique leading to infection.
- Failure to correctly identify and confirm identification of intended patient incompatibilities between medication, diluents, other medication and infusion sets or devices.

Chapter 9 - Controlled Drugs

This chapter will ensure that the UHB has a robust framework in place for the management of controlled drugs (CDs) in secondary care.

9.1 Accountability.

C&V UHB has identified the Executive Medical Director as Accountable Officer to be responsible for all aspects of the safe and secure management of CDs.

9.2 Roles and responsibilities.

It is the responsibility of the Clinical Boards to ensure that their staff are trained and competent to carry out the tasks required of them in the management of CDs.

The registered nurse, midwife or clinical lead in charge of a ward or department is responsible for the safe and appropriate management of CDs in that area.

The practitioner in charge can delegate control of access (i.e. key-holding) to the CD cupboard to another registered nurse, however, legal responsibility remains with the practitioner in charge. Whilst the task can be delegated, the responsibility cannot.

On occasions, for the purpose of stock checking, the CD key may be handed to a pharmacist or pharmacy technician on production of a current UHB ID badge.

If CD keys go missing, urgent efforts must be made to contact staff who have just gone off duty. The senior nurse on duty must be informed immediately and the pharmacy department when they next open if the keys are not located.

A duplicate set of CD keys must be supplied to the pharmacy department who will keep them secure. In the event that a set of keys goes missing and cannot be located the practitioner in charge should contact the pharmacy department or on-call pharmacist for advice. If necessary the duplicate set can be issued by the pharmacy or site practitioner. The senior nurse on duty must sign for the duplicate set.

If the original set of keys is located, the duplicate must be signed back into the pharmacy.

If the original keys are not found, the locks must be changed as soon as practical, and a duplicate set of the new keys given to pharmacy.

An entry of the incident should be completed on Datix.

When the locks on the CD cupboard need changing for reasons other than lost keys, a duplicate set must also be provided to pharmacy.

An authorised signatory is a qualified nurse, midwife or operating department practitioner (ODP) whose signature has been provided to pharmacy.

9.3. CONTROLLED DRUG STATIONERY

All stationery which is used to order, return or distribute controlled drugs must be stored securely and access to it must be restricted.

CD stationery (i.e. requisition books and registers) will be issued from pharmacy against a requisition that will be written by an authorised signatory from that ward or department. Stationery will not be issued against a signature that is not on the authorised signatory list.

A record will be made of CD stationery supplied by pharmacy.

The record will include:

- ☐ Date
- ☐ Ward/department
- ☐ Name of person ordering the stationery
- ☐ Type of stationery issued
- ☐ Quantity
- ☐ The serial numbers of the stationery – to be added at the time of issue
- ☐ Signature of the member of pharmacy staff making the supply
- ☐ Signature of the member of ward staff receiving the stationery

Loss of any CD requisition books must be reported to the pharmacy and an incident form, e-Datix completed by the area responsible for the loss of the requisition book as soon as possible following recognition of the incident.

When a new CD register is started, the balance of CDs in stock must be written into the new book promptly by a registered nurse and witnessed by a second nurse or another registered health professional. It is good practice to write the start date on the front cover.

Completed ward requisition books and CD registers must be retained for a minimum of two years from the date of the last entry by the ward or department. When the CD register is complete, write on the cover a date 2 years on from the last entry. This is the date that the register can be appropriately disposed of as confidential waste.

Other requirements for the retention of CD records are listed below:

- ☐ Aseptic Worksheets (paediatric) – 26 years
- ☐ Aseptic Worksheets (Adult) – 13 years
- ☐ Clinical trials – 5 years
- ☐ Destruction of CDs – 7 years
- ☐ External Orders and delivery notes – 2 years
- ☐ Extemporaneous preparation worksheets 13 years
- ☐ Prescriptions (inpatients and outpatients) 2 years

9.4. STORAGE OF CONTROLLED DRUGS

Ward CD cupboards must conform to the British Standard reference BS2881 or be otherwise approved by the pharmacy department. This is a minimum security standard and may not be sufficient for areas where there are large amounts of drugs in stock at a given time, and/or there is not a 24 hour staff presence, or easy control of access. In this case, a security cabinet that has been evaluated against the SOLD SECURE standard SS304 should be used (www.soldsecure.com)

Where a ward or department is to be closed for greater than 5 days, Controlled Drugs, requisition books, registers and keys must be removed from the ward and stored in pharmacy. The stock should be reconciled against the levels in the register by 2 qualified members of staff. Either 2 ward staff or a member of ward staff and a pharmacist or pharmacy technician can undertake this role. A record stating “Number returned to pharmacy XX” for each drug held in stock. The CDs will be stored in a sealed box securely in the pharmacy. When the ward or department reopens the stock will be returned and reconciled immediately against the register and an entry made in the register “Number returned to ward XX”.

The measures below must be observed for the storage of CDs:

- ☐ Cupboards must be kept locked when not in use.
- ☐ The lock must not be common to any other lock in the hospital.
- ☐ Keys must only be available to authorised members of staff and at any time the key holder must be readily available.
- ☐ The cupboard must be dedicated to the storage of CDs.

9.5. ORDERING AND DELIVERY of CD's

Controlled drugs must be requisitioned using the controlled drug order book and the requisition must be signed in full by the nurse who is an authorised signatory for that ward or department. The name of the nurse must also be printed on the requisition. A copy of the signature of each authorised signatory should be available in the pharmacy department for validation. Ward or department managers will be responsible for ensuring that new members of staff provide a specimen signature to pharmacy and inform pharmacy when members of staff leave in order that their names can be removed from the approved list. Pharmacy will co-ordinate an annual update of the records held.

Each order must be in duplicate, with the white page as the top copy and one item ordered per page.

Requisitions must contain the following:

- ☐ Name of the hospital
- ☐ Ward/department
- ☐ Drug name, form, strength, ampoule size if more than one is available
- ☐ Total quantity required e.g. 5, 10 etc – not a number of boxes (i.e. one box). When quantities ordered do not correspond to a complete box the quantity will be altered by pharmacy to the nearest appropriate number.
- ☐ Signature and printed name of the registered nurse
- ☐ Date
- ☐ Signature of the person issuing from the pharmacy

The order book must be kept in a locked cupboard or drawer when not in use. Spare CD stationery must also be kept secure.

Each ward/department should only have one order book in use at any given time. If a ward/department has more than one controlled drug cupboard then a separate book may be used for each cupboard.

Orders for stock controlled drugs from the agreed ward stock list must be sent to the pharmacy before 10:00 a.m. Controlled drugs will normally be delivered to the wards by a porter at UHW and UHL.

Cardiff and Vale
University Health Board

Controlled drugs for departments or wards may be collected by a messenger who must be a member of UHB staff and bring an official organisational ID badge for identification. The messenger need not be a qualified nurse.

The messenger or porter transporting the controlled drug to the ward/department is responsible for the safe custody of the drug until signed for by the qualified member of staff.

Controlled drugs delivered by a messenger or porter must be checked immediately on arrival at the ward/department by a qualified member of staff. The pink copy of the requisition must be signed to accept the CDs onto the ward. On receipt the CDs must be entered into the controlled drug (CD) register immediately.

The following details should be recorded on the appropriate page in the CD register:

- ☐ Date of entry
- ☐ Name and signature of nurse making the entry
- ☐ Name and signature of the witness
- ☐ Balance in stock
- ☐ The serial number of the requisition
- ☐ Quantity received

9.6. EMERGENCY SUPPLY OF CONTROLLED DRUGS

Under normal circumstances all supplies of CDs must be through the pharmacy department. If a controlled drug is required urgently for a patient when the relevant pharmacy is closed, the drug is not available on the ward and no other drug is a suitable alternative, then one dose may be obtained from another ward.

The ward requiring the dose must take their CD register to the ward providing the dose. The dose of the drug required should be signed out of the CD register on the providing ward and into the CD register of the receiving ward by 2 qualified members of nursing staff. The following must be recorded in both CD registers:

- ☐ Date and time when dose is transferred
- ☐ Name of patient
- ☐ Names & signatures of nurses who transferred the dose
- ☐ Quantity transferred
- ☐ Balance in stock in both CD registers

9.7. RETURN OF CONTROLLED DRUGS TO PHARMACY

Controlled drugs are returned to pharmacy for two purposes, safe destruction or recycling and re-use. The following must be recorded in the ward CD register when CDs are returned to the pharmacy

- ☐ Date
- ☐ Name and Signature of the nurse.
- ☐ The name and signature of the pharmacist or pharmacy technician accepting the CDs for return.
- ☐ The quantity of drug being returned.
- ☐ Reason for return e.g. out of date, excess stock
- ☐ Balance remaining.

On return to the pharmacy, the pharmacist or technician who accepted the CDs for return and re-use must enter the CDs into the appropriate page in the pharmacy CD register immediately. The stock must be booked back into the computer stock balance and a reconciliation of the balance on the shelf, the balance in the register and the balance on the computer be made. All 3 levels must tally. Any discrepancy must be investigated immediately. The following details must be recorded on the relevant page of the pharmacy CD register:

- ☐ Date
- ☐ Ward from which the return is being made.
- ☐ The amount of preparation being returned
- ☐ The name and signature of the pharmacist or technician making the return.
- ☐ Balance in stock.

If the CDs are for destruction an entry must be made in the appropriate destruction register in the pharmacy - i.e. patient's own or returned stock registers.

Patient's own returns can be destroyed without the presence of an Authorised Person. The details required in the register are:

- ☐ Date
- ☐ The ward & the name of patient, if appropriate
- ☐ The preparation and quantity being returned
- ☐ The name & signature of the pharmacist/technician making the return
- ☐ The next reference number for destruction

If the CD is "date expired stock" for destruction it must be entered in the destruction register for this purpose and the above details recorded as appropriate

9.8. PRESCRIBING CONTROLLED DRUGS

Inpatient Prescribing

For hospital inpatients, CDs can be prescribed on the inpatient medicines chart or the anaesthetics card in line with local policies and procedures.

The written requirements for controlled drugs on these charts are the same as for other medicines: if prescribed “when required” e.g. for breakthrough pain, a minimum interval for administration should be specified e.g. every six hours; and a total quantity to be administered in 24 hours. **Prescribing for Outpatients or discharge prescribing** Prescriptions for CDs for outpatients or discharge must comply with all the requirements of the Misuse of Drugs Act. Prescriptions must be written on a discharge form or an outpatient form. Doctors who have not achieved full registration with the GMC are permitted to prescribe CDs for patients on discharge but not for out patients. Under normal circumstances a maximum of 30 days only should be prescribed. If there are compelling circumstances for the prescription of more than this duration then the reasons must be documented in the patient’s notes. A prescription for a controlled drug is valid for a period of 28 days from the date of issue.

Cardiff and Vale
University Health Board

Documentation and Prescription The prescription must be indelible i.e. written by hand, typed or computer generated. Addressographs may be used. If an addressograph is used, it must be tamper evident. Prescribers should also sign across a corner of the addressograph. This is a further safeguard to ensure addressographs are not tampered with or another addressograph is not placed on top of the one that the prescriber signed for.

The prescription must include the following details:

- ☐ The patient's full name, address and, where appropriate age
- ☐ The patient's hospital number
- ☐ The name and form of the drug e.g. tablets, capsules even if only one form exists
- ☐ The strength of the preparation, where appropriate
- ☐ The dose to be taken
- ☐ The total quantity of the preparation (liquids) or the number of dosage units (tablets, capsules, ampoule, patches) to be supplied in both words and figures

The prescription must be signed by the prescriber with his/her usual signature, in his/her own handwriting (this must be handwritten) and dated by him/her (the date does not have to be handwritten).

A pharmacist is authorised to dispense a prescription for a Schedule 2 or 3 controlled drug if it specifies the total quantity only in words or in figures, or if it contains minor typographical errors, provided that any amendments are indelible and clearly attributable to the pharmacist dispensing.

Nurse Independent Prescribers

Nurse Independent Prescribers are now able to prescribe any licensed medicine for any medical condition within their competence, including some CDs for specific conditions.

Nurse Independent Prescribers are permitted to prescribe, administer, or direct anyone to administer as prescribed.

9.9 ADMINISTRATION of CD

Controlled drugs must only be administered against a prescription signed by an appropriately qualified prescriber, or in the case of midwives a relevant drug protocol. Two practitioners must be involved in the administration of CDs; one of them must be a registered nurse, midwife, ODP or doctor. The second can be one of these groups or a 2nd or 3rd year student nurse, except when checking intravenous drugs. The exception to using student nurses is in paediatrics where 2 registered nurses must administer the CD. Both practitioners must be present during the whole of the administration procedure. They should both witness:

- ☐ The preparation of the CDs to be administered
- ☐ The CD being administered to the patient (except in the administration of CDs by midwives attending a home birth where a midwife has collected the CD from the Midwifery Led Unit, and single nurse practitioners in the community) The destruction of any surplus drug e.g. part of an ampoule not required

A record must be made in the ward or department CD register when a CD is removed from the CD cupboard. The following details must be recorded on the relevant page in the CD register:

- ☐ Date and time when dose administered
- ☐ Name of patient
- ☐ Quantity administered
- ☐ Name and signature of nurse who administered the dose
- ☐ Name and signature of the witness
- ☐ Balance in stock

If part of a vial is administered to the patient, the registered nurse must record the amount given and the amount wasted e.g. if the patient is prescribed 2.5 mg diamorphine and only a 5mg preparation is available, the record should show, *"2.5mg given and 2.5mg waste"* This must be witnessed by a second registered nurse who must also sign the record. If a second registered nurse is not available, the administration can be witnessed by any of the staff listed as appropriate checkers

Individual doses of CDs which have been prepared for immediate administration but not administered must be destroyed by a registered nurse midwife or registered health professional on the ward or department in the presence of a witness who can be another registered nurse, doctor, pharmacist or pharmacy technician. The reason must be documented and signed in the CD register by the practitioner and the witness.

9.10. DISPOSAL/DESTRUCTION OF CONTROLLED DRUGS

CDs must be destroyed in such a way that the drug is denatured or rendered irretrievable so that it cannot be reconstituted or reused. Where denaturing is carried out on the wards, the methods used should be those currently recommended by the Royal Pharmaceutical Society. Any pharmacy held stock of obsolete, expired or unwanted Schedule 2 CDs, other than those returned by patients, which require destruction, may only be destroyed in the presence of an authorised person. Authorised witnesses currently include inspectors of the Royal Pharmaceutical Society, Police constable, the Accountable Officer and the Chief Pharmaceutical Officer to Welsh Government.

The Accountable Officer for the UHB can also nominate Executives of the organisation to witness destruction.

Until they can be destroyed, obsolete, expired and unwanted stock CDs requiring safe custody, must be kept segregated from other CDs in the CD cupboard. Stock CDs awaiting destruction should be clearly marked in order to minimise the risk of errors and inadvertent re-issue or administration.

Small amounts of CDs, for example, the surplus when a dose smaller than the total quantity in an ampoule or vial is drawn up or when a dose is drawn up but not used, must be rendered irretrievable by emptying into a yellow top sharps bin. The emptied vial or ampoule must then be placed in the sharps bin. When the bin is sent for destruction it should be labelled "contains mixed pharmaceutical waste and sharps – for incineration".

Larger quantities of CDs, for example, discontinued infusions or patient-controlled analgesia (PCA) syringes, must be denatured on the ward using denaturing kits.

All destruction must be documented in the appropriate section of the CD register. It must be witnessed by a second professional such as a registered nurse, midwife or ODP. If any of the previously listed staff are not available to witness the destruction then a doctor, pharmacist or pharmacy technician may witness it. Both persons must sign the CD register.

Individual doses of CDs which have been prepared but not administered must be destroyed by a registered nurse, midwife or registered health professional on the ward or department in the presence of a witness and the reason documented in the CD register.

Controlled drugs that are time-expired or otherwise unfit for use (e.g. opened liquids) or are excess stock must be returned to the pharmacy for safe destruction.

If it is necessary to destroy the contents of a PCA/PCEA syringe that has been transferred to the ward, the destruction must be recorded in the CD register

9.11. CONTROLLED DRUG REGISTERS AND RECONCILIATION OF BALANCES

The CD register must be bound with sequentially numbered pages and it should have separate pages for each drug, formulation and strength of formulation, so that a running balance can be easily kept. Entries must be made in chronological order, in ink or be otherwise indelible.

- If a mistake is made it must be bracketed in such a way that the original entry is still clearly legible. No crossings out or alterations are allowed. The entry must be signed, dated and witnessed by a second registered nurse, midwife or other registered professional. The witness must also sign the correction.
- On reaching the end of a page in the CD register, the balance must be transferred to another page. The new page number must be added to the bottom of the finished page and the index updated.
- The stock balances of all controlled drugs on all wards must be reconciled a minimum of once daily and a record of the check recorded. The registered nurse in charge is responsible for ensuring that the CD stock check is carried out by staff in the ward or department
- Original packs of CDs with intact tamper evident seals, do not need to be opened for checking purposes.
- If stock reconciliations do not balance, the matter must be reported immediately to the appropriate senior nurse manager who will inform a principal pharmacist/senior member of pharmacy team e.g. PSG bleep, or deputy at the earliest convenient opportunity. An investigation to confirm the loss will be undertaken by the senior nurse in conjunction with the ward pharmacist if necessary. A formal incident form must be completed with advice to the Accountable Officer on escalation.
- The pharmacy department will carry out a full stock reconciliation on the wards and departments at a minimum of every six months. The quality of record keeping will also be assessed at that time and feedback on the quality of record keeping will be discussed with the nurse in charge. If necessary, recommendations for improvements will be agreed.
- All controlled drugs in the pharmacy must be checked every 12 months. This check may be undertaken by any competent person approved by the pharmacist with operational responsibility for CDs or a suitable deputy approved by the chief pharmacist.
- This check is in addition to the rolling checks on the CD register.

9.12 USE OF A PATIENT'S OWN CONTROLLED DRUG ON THE WARD

Temporary storage of patients' own controlled drugs on the ward may be necessary whilst they are awaiting collection and removal to the pharmacy or to the patient's home. In this situation, they must be placed in the CD cupboard but should be marked and kept separate from ward stock. An entry detailing the patient's CD must be made on Patients Own record of the administration of a dose must be documented in the CD register.

If patients' own CDs are not required for use during the patient's admission then one of the following actions should be followed and recorded in the CD register.

- If the patient or the patient's representative agrees, medicines may be sent to the pharmacy for safe destruction. The pharmacist must take responsibility for destruction. Document the agreement to destroy the drugs in the patient's notes.
- If the patient wishes, the medicines may be returned home via an identified adult. Responsibility for security is given to that adult and this action documented in the patient's notes. If the medicines are not safe and/or appropriate for use, then the patient and/or patient's representative should be advised and they should be encouraged to send them to the pharmacy for safe destruction. This must be documented as for any other CD returned to pharmacy.

Cardiff and Vale
University Health Board

☐ If a patient has brought in CDs and is awaiting assessment of competence for self administration, the CDs should be held in the ward CD cupboard until the assessment is completed. A record of the CDs must be made on a page of the ward CD register headed Patients' Own CDs.

In areas where the UHB Patients Own Medicine procedure (POMS available on Cav. Web) operates, self administration of CDs is acceptable providing the following steps are undertaken:

- ☐ The patient must be assessed as competent to level 3 for self administration in the POMS procedure
- ☐ Where patients require extra supplies, they must be dispensed as for discharge i.e. using a TTH form – discharge prescription form.
- ☐ Patients receiving CDs for self-administration should sign for receipt of the specified number of doses. A separate page of the CD register can be used for this purpose.
- ☐ The CDs for patients who self-administer their medicines must be kept locked in their bedside locker. It is not acceptable for patients self administering CDs to keep them in any other place.

9.13. CONTROLLED DRUG DISCHARGE MEDICINES (TTHs) AND RECEIPT OF CDs BY OUTPATIENTS

When Schedule 2 CD TTHs are collected from the pharmacy, the person collecting them will be asked to sign for receipt. They may be signed for by a healthcare professional, porter or a healthcare assistant.

The following details will be recorded in the CD collection register:

- ☐ The date, the name, form and strength of the drug and the patient's name
- ☐ The name and address of the healthcare professional collecting the CDs
- ☐ The form of identification provided by the healthcare professional e.g. identity badge or whether the messenger is known to the dispenser.
- ☐ The name of the member of pharmacy staff handing out the prescription

When an outpatient prescription is being given to the patient or their representative or relative the following details must be recorded:

- ☐ Whether the person who collected the drug was the patient, the patient's representative or a healthcare professional acting on behalf of the patient
- ☐ If the person who collected the drug was a healthcare professional acting on behalf of the patient, that person's name and address (as above)

Cardiff and Vale
University Health Board

- ☐ If the person who collected the drug was the patient or their representative, whether evidence of identity was requested. As a matter of good practice, a note as to why the dispenser did not ask may be included but this is not mandatory.

9.14. TRANSFERS BETWEEN CLINICAL AREAS

When a patient on a PCA/PCEA containing a CD transfers between 2 clinical areas the following steps must be taken:

- ☐ The nurse/practitioner transferring the patient must make an entry on the PCA/PCEA observation sheet detailing the amount left in the syringe. He/she must sign and date the entry.
- ☐ A second practitioner must sign and date the entry as a witness.
- ☐ The nurse/practitioner accepting the patient in the new clinical area must check the contents of the syringe on receiving the patient and sign and date an entry on the PCA record which must be countersigned by the nurse/practitioner transferring the patient.

Cardiff and Vale
University Health Board

A patient transferring between 2 clinical areas on a sub-cutaneous syringe driver containing a CD must have a similar record of the amount remaining in the syringe made on the Sub Cutaneous Syringe Driver Chart.

Patients' own CDs stored in a ward CD cupboard should be transferred with the patient. The CDs must be signed out of the first CD register by two registered practitioners and into the second CD register by two registered practitioners.

9.15. CONTROLLED DRUGS FOR MIDWIVES

Midwives working in the Consultant Led Unit on UHB sites must follow all the elements of this policy.

A registered midwife may possess diamorphine, morphine, pethidine and pentazocine in her own right so far as is necessary for the practice of her profession.

Midwives providing care for women during a home birth where pethidine is required will acquire the pethidine from the Midwifery Led Units (MLU) where stock for community use is stored. The procedures for administration will be followed. Midwives will carry the pethidine in a locked box on route to the woman's home. If the pethidine is not used the midwife will return it to the MLU stock and record this in the relevant CD register.

9.16. RECEIPT AND HANDLING OF CDs BY PHARMACY

The is responsible for the safe and appropriate management of CDs in the pharmacy. Day-to-day management of CDs in the pharmacy will normally be delegated to a suitably-trained, competent registered pharmacy technician or pharmacist. However, legal responsibility for CDs remains with the Director of Pharmacy.

On receipt of a CD order from a wholesaler, the CDs must be brought to the member of staff in the purchasing section with responsibility for processing CD orders. He/she will take the following action:

- ☐ The delivery will be checked against the order and delivery note for accuracy.
- ☐ The delivery will be locked in the CD cupboard/room at the first opportunity.
- ☐ The quantity delivered will be checked against the delivery note and added to the balance in the register. The new total must be reconciled with the CD register and pharmacy computer system balance. All balances must be reconciled.

Cardiff and Vale
University Health Board

- ☐ When the balance is reconciled, the CD delivery must be entered into the CD register and onto the pharmacy computer system balance.
- ☐ If there is a discrepancy between the order and the delivery, the delivery should be locked in the CD room/cupboard until the discrepancy has been investigated. This should be done within 24 hours when practical but at the earliest opportunity at times such as weekends or Bank Holidays.

9.17. TRANSFER OF CDs USING MESSENGERS

A person who conveys CDs between sites is acting as a messenger and is responsible for delivering a sealed or locked container. The seals or locks used must be tamper evident.

The messenger is responsible for the delivery of a sealed intact container.

A transport log will be used to provide an audit trail for the transport of CDs and will require a signature at each point of transfer. See Appendix 3.

The procedure below will be followed:

- ☐ The CDs will be sealed in the container for transport along with the CD requisition book.
- ☐ The white copy of the CD requisition will be annotated with "Into bag/container" rather than being signed and if a numbered seal is being used the number of the seal will be recorded on the white copy.
- ☐ The sealed bag/envopak/box will be signed for on the transport log by the messenger.
- ☐ On delivery to the receiving ward the transport log will be signed by a member of staff who is qualified to handle CDs.
- ☐ This member of staff will break the seal and verify the contents of the bag and match it the order. They will enter the CDs into their CD register in the normal way.
- ☐ Any discrepancies must be reported to the duty pharmacist immediately
- ☐ The white copy of the CD requisition and the transport log will be returned to the issuing pharmacy as soon as possible by the receiving clinical area.
- ☐ All members of UHB staff signing for CDs to transport must show a valid ID badge.
- ☐ If taxis are being used to transport CDs, a record of the taxi-drivers' car registration or taxi licence number must be obtained.
- ☐ If, at any site, the sealed bag is to be left for collection, a signature from a member of UHB staff (e.g. a porter at the porters lodge) must be obtained on the transport log. Also if the driver is required to leave the sealed bag at a porter's lodge for onward delivery to the ward it must be signed for. The person signing to accept the bag for onward delivery must also obtain a signature from the destination ward/department staff on the transport log when they deliver the bag.

9.18. CONTROLLED DRUGS WITHIN ANAESTHETIC ROOMS

- ☐ A specific controlled drug record book is available for use in Theatres/Anaesthetic rooms within the UHB.
- ☐ Controlled drug supplies may be received directly from pharmacy or from theatres suite central CD stock.
- ☐ Receipt of controlled drugs may be undertaken and witnessed by a registered nurse or registered ODP
- ☐ The quantity supplied to a doctor for a specific patient must be recorded against that specific patient name in the controlled drug record book, signed for by that doctor and signed for by an authorised witness. The quantity administered to the patient must be recorded and signed for by the doctor. The quantity destroyed must be recorded, signed for by the doctor and signed for by an authorised witness.
- ☐ The doctor is responsible for this supply whilst in their possession.
- ☐ The stock balance must be confirmed at the end of each transaction i.e. receipt, issued to doctor and recorded in the relevant column.
- ☐ The stock balance must be checked at the beginning and end of each operating list. Stock reconciliation should be recorded in the stock checks section at the back of the controlled drug record book, which the checker and witness must sign.

Chapter 10 – Return, Disposal and Destruction of Medicines

Medicines that are no longer needed retain their legal status as medicines until such time as they are assessed and destroyed when their legal status becomes controlled under Waste Regulations. It follows that the management and handling of excess or unwanted medicines requires equal diligence to the management and handling of other medicines in current use.

10.1 Return of excess or unwanted medicines

10.1.1 Acute and community hospitals

All excess or unwanted medicines must be held within the ward or clinical area until such time as safe arrangements has been made for their disposal. Wards receiving stock control by pharmacy staff must not make returns without prior agreement with the pharmacy. Pharmacy staff will return stock to pharmacy at the time of stock control. Wards who order their own stock should notify pharmacy of any excess or unwanted medicines usually by e-mail. Safe arrangements should be made for the return of these excess or unwanted medicines to pharmacy during normal pharmacy opening hours, using hospital transport or a porter with an auditable record of dispatch. It would be considered good practice for wards to have a record of items returned.

10.1.2 Community nurses

Community nurses requested to return medication of patients in the community should encourage the patient or a carer to take them to the supplying pharmacy for destruction.

10.1.3 Medicines brought into hospital by patients

These medicines remain the patient's property, and when they are brought into hospital they should be identified and those products that are appropriate to be continued, are to be retained in the patient's PODs cupboard. Medicines not required should be sent home, or with the patients permission to pharmacy for disposal.

10.2 Disposal of cytotoxic medicines

Arrangements for the disposal of cytotoxic medicines should be in accordance with the recommendations contained in the current policy on the disposal of clinical waste.

10.3 Disposal of Controlled Drugs

Excess or unwanted CDs must be returned and disposed of in accordance with the Medicines Code Chapter 9.

10.4 Disposal of part used syringes and injections

Syringes that are not fully discharged and partly used infusion bags containing prescription only medicines (POMs) should be disposed of utilising an appropriate 'sharps' container. They must not be returned to pharmacy.

10.5 Disposal of medicines by the pharmacy

All disposal and destruction of medicines within the pharmacy must be in accordance with departmental procedures and in line with current Waste Regulations and guidelines from the Professional Regulatory body for pharmacy.

Chapter 11 - Defects, Hazards, Adverse Reactions and Incidents Involving Medicines

11.1 Losses and discrepancies

Loss or suspected loss or misuse of medicines should be reported to the Sister/charge nurse/clinical lead or nurse-in-charge and the senior pharmacist who can then decide on a further course of action. A Datix entry must be submitted

11.2 Management of medication errors

In order to prevent medication errors, it is in the individual responsibility of all practitioners to adhere to their Code of Practice, Regulatory Guidance, National and Local Policy and Procedures and to the C&V UHB Hospitals' Medicines Code at all times. Adhering to this guidance will maximise patient safety and minimise risk.

A medication error can be defined as a preventable error that may cause or lead to inappropriate medication use or patient harm while medication is in control of the health care professional or patient. Such events may be related to professional practice, health care products, procedures and systems including prescribing; order communication, product labeling, packaging and nomenclature; compounding; dispensing; administration; counseling and monitoring. Health practitioners should learn from any medication error, near miss or adverse outcome in order to prevent repetition. A balanced approach is required to protect patients and staff alike. Staff must be given adequate support by their line manager as applicable to the circumstances specific to the medication error.

The over-riding concern is to protect patient care and the immediate clinical action that may be required to reverse or negate any adverse clinical consequences.

11.3

11.2.1 Action to be taken in event of medication error

Action is to be taken following a medication error (this includes administration, dispensing or prescribing errors) that has led to inappropriate medication administration to a patient: - Patient safety must be maintained. Inform a member of the patient's medical team.

The patient must be reviewed and a medical action plan produced specific to the nature of the medication error.

Cardiff and Vale
University Health Board

The ward/department manager/nurse/clinical lead in charge must be informed.

In the event of a dispensing error that has led to inappropriate medication administration, inform a senior member of the pharmacy staff.

11.2.2 Reporting a medication error

All incidents involving medicines that have led to inappropriate medication administration must be reported using a Datix entry.

This is to ensure that the Patient Safety Team is informed of all incidents in a timely manner, delivery of the incident information should not be delayed until all proposed actions have been carried out. Instead, simply specify the actions proposed.

- When completing the report, the staff member involved in, or witnessing an incident must ensure that the details recorded are concise, a true version of events and complete. An appropriate record must also be made in the clinical notes, medical / nursing. This is not duplication since all events relating to the patient need to be clearly stated, as the incident report does not form part of the medical record. It is important for the person reporting the incident to confine themselves absolutely to the facts. There is no place for an expression of opinion however well meant. No reason for events is required, even if the person reporting the incident is implicated. Merely state the facts as they are. Further information may be required at investigation, statements from staff, number of patients, dependency, staffing levels, time of day and any other circumstances which might impact on the issues.

A senior member of the multi disciplinary team must inform the patient / relative and this should be recorded in the clinical notes.

Where equipment is involved in the medication error, staff must ensure that the item is removed from use immediately and defects are reported to the Biomedical Engineering.

11.2.3 Serious medication errors

A serious medication error is when patient harm occurs or is anticipated. In the event of a serious error the consultant must be informed as soon as possible. If this is outside normal working hours, the Site Practitioner must be contacted via switchboard. He/she will then contact the on call manager / consultant as appropriate.

It is important that the Executive Medical Director, the Director of Nursing and the Director of pharmacy and the patient safety team are informed of the error and the relevant circumstances at the earliest opportunity. Serious incidents may be deemed notifiable to the

Cardiff and Vale
University Health Board

Welsh Government and this is required within 24 hours of the incident or the next working day.

In the event of a serious medication error, the Patient Safety Team will facilitate the preliminary investigation under the guidance of the Executive Medical Director and Medicines Safety Executive

All serious medication errors along with patient related incidents will be reported to the National Recording and Learning System (NRLS) via the Patient Safety Team.

Error analysis and recommendations will be conducted in accordance with local procedures.

11.3 Near misses

Any event that would have led to an error but did not actually happen due to last minute intervention should be reported as a 'near miss'. In clinical risk management terms, reporting a near miss is just as important as reporting an actual error. Medication errors are rarely the 'fault' of individual practitioners and are commonly the result of poor processes/systems. The collation of information on near misses can provide valuable data that may indicate poor system design.

It is important that the continued reporting of errors and near misses is seen as a means of learning in order to minimise future risk.

11.3

11.4 Medicines Safety Executive a sub group of the Corporate Medicines Management Group

Will review medication errors and pharmacy intervention data and undertake trend and root cause analysis. The group will co-ordinate actions required in the event of national safety alerts and produce and issue to the clinical areas any local safety alerts deemed appropriate. The group has the authority to initiate action, which may involve system redesign and improvement and/or education, training and competency assessment of healthcare professionals on any aspect of medicines use.

Cardiff and Vale
University Health Board**11.5 Management of staff involved in medication errors.**

All medication errors should be investigated locally to determine whether the incident is due to a system failure or inappropriate action(s) by a member of staff. This procedure will only be used if it is determined that the incident is the result of inappropriate action(s) by a member of staff.

Procedures need to be in place to identify if this is the first or subsequent time (s) the individual/individuals have been involved in such an incident and the time span in which the incidents have occurred. Consideration should be given to the circumstances surrounding the incident and the individual's previous practice and performance.

In the event of a culpable individual making an initial error the recommendation will be to provide guided supervision to the staff member by their line manager. This will involve explaining the relevant area of the UHB Medicines Code. The error will be documented in the staff member's personal file where it will remain live for 2 years.

In the event of a sentinel event involving medication errors a Root Cause Analysis and its subsequent findings will be used to determine the management of staff involved.

If an individual makes a subsequent medication error within a rolling two year period then they will be provided with guided supervision and be expected to undertake training, (during this time consideration may be given to refrain the individual from prescribing, dispensing or administering drugs until a formal session of training by nurses, midwives, doctors and pharmacists dependent on the profession involved this should include a competency assessment relating to prescribing, supplying and / or administration.

If however an individual's practice results in a 3rd error within two years and where the individual has been fully supported with education and deemed competent following previous errors within the preceding two years consideration of whether implementation of the UHB's Capability and/or Disciplinary Policies is appropriate at this point must be discussed.

Following a 4th error within a two year period the UHB Capability and/or Disciplinary Policies must be implemented.

Each profession will need to interpret this guidance according to their Professional Code of Practice

If a UHB bank member of staff makes a drug error they may be limited to where they can work until such time that training has been instigated and assessed.

If an agency member of staff makes an error they will be referred to their manager for training. Evidence of that training will be required by the UHB. If any subsequent errors are made, consideration will be given as to whether placement within the UHB is appropriate.

11.6 Reporting and recording adverse drug reactions and defective medicinal products

11.6.1. Adverse drug reactions

All suspected and confirmed adverse reactions to medicines including contrast media should be reported to the Commission on Human Medicines (CHM), Medicines and Healthcare Regulatory Agency (MHRA) using the "Yellow Card system", or available on line. These can be found in the back of each copy of the British National Formulary www.yellowcard.mhra.gov.uk The nature of the adverse reactions and the medicine involved should be accurately recorded in the patients' case notes. A clearly visible statement to the effect that the patient has suffered an actual or suspected adverse reaction to a given medicine should be permanently imprinted inside the front of the case notes and/or the electronic patient record and also on the in-patient chart (patient medication record) and out-patient and discharge prescriptions, either in large lettering or using specially prepared label.

11.6.2 Defective medicinal products

The Medicines and Healthcare products Regulatory Agency (MHRA) investigates all reports of defective medicines. Where the results of investigations have implications for other patients or users, the MHRA will issue a Hazard or Medicines Alert, which advises of hazardous products or unsafe practices.

Healthcare staff must report their concerns to a duty pharmacist or emergency duty pharmacist (if out of normal working hours) if a defective or potentially defective medicine is suspected. Examples of defective medicines include defective products themselves, wrong products contained in outer packaging, poor or incorrect product labelling, poor or incorrect instructions for use. If a health professional has concerns regarding a potentially defective medicinal product they should contact the pharmacy department. The pharmacy department is responsible for informing the MHRA of defective or potentially defective products. During normal working hours the senior pharmacist on site must be informed of the defect or potential defect. Details should be discussed with a member of pharmacy quality control prior to transmission of details to the MHRA.

Outside of normal working hours the emergency duty pharmacist should contact the Director of Pharmacy or a senior pharmacist prior to a decision to inform the MHRA. When a decision has been made to inform the MHRA, the Director of Pharmacy or other senior pharmacist should complete the Medicinal Product – Suspected Defect Report Form available online at www.yellowcard.mhra.gov.uk.

Chapter 12 - Unlicensed Medicines and Unlicensed Indications

Note: Cardiff and Vale University Health Board's procedure for the use of unlicensed medicines and medicines outside their product licence, and the Welsh Risk Pool Services' Technical note on prescribing of unlicensed drugs or using drugs for unlicensed indications are under review. The information contained in this chapter will be updated in line with any changes in the above guidance when available.

12.1 What is a product licence?

A medicine must be granted a product licence or marketing authorisation from the Medicines and Healthcare products Regulatory Agency (MHRA) or the European Medicines Agency (EMA) before it can be widely used within the UK (1). Licences are granted only if acceptable standards of efficacy, safety and quality are met (1,2).

A licensed product must work for the purpose for which it is intended. The product license defines the medicine's terms of use and is detailed in the manufacturers Summary of Product Characteristics (SPC). Information is provided on the indication(s), recommended dose(s), contraindications, special warnings and precautions for use (3).

The licensing process therefore reduces risk in medicines usage. Occasionally there may be a clinical need for a patient to be treated with an unlicensed medicine (a medicine with no UK product license) e.g. midodrine or mexilitine; or with a licensed medicine outside the terms of the licence ("off-label") e.g. vitamin K intravenous formulation administered via the oral route for the reversal of over anticoagulation in warfarinised patients (2).

The use of unlicensed medicines or medicines outside their product licence is indemnified by the All Wales Risk Pool only if supported by an appropriate policy (4). Cardiff and Vale University Health Board requires that this Procedure for the Use of Unlicensed Medicines and Medicines Used Outside their Product Licence is followed so that they may take vicarious liability for healthcare staff involved in any aspect of unlicensed medicines procurement, prescribing, supply or administration.

12.2 Healthcare professionals' responsibilities in prescribing, supplying and administering medicines

The responsibility that falls on healthcare professionals when using an unlicensed medicine or a medicine off-label may be greater than when prescribing a licensed medicine within the terms of its licence. Prescribers have a duty to ensure they are aware of the legal status of the medicines they prescribe. Prescribers should pay particular attention to the risks associated with using unlicensed medicines or using a licensed medicine off-label. These risks may include: adverse reactions; product quality; or discrepant product information or labeling (e.g. absence of information for some unlicensed medicines, information in a foreign language for unlicensed imports, and potential confusion for patients or carers when the Patient Information Leaflet is inconsistent with a medicine's off-label use) (3).

The General Medical Council's Good Practice in Prescribing Medicines (2013) document provides guidance on prescribing unlicensed medicines and prescribing medicines for use outside the terms of their licence (off-label). In either situation the prescriber must:

- Be satisfied that an alternative, licensed medicine would not meet the patient's needs.
- Be satisfied that there is a sufficient evidence base and/or experience of using the medicine to demonstrate its safety and efficacy.
- Take responsibility for prescribing the unlicensed medicine and for overseeing the patient's care, including monitoring and any follow up treatment, or arrange for another prescriber to do so.
- Make a clear, accurate and legible record of all medicines prescribed and, where common practice is not followed give reasons for prescribing the medicine.
- Give patients (or their parents or carers) sufficient information about the medicine to allow them to make an informed decision. In emergencies or where there is no realistic alternative treatment and such information is likely to cause distress, it may not be practical or necessary to draw attention to the licence. In other cases, where prescribing unlicensed medicines is supported by authoritative clinical guidance, it may be sufficient to describe in general terms why the medicine is not licensed for the proposed use or patient population.
- Answer questions from patients (or their parents or carers) about medicines fully and honestly (4).

Cardiff and Vale
University Health Board

Where an unlicensed medicine or a medicine used for an unlicensed indication is prescribed the prescriber is to inform the nurse administering the medicine (where appropriate) and the patient/carer of the unlicensed use. Pharmacists supplying the medicine must consider the need to ensure the prescriber, the nurse administering the medicine (where appropriate) and the patient/carer concerned are aware of the risks of such use

The methods used for the administration of licensed medicines may in some circumstances lie outside the product licence. It is important to note that for example the crushing or dispersing of a licensed solid dosage form for ease of administration may mean that the use of the medicine becomes unlicensed. In situations where the medicine is manipulated in a way that is not covered by the product licence prior to administration there should be discussion and agreement between the prescriber and the person who will administer the medicine. Discussion should also take place with the pharmacist to check the administration method is appropriate and that the efficacy of the medication is not changed as a result. The patient/carer should also be involved in the decision to use the medicine in this way. Refer to chapter 7 for further information.

Medicinal products covered by this procedure include:

1. Medicines which do not have a UK product licence (an unlicensed medicine).

These may include medicines manufactured by a licensed manufacturer but which are awaiting a UK product licence, are manufactured for export, have been withdrawn from the UK market or where the manufacturer does not intend to apply for a UK licence. These products are usually obtained on a "named patient basis". The pharmacy will purchase such products, usually on a named patient basis, on receipt of a written request from a consultant. In an emergency this may be supplied retrospectively. Acceptance of liability by the UHB will also depend on "peer group support" as above

2. Unlicensed medicines prepared by a manufacturer with a Specials Manufacturing Licence.

These are widely referred to as "specials". They are not usually obtained for a named patient. The responsibility for establishing the quality of the product lies with the pharmacist. A certificate of analysis will be obtained where appropriate. Where the quality of the product is judged to be unsuitable or cannot be established the prescriber will be informed.

Cardiff and Vale
University Health Board

3. Use of licensed products outside their product licence. The indication may be unlicensed, the dose range or age of the patient may be outside the licence, the route or method of administration may be unlicensed. In some circumstances the product may require unlicensed reformulation before administration. The UHB will accept liability for problems associated with such use if the use would have “peer group support”. Peer group support for the use of unlicensed medicines or medicines outside of product licenses will be determined by a variety of means for example by reference to literature which contains evidence, standard texts, specialist texts, and that which is currently accepted as reasonable clinical practice.

Prescribers have a duty to ensure that they are aware of the legal status of their use of medicines. Where pharmacists are aware of unlicensed use they must consider the need to ensure that the Prescriber is aware of the risks and benefits of such use.

12.3 Monitoring and Recording

Supplies of unlicensed medicines ordered at the request of a consultant will be recorded by the pharmacy. Supplies made to individual patients will be recorded manually and on the pharmacy computer system. The issue of “specials” will be recorded on the pharmacy computer system.

The pharmacy will report on the purchase and issue of unlicensed drugs annually to the Central Risk Management Committee.

12.4 Unlicensed Medicines Risk Assessment Form

Prescribers wishing to use an unlicensed medicine or a medicine outside of the terms of its product license must complete an unlicensed medicines risk assessment form giving details of the product and purpose for its use. The top section will be completed by the Pharmacist and sent to the Prescriber/Consultant who should complete the remaining sections, providing evidence from standard texts/publications or “peer support” i.e. Clinical Director’s signature.

The completed form should be returned to Pharmacy and will be entered into the Unlicensed Medicines database

12.5 Non-Medical Prescribing

Nurse or pharmacist prescribers may prescribe outside the terms of the manufacturer’s product license (“off-label”) as either independent or supplementary prescribers. Since December 2009 Pharmacist IP’s and Nurse IP’s can prescribe unlicensed medicines for their patients on the same basis as doctors and provided they are competent and take responsibility for doing so.

12.6 Packaging

On receipt of the medication, pharmacy will confirm that the pack is appropriately labeled with an English generic drug name, form, strength, expiry date and has an English version of the SPC. Where necessary the pack will be over labeled and an English SPC will be sourced to reduce the risk of dispensing errors and errors during administration.

12.7 Prescribing interface with GPs for unlicensed medicines and medicines outside of license

Hospital prescribers wishing to transfer the care of a patient for whom they prescribe an unlicensed medicine or a medicine outside of its product license must first seek agreement from the patient's GP. The GP may refuse to undertake ongoing prescribing. Information supporting the prescribing of the unlicensed medicine concerned must be provided where appropriate.

Chapter 13 - Medicines in Clinical Trials

13.1 Cardiff and Vale Research Review Service (CaRRS)

All clinical trials involving Investigational Medicinal Products (IMPs) are governance reviewed by the Cardiff and Vale Research Review Service (CaRRS), a pharmacy assessment forms part of this service.

All clinical trials involving IMPs that are sponsored by Cardiff University or Cardiff and Vale UHB, are also reviewed by the pharmacy clinical trials team as part of the sponsored assessment process (SAP).

The sponsor should provide copies of Research Ethics Committee, Medicines and Healthcare Products Regulatory Agency (MHRA) and UHB Research and Development Department approvals to the pharmacy clinical trials team, before a clinical trial involving medicines can commence.

13.2 Clinical trial storage, prescribing and supply

All medicines used in clinical trials within C&V UHB should be stored and dispensed by the Pharmacy department and managed to the same standards as other medicines used therapeutically.

- IMP must not be stored in offices, clinics or ward areas unless by prior arrangement with pharmacy and only where appropriate risk management processes and standard operating procedures (SOPs) are in place.
- IMP must only be used in patients recruited to the trial.
- All IMP deliveries will be correctly received and recorded by a member of the pharmacy clinical trials team.
- Temperature records will be maintained for all IMP storage locations as specified by the trial sponsor.

A prescription for a clinical trial medicine must be signed by an approved prescriber and member of the investigational team on a trial specific prescription form.

The IMP will be dispensed following a trial specific pharmacy dispensing procedure.

Accurate accountability records will be maintained for all IMPs, this level of support may vary between trials.

The clinical trial prescription will be retained in the pharmacy.

13.3 Unblinding a clinical trial medication

Pharmacy will ensure that a trial specific emergency unblinding procedure is written for all blinded trials before the trial commences.

Occasionally copies of the unblinding code breaks or trial randomisation codes may be kept in pharmacy. Pharmacy will ensure that the blind is maintained throughout the trial. Code break envelopes or codes will be returned to the sponsor or investigator at the end of the trial. Code break envelopes or randomisation lists will only be released to the trial sponsor (or investigator) when written evidence from the sponsor has been provided to the clinical trials pharmacist that the final locked dataset has been verified.

13.4 Disposal or return of clinical trial medicines

Any unwanted clinical trial study medication must be returned to the hospital pharmacy. Returned clinical trial study medication should be reconciled and recorded in the pharmacy site file as set out by the clinical trial sponsor. Returned clinical trial medicines or any un-issued clinical trial medication must be returned to the sponsor or disposed of in accordance with the clinical trial sponsors instructions.

This procedure is not applicable to clinical trials involving blood products or wound healing products.

Chapter 14 Strong Potassium Injections, **Ordering, Storing, Prescribing and Administration**

The information in this chapter reflects the requirements set out by the National patient Safety Agency in an alert aimed to minimise the risk of accidental overdose of intravenous (IV) Potassium. This information recognises the need to ensure that seriously ill patients in critical care areas who require intravenous strong Potassium as part of their treatment continue to receive it promptly

The definition of Strong Potassium injections includes:

- Solutions of Potassium Chloride of 10% or more (i.e. 1gram of potassium in 10ml)
- Solutions of Potassium Hydrogen Phosphate and Potassium Dihydrogen phosphate in ampoules and vials.

Prescribing.

IV treatment of hypokalaemia should only be instigated when the oral/enteral route is unavailable or will not achieve the required increase of serum Potassium within the clinically acceptable time.

Wherever possible prescribed ready mixed infusions. Prescriptions must be expressed as mmols of Potassium and must include rate of infusion and carrier fluid.

The rate of administration in adults should not normally exceed 10mmols/hour. ECG monitoring is recommended for higher rates.

Further guidance on dosing of Potassium is given in the UHB Good Prescribing Guide.

Pharmacy and/or your ward Pharmacist will be able to provide information on the ready mixed preparations available.

Ordering and Storage

Strong Potassium injections as defined above will be treated as a controlled drug. Ordering, supply, storage and administration must follow the procedural guidance set out in Chapter 9.

Wards required to keep a supply of strong Potassium injection are :-

Cardiff and Vale
University Health Board

UHW SITE

ICU-B3, ICU-A3, ICU/HDU Cardiac, A3 HDU, CCU

CAU, PICU, Rainbow, Neonatal

B4 Haematology, B5, CAPD Unit, RTU (T5)

EU Resus.

UHL Site

ICU, ECU, MEAU

Hafan y Coed

ECT

Wards other than those named above will only be provided with a supply of strong Potassium Chloride on receipt of a prescription chart for the individual patient, it is likely that the pharmacist will wish to discuss this individual prescription with the prescriber. If authorised the ward will again need to follow the CD process.

Administration

A two registered person independent whole process check is required for the administration of strong Potassium. As per CD procedure discussed in chapter 9.

Infusions prepared with strong Potassium must be thoroughly mixed with repeated inversion and agitation of the container.

NB Wards must not obtain supplies of strong Potassium from other wards. In normal working hours supplies should be obtained from pharmacy. Outside normal hours supplies must be facilitated via the H@N Co-ordinator/Site Practitioner.

11.3

Chapter 15 Storage of Records Relating to Medicines

Delivery notes accompanying ward/department stock deliveries

Once items delivered have been checked against the delivery note, and there are no apparent discrepancies by way of delivery error or costing error, the delivery note is to be kept on the receiving ward for 3 months and then may be destroyed.

Controlled Drug order book

These are to be kept on the ward/department for 2 years after the date of the last order entry in the book. The CD order book can then be destroyed.

Cardiff and Vale
University Health Board

Controlled Drug record book

These are to be kept on the ward/department for 2 years after the date of the last entry of receipt or administration, whichever is the later. The CD record book can then be destroyed.

If the CD Controlled Drug Record Book contains a record of destruction it must be retained for 7 years.

Medicines transit records

Upon completion of signature of the receipt, the delivery driver/ porter must return the record of receipt to the dispatching pharmacy as soon as possible. The delivery record will be kept for 3 months and then may be destroyed.

Pharmacy records

The pharmacy will retain records of orders, receipt and supply as set out in WHC (2000)/71 which details document retention as follows:

3 months: Picking records/ delivery notes to wards & departments

1 year: Stock-take reports plus current year

Worksheets for resuscitation boxes (one year after expiry of longest dated item)

2 years: Orders/requisitions for medicinal products supplied by the pharmacy including all dispensing

Top Copy of Discharge Prescription (TTH)

Controlled Drug Registers and Requisitions (2 years after last date of entry) Hazard Warnings

5 years: Unlicensed medication requests and issues

Worksheets for chemotherapy, aseptic and total parenteral nutrition

- Repackaging
- Certificates of analysis
- Recall Documentation
- Clinical trials records (5 years after end of trial)

6 years: Orders

Financial records including invoices

Disposal of waste records

7 years: Records of Controlled Drug destruction (Hospital stock or patient's own)

8 years: Medicines Information questions and answers

(25 years in case of child or obstetrics & Gynaecology)

13 years: Production records including extemporaneous Controlled Drug products and radio pharmacy

Cardiff and Vale
University Health Board

Resources

Summary of Product Characteristics (SPC) for each medicine is produced by the manufacture

eIV guide is a database

accessible via HOWIS Local

Hospital Medicines Guide

Good Prescribing Guide

British National Formulary (BNF)

Nursing Midwifery Council Standards on Medicines Management

General Medical Council

Royal Pharmaceutical Society of Great Britain

General Pharmaceutical Council

The Pharmaceutical Journal (Vol 285) 24/31 'How to keep proper pharmacy records'

NHS Choices. Medicines Information – Licensing

www.nhs.uk/Conditions/Medicinesinfo/Pages/Safetyissues.aspx accessed 20/3/2017

Medicines and Healthcare products Regulation Agency. Medicines and medical devices regulation: what you need to know Revised 2008 Available at:

www.mhra.gov.uk/home/groups/comms-ic/documents/websiteresources/con2031677.pdf Accessed 20/3/2017

Medicines and Healthcare products Regulation Agency. Off-label or unlicensed use of medicines:prescribers' responsibilities. Published 1/4/2009. Available at

<https://www.gov.uk/drug-safety-update/off-label-or-unlicensed-use-of-medicines-prescribers-responsibilities>. Accessed 20/3/2017

NHS Wales Shared Services Partnership Welsh Risk Pool Services Technical note 14: Prescribing of unlicensed drugs or using drugs for unlicensed indicators. Reviewed 8/11/2004

General Medical Council. Good practice in prescribing and managing medicines and devices. Available at: www.gmc-uk.org/static/documents/content/Prescribing_guidance.pdf Accessed on 21/3/2017

Specialist information on medicines can be found from the Medicines Information Centre UHW – number 02920742251

Cardiff and Vale
University Health Board

Glossary

Doctor: A doctor holding both registration and licence to practice with the General Medical Council.

Dentist: A dentist holding registration with the General Dental Council

Non Medical Prescriber: A registered prescriber who is not registered as a doctor or dentist.

Nurse: A nurse whose name is held on the Nursing and Midwifery Council register as a person who is capable of safe and effective practice as a nurse.

Healthcare Support Worker: A person working alongside, and undertaking care as delegated by a registered nurse midwife or health professional.

Midwife: A professional on the midwives part of the Nursing and Midwifery Councils register

Pharmacist: A pharmacist holding registration for practice with The General Pharmaceutical Council

Dietician: A dietician holding registration for practice as a dietician with the Health Professions Council.

Operating Department Practitioner: A person who is registered as an operating department practitioner under the Health Professions Order 2001.

Controlled Drug: A medicine included in the Schedules of The Misuse of Drugs Regulations.

Cardiff and Vale
University Health Board

Patients Own Medicine/Patients Own Drugs: Medicines brought into hospital by a patient having been dispensed for that patient outside of the hospital. It also includes over the counter (OTC) medication purchased by the patient and brought into the hospital.

Unlicensed Medicine: A medicine that does not have a product licence.

Parenteral Administration: Administration of a medicine by means other than the alimentary canal e.g. IV, IM or s/c

Prescription: Written instructions from a registered prescriber permitting a person so authorised to supply a prescription only medicine (POM) to the holder of the prescription.

Transcription: Copying of something written e.g. prescription, from one record to another.

Patient Group Direction: A written instruction for the supply and or administration of a licensed medicine in an identified clinical situation, signed by a doctor or dentist and a pharmacist. It applies to groups of patients who may not be individually identified before presenting for treatment.

Patient Specific Direction: A written instruction from a prescriber for a medicine to include dose, route and frequency

APPROVAL OF PRECEPTORSHIP FOR NEWLY REGISTERED NURSES AND MIDWIVES POLICY AND PROCEDURE

Name of Meeting Quality, Safety and Experience Committee

Date of Meeting 6th December 2017

Executive Lead : Executive Nurse Director

Author : Clinical Teacher Tel: 029 20687661

Caring for People, Keeping People Well : Following the Health Board's Strategy both procedure and policy are in keeping with the ethos of caring for people and Keeping people well. This report underpins the Health Board's strategy of "culture" and "population" in enabling newly qualified nurses and midwives to deliver outcomes that matter to people in a quality learning environment.

Financial impact : NA

Quality, Safety, Patient Experience impact : Compliance with this Policy and Procedure aims to ensure that there is a standardised approach to Preceptorship throughout the Health Board.

Health and Care Standard Number: 7.1

CRAF Reference Number:

Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION:

ASSURANCE is provided by;

- The policy and procedure are based on national guidelines, best practice and regulatory requirements and subsequent recommendations.
- Allocation of a trained preceptor to support and guide all newly registered nurses and midwives.
- Staff have access to education and training provided through the Nurse Foundation Programme or equivalent in-house training.
- Preceptors Identifying any new nurses or midwives who require additional support.
- Maintaining staff training records and conducting PADR/Appraisal.
- Evaluation of preceptorship programmes and feedback.

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the Preceptorship for Newly Registered Nurses and Midwives Policy and Procedure.
- **APPROVE** the full publication of the Preceptorship for Newly Registered Nurses and Midwives Policy and Procedure in accordance with the UHB Publication Scheme

11.4

Document Title: <i>Insert document title</i>	2 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

SITUATION

This document is being presented to the Committee for approval in line with the [Written Control Documents Development and Approval Procedure/ UHB Scheme of Delegation](#).

The Preceptorship for Newly Registered Nurses and Midwives Policy and Procedure has been updated and revised in line with national and regulatory guidelines. There has been a variety of Preceptorship models in operation which has resulted in variable standards of support. This policy will ensure that all newly qualified nurses are able to provide high quality care in a safe and supportive environment. Preceptors will support and nurture newly qualified nurses in order to 'deliver outcomes that matter to people'. A consistent approach to Preceptorship will make Cardiff and Vale Health board a great place to work and learn.

BACKGROUND

Preceptorship enables all newly registered nurses and Midwives to be supported as they make the transition from student nurse to new registrant. In 2014, 'Core Principles for Preceptorship' were developed by the Workforce, Education and Development Service (WEDS) and preceptorship programmes became mandatory. The Preceptorship Procedure has been updated to reflect this and provide structured guidance for all preceptors and preceptees.

ASSESSMENT

Wide consultation has taken place to ensure that the policy and procedure meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 11th July and 9th August 2017.
- The document was shared with;
- Clinical standards and Innovation Group
- Nursing and Midwifery Board

Comments were invited via individual e-mails from;
 Senior Nurse, Standards and Professional Regulation
 Practice Development Nurse for Surgery Clinical Board
 Corporate Affairs Manager
 Senior Nurse for Education
 Equality Manager
 Senior Nurse, Health Visiting

Document Title: <i>Insert document title</i>	3 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Where appropriate comments were taken onboard and incorporated within the draft document.

The primary source for dissemination of this document within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Document Title: <i>Insert document title</i>	4 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Reference Number: <i>TBA unless document for review</i>	Date of Next Review: <i>To be included when document approved</i>
Version Number: <i>1 unless document for review</i>	Previous Trust/LHB Reference Number: 354

Preceptorship for Newly Registered Nurses and Midwives Policy

Policy Statement

To ensure that the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will provide a robust preceptorship process for all newly qualified nurses and midwives who are employed in this organisation.

Preceptorship enables all newly registered practitioners to be supported as they make the transition from student to new registrant in a supportive and nurturing environment. This period of support will increase confidence, develop knowledge and skills which will facilitate a competent workforce and ensure a high quality experience for new registrants and the patients/clients that they care for.

Policy Commitment

Cardiff and Vale University Health Board are committed to ensuring that suitably experienced and trained nurses and midwives are identified and available to undertake the role of preceptor. This policy sets out preceptorship arrangements for Band 5 entrants and provides a standardised approach to ensure consistency across this Health Board.

The Preceptorship Procedure will provide role clarity and key responsibilities of the preceptor, preceptee, sister/charge nurse or midwife, senior nurse/midwife and clinical board nurse/midwife. An overview of the process for monitoring the development and competence of the new registrant will also be outlined.

Document Title: <i>Insert document title</i>	5 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Document Title: <i>Insert document title</i>	6 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Supporting Procedures and Written Control Documents

This policy is supported by the following documents:

Capability Policy

<http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Capability%20Policy%20June%2020131.pdf>

Disciplinary Policy and Procedure

<http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/NHS%20Wales%20Disciplinary%20Policy%20and%20Procedure%20adopted%20PPP%2016.05.17.pdf>

Health and Safety Policy

<http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Health%20and%20Safety%20Policy%20final%20Nov16%20.pdf>

Mandatory Training Policy

<http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Mandatory%20Training%20Final%203.pdf>

Conducting Personal Appraisal Development Reviews Policy

<http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/PADR%20Policy%20Approved%20by%20ver%202.pdf>

Other supporting documents are:

Department of Health (2010) Preceptorship Framework for Newly Registered, Midwives and Allied Health Professionals.

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@abous/documents/digitalasset/dh_109794.pdf

Welsh Government (2014) Core Principles for Preceptorship

<http://www.weds.wales.nhs.uk/sitesplus/documents/1076/Final%20Report%20for%20Preceptorship.pdf>

Nursing and Midwifery Council (NMC) (2015) The Code. Professional standards of practice and behaviour for nurses and

midwives. <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf>

Scope

This policy applies to all newly registered nurses and midwives (band 5) who are employed by Cardiff and Vale University Health Board, including staff who have completed 'Return to Practice' or 'Adaptation' programmes. It also applies to experienced registered nurses who will act as preceptors and the nursing leaders who will be responsible for policy implementation.

Equality and Health

An Equality and Health Impact Assessment (EHIA) has been

Document Title: <i>Insert document title</i>	7 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Impact Assessment	completed and this found there to be potentially very limited impact identified.

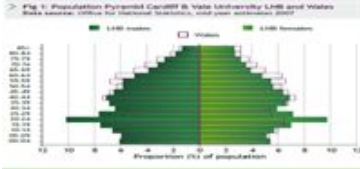
Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Learning, Education and Development
Accountable Executive or Clinical Board Director	Executive Nurse Director
<u>Disclaimer</u> If the review date 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	18 th Nov 2008	2008	<i>New Document</i>
2			The original policy has been updated and redrafted into separate Policy and Procedure documents. Reviewed and updated in line with Core Principles for Preceptorship (Welsh Government 2014). This document has been condensed for this Preceptorship of Newly Registered Nurses and Midwives Policy. All supplemental information has been contained within a new Preceptorship of Newly Registered Nurses and Midwives Procedure.

Equality & Health Impact Assessment for Preceptorship for Newly Registered Nurses and Midwives Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	• Patricia Brown, Clinical Teacher. Tel: (029)20687661 • Corporate nursing, Learning, Education and Development.
3.	Objectives of strategy/ policy/ plan/ procedure/ service	• To ensure that suitably experienced and trained nurses and midwives are identified to undertake the role of preceptor. • To provide role clarity and outline the key responsibilities of the preceptor, preceptee and the line manager. • To provide a clear process for monitoring the progress, professional development and competence of the preceptee.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research	The UHB's usual arrangement with regard to consultation was followed (i.e. 28 days on the intranet). The following staff reviewed and commented on this policy; • Senior Nurse for Trauma and Orthopedics • RCN Convener • L.E.D Manager for Coaching, communication and clinical skills.

Document Title: <i>Insert document title</i>	9 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

• 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 Observatory¹ and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need².	• Practice Development Nurse – Surgery Clinical Board The EHIA form was reviewed by; • Equality & Diversity Manager for Cardiff and Vale UHB, • Welsh Language Officer for Cardiff and Vale UHB • Representative from Public Health Wales Cardiff & Vale University Local Health Board (LHB) area is the smallest and most densely populated LHB area in Wales, primarily due to Wales' capital city: Cardiff. 72.1 and 27.9 percent of the LHB area population live within Cardiff and the more rural Vale of Glamorgan respectively.  Population Data – Potential numbers of staff accessing the Nurse Foundation Programme per year = approximately 200 new starters. History of the Nurse Foundation Programme The Nurse Foundation Programme (NFP) was designed by the Nurse Education Department and Professional Development Nurses in response to discrepancies and deficits in training around the Trust in

¹ <http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf>

² <http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face>

Document Title: <i>Insert document title</i>	10 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

	2008. Clinical areas were providing different levels of training for their new starters which resulted in inequity of access and a lack of parity across the organisation. The group developed a comprehensive training programme for newly qualified practitioners and incorporated mandatory training, essential clinical skills and peer support. The programme was piloted in September 2008 and has run twice a year since then to coincide with University graduation dates. Evaluations from last 3 years of NFP programme were reviewed in relation to the protected characteristics The NFP programme was formally reviewed and evaluated by Dr Aled Jones (Cardiff University) to ensure the programme was meeting the needs of the newly qualified nurses, preceptor's and aligned to the Cardiff and Vale Nursing and Midwifery Strategic Framework 2014-2017. This Policy is underpinned by the Department of Health (2010) Preceptorship Framework and the Welsh Government (2014) Core Principles for Preceptorship. The following Preceptorship Policies have been reviewed in terms of equality impact. Although not exhaustive they provide a representation of the view that the policy would have no impact. Preceptorship Policy for foundation Band 5 staff Nursing and Allied Health (2015) – Mersey Care NHS Trust. Preceptorship Policy (2016) – Sheffield Health and social Care NHS Foundation Trust

Document Title: <i>Insert document title</i>	11 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

		Preceptorship policy (2016) – Gateshead Health NHS Foundation trust This policy states that there is no evidence to support that this policy is likely to have any differential impact of effect on any of the protected characteristics.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	This policy applies to; • All newly qualified registered Nurses or Midwives who gain employment at Cardiff and Vale University Health Board. • Nurses who have recently completed a 'Return to Practice' or 'Adaptation' programme and require a period of preceptorship. • Registered nurses who will be taking on the role of Preceptor • Line Managers who are employing any of the above

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.

Document Title: <i>Insert document title</i>	12 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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	This policy has a positive impact on this group by ensuring that all staff are able to access support from a preceptor and to a preceptorship programme and will be treated in the same way. This policy applies to working age groups only. No documented evidence found from the assessment review to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of age.	NA	NA
6.2 Persons with a disability as defined in the Equality Act 2010	This policy has a positive impact on this group by the processes to be followed for any member of staff who may have a disability, thereby ensuring that all staff accessing the preceptorship programme will be treated fairly and supported in appropriate ways to access	Within the taught NFP Preceptorship programme, all power point	

Document Title: <i>Insert document title</i>	13 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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
Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	available support. The UHB is aware from its demographic information that it employs staff who has disabilities as defined within the Act. As such, the Policy has been made accessible to staff in both electronic and paper copy.	presentations to use appropriate background and font. Presentations are available on the intranet for all staff to access a week before timetabled sessions. All classrooms used for teaching purposes are accessible to all. "It may be beneficial to consider the preceptee working	

Document Title: <i>Insert document title</i>	14 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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
		7.5 hour shifts during the supernumerary period to enable them to experience department routines over more days and maximize their exposure to learning experiences. It will also enable the preceptee to reflect and consider their learning needs between shifts and	

Document Title: <i>Insert document title</i>	15 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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
		take full advantage of this supernumerary period.” Direct quote from policy	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment NB Gender-reassignment is anyone who proposes to, starts, is going	There appears not to be any impact on staff regarding gender. No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, conditions, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of gender	NA	

Document Title: <i>Insert document title</i>	16 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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 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			
6.4 People who are married or who have a civil partner.	There appears not to be any impact. No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of sexual	NA	

Document Title: <i>Insert document title</i>	17 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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
	orientation. Stonewall and Terrance Higgins Trust websites accessed and no evidence found		
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.	This policy has a positive impact on this group by ensuring that all staff accessing preceptorship support and the preceptorship programme will be treated fairly and supporting them in appropriate ways to access available support This policy supports the 'Occupational Health Policy' (2012). Staff that go on maternity leave during their preceptorship period will be provided with a preceptor on their return and will be given the opportunity to join the current preceptorship programme. There appears not to be any impact	NA	

Document Title: <i>Insert document title</i>	18 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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	There appears not to be any impact regarding race, nationality, colour, culture or ethnic origin. No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of race. Cultural diversity between preceptor and new registrant can be a positive asset for the Preceptorship programme and the organization. However, it is acknowledged that this could potentially have a negative impact on either preceptor or preceptee.	Preceptor and preceptee to report any identified issues in relation to culture, race or ethnic origin with the sister/charge nurse/midwife if this is impacting on the learning relationship and learning environment.	

Document Title: <i>Insert document title</i>	19 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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	This policy has a positive impact on this group by ensuring that all staff accessing preceptorship support and the preceptorship programme will be treated fairly and supporting them in appropriate ways to access available support.	Staff who have specific needs in relation to religion can discuss these with the NFP lead and line manager. Staff are able to raise any issues with their line manager/Human Resources.	

Document Title: <i>Insert document title</i>	20 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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)	This policy has a positive impact on this group by ensuring that all staff accessing preceptorship support and the preceptorship programme will be treated fairly and supporting them in appropriate ways to access available support. This is in line with equity of access.	NA	
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design	Positive impact as they can work using their first language of Welsh in a confident manner with MDT colleagues and patients where possible and appropriate. Positive impact for this organisation in providing bilingual provision and service for its patients and staff as outlined in the Welsh government strategic framework 'More than just words'(2012)	Recruitment – ascertaining where welsh speaking preceptors work and wherever possible allocate welsh speaking	

Document Title: <i>Insert document title</i>	21 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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	http://www.wales.nhs.uk/sites3/documents/415/web%20-%2016184_narrative_e_web.pdf - Welsh Language (Wales) Measure 2011³ - Self-development for preceptor and preceptee This experience may also enable Welsh speaking preceptors to also mentor welsh speaking student nurses undertaking the Coleg Cymraeg Cenedlaethol incentive scholarship.	newly qualified staff to a Welsh speaking preceptor. -Liaise on a quarterly basis with the Welsh Language officer to advise on matters relating to Welsh provision. -ESR for current and accurate information regarding location	

³ <http://www.legislation.gov.uk/mwa/2011/1/contents/enacted>

Document Title: <i>Insert document title</i>	22 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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 welsh speaking staff - Cross reference database mentors/preceptors -All relevant documentation to be available in Welsh (on request)	
6.10 People according to their income related group: Consider people on low income,	This policy has a positive impact on this group by ensuring that all staff accessing preceptorship support and the preceptorship programme will be treated fairly and supporting them in appropriate ways to access available support. There appears not to be any impact	NA	

Document Title: <i>Insert document title</i>	23 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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
economically inactive, unemployed/workless, people who are unable to work due to ill-health			
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	This policy has a positive impact on this group by ensuring that all staff accessing preceptorship support and the preceptorship programme will be treated fairly and supporting them in appropriate ways to access available support.	NA	

Document Title: <i>Insert document title</i>	24 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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	No evidence was found to suggest that any other groups or risk factors relevant to this policy and accompanying procedure have a negative impact.	Discussion with line manager and preceptor if new starter has caring responsibilities which need consideration to enable access to all support mechanisms within preceptorship process	

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?

Document Title: <i>Insert document title</i>	25 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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	The aim of this policy is to ensure that ALL newly registered nurses and midwives who join the organization receive active support during their transition from student nurse to registrant and are competent and fit for practice. It is based on the Department of Health's (2010) Preceptorship Framework .	- Line manager and Preceptor to monitor progress to ensure that those from lower income groups do well and progress	
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active,	This policy has a positive impact by ensuring that all staff accessing preceptorship support and the preceptorship programme will be treated fairly and	NA	

Document Title: <i>Insert document title</i>	26 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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
no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (e.g. immunization 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	supporting them in appropriate ways to access available support. In the same way irrespective of the individuals' ability to improve or maintain healthy lifestyles		
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,	The Cardiff and Vale Health Board staff has a yearly PADR where the preceptee and preceptor will have the opportunity to discuss progress and competency The PADR process should be	"If preceptors work part time it may be beneficial to allocate a co-preceptor to ensure full time support is provided." A direct quote from the policy	

Document Title: <i>Insert document title</i>	27 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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
job security, working conditions Well-being Goal – A prosperous Wales	utilized to formally assess the preceptee at six months and twelve months. These reviews will need to be linked to the Pay Progression process.		
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 neighborhoods, exposure to crime; road safety and preventing injuries/accidents;	For this policy there appears to be no impact		

Document Title: <i>Insert document title</i>	28 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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
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; neighborliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	For this policy there appears to be no impact		

Document Title: <i>Insert document title</i>	29 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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
7.6 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	For this policy there appears to be no impact		

Document Title: <i>Insert document title</i>	30 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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	On reviewing the previous policy and writing the latest version, improvements have been made in people who communicate using the Welsh language and people who require reasonable adjustments within the preceptorship process. Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this policy.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

Document Title: <i>Insert document title</i>	31 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

	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?	6.2 Within the taught NFP Preceptorship programme, all power point presentations to use appropriate background and font. Presentations are available on the intranet for all staff to access a week before timetabled sessions. All classrooms used for teaching purposes are accessible to all. “It may be beneficial to consider the preceptee working 7.5 hour shifts during the supernumerary period to enable them to experience department routines over more days and maximize their exposure to learning experiences. It will also enable the preceptee to reflect and consider their learning needs between shifts and take full advantage of this supernumerary period. As there has been			

Document Title: <i>Insert document title</i>	32 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

	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?	As there has been potentially very limited impact identified, is unnecessary to undertake a more detailed assessment			

[illegible]

Document Title: <i>Insert document title</i>	34 of 46	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Reference Number: <i>TBA unless document for review</i> Version Number: 1	Date of Next Review: <i>To be included when document approved</i> Previous Trust/LHB Reference Number: 354
Preceptorship for Newly Registered Nurses and Midwives Procedure	
Introduction and Aim The aim of this Procedure is to support the Preceptorship for Newly Registered Nurses and Midwives Policy in providing a robust preceptorship for all newly registered practitioners who are making the transition from student to registered practitioner. The preceptorship arrangements for newly registered nurses and midwives, their preceptors, ward sisters and professional leads will be outlined. The Policy and Procedure has been designed to provide a consistent and structured approach to preceptorship which will promote consistency and equity of access across all areas of the Health Board for all newly registered nurses and midwives.	
Objectives • To ensure that suitable staff are identified to undertake the role of preceptor. • To provide role clarity and the key responsibilities of the preceptor, preceptee and line manager.	
Scope This procedure applies to all newly registered nurses and midwives (band 5) who are employed by Cardiff and Vale University Health Board, including staff who have completed 'Return to Practice' or 'Adaptation' programmes. It also applies to experienced registered nurses who will act as preceptors and the nursing leaders who will be responsible for the procedure implementation.	
Equality Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed. The Equality Impact Assessment completed for the policy found there to be potentially very limited impact identified.
Documents to read alongside this Procedure	This Procedure is supported by the following documents: Preceptorship for Newly Registered Nurses and Midwives Policy. Capability Policy http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Capability%20Policy%20June%2020131.pdf

11.4

	Disciplinary Policy and Procedure http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/NHS%20Wales%20Disciplinary%20Policy%20and%20Procedure%20adopted%20PPP%2016.05.17.pdf Health and Safety Policy http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Health%20and%20Safety%20Policy%20final%20Nov16%20.pdf Mandatory Training Policy http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Mandatory%20Training%20Final%203.pdf Conducting Personal Appraisal Development Reviews Policy http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/PADR%20Policy%20approved%20by%20ver%202.pdf Key Supporting Documents Department of Health (2010) Preceptorship Framework for Newly Registered, Midwives and Allied Health Professionals. http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@about/documents/digitalasset/dh_109794.pdf Welsh Government (2014) Core Principles for Preceptorship http://www.weds.wales.nhs.uk/sitesplus/documents/1076/Final%20Report%20for%20Preceptorship.pdf Nursing and Midwifery Council (NMC) (2015) The Code. Professional standards of practice and behaviour for nurses and midwives. https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
Approved by	Quality, Safety and Experience Committee

11.4

Accountable Executive or Clinical Board Director	Executive Nurse Director
Author(s)	Patricia Brown - Clinical Teacher
<u>Disclaimer</u> 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	Date of Committee or Group Approval	TBA	Original Policy has been split into separate Policy and Procedure documents. Developed in line with Core Principles for Preceptorship (Welsh Government 2014). Policy for the Preceptorship of Newly Registered Nurses and Midwives.

11.4

Contents Page

1. Introduction	5
2. Purpose of Preceptorship	5
3. Definitions	6
4. The Preceptorship Process	
4.1 length of preceptorship period	6
4.2 Allocation of Preceptor	6
4.3 Awaiting PIN number	6
4.4 Supernumerary period	7
4.5 Preceptor support	7
4.6 Preceptorship, PADR process and revalidation	7-8
5. Preceptor criteria	8
6. Key Responsibilities	
6.1 Role of the Preceptor	9
6.2 Role of the Preceptee	9-10
6.3 Role of the Sister/Charge Nurse/Midwife	10
6.4 Role of the Senior Nurse	11
6.5 Role of Clinical board Director of Nursing	11
6.5 Role of the NFP Lead	11
7. Resources	11
References	12
Appendix 1 – Flowchart of the Preceptorship Process	13

11.4**1. Introduction**

Adapting from the role of a student to entering the workforce as an accountable registered practitioner can be a challenging time. Newly registered nurses and midwives often experience anxiety about their transition from a student nurse to a registered practitioner. The phrase 'reality shock' was coined by Kramer (1974) to describe the gap between the expectations of

the novice nurse and the reality of clinical practice (Sharples and Elcock 2011).

Good support and guidance during this period is essential. Newly registered practitioners who successfully manage this transition are able to provide effective care, feel better about their role and are more likely to remain in the profession (DH 2010).

The Nursing and Midwifery Council (NMC) (2006:1) strongly recommend that:

'All new registrants have a period of preceptorship on commencing employment, this applies to those admitted to the NMC register who have completed a pre-registration programme in the UK for the first time, or have subsequently entered a new part of the register. New registrants also include those newly admitted to the register from other European Economic Area states and other nation states'

The All Wales Principles of Preceptorship (2014:6) state that, 'preceptorship will comprise a formal process for all newly registered practitioners, with health board level accountability for implementation, resource and impact assessment of preceptorship programmes'.

Cardiff and Vale University Health Board embraces these principles through the success of the Nurse Foundation Programme (NFP) which is a structured preceptorship programme. This enables newly qualified nurses and midwives to consolidate their training, build confidence and develop competence in their new role as registered practitioners.

2. The Purpose of Preceptorship

- To assist in the socialisation of staff into the clinical environment.
- To ensure that newly registered nurses and midwives receive active support during their transition from student nurse to registrant.
- To ensure that new registrants are safe, competent and fit for practice
- To enable the development of knowledge and skills within a supportive environment.
- To provide a structured framework for new Band 5 entrants to achieve objectives set out within the Knowledge and Skills Framework (KSF) foundation outline.
- To promote peer support and networking for new registrants.

3. Definitions

Preceptorship	A period of structured transition for the newly qualified nurse to develop their confidence as an autonomous practitioner, refine skills, values and behaviours and to continue on their journey of life-

	long learning (Department of Health, 2010).
Preceptor	A preceptor is defined as 'a registered practitioner who has been given a formal responsibility to support a newly registered practitioner through preceptorship' (Department of Health 2010).
Preceptee	A newly registered nurse undertaking a period of preceptorship.
Supernumerary	A period of time when the preceptee is not in the establishment/workforce numbers. This allows the preceptee to work alongside the preceptor under supervision.

4. The Preceptorship Process

4.1 Length of preceptorship period

The preceptorship period has been set in line with Department of Health (2010) guidelines that recommend 6 months -1 year. At Cardiff and Vale UHB we recognise the benefits of supporting newly registered nurses up until the first year of practice is completed. A longer period of preceptorship can be negotiated locally.

4.2 Allocation of preceptor

Preceptors will be identified by the ward sister/charge nurse or midwife on appointment of the new registrant, enabling them to plan ahead and ensuring that off duty supports the preceptorship process. Preceptors will have the knowledge and skills required to support new registrants (see criteria of preceptor section 6). The new registrant (preceptee) will meet their preceptor during their first week in employment. If preceptors work part time it may be beneficial to allocate a co-preceptor to ensure maximum support is provided.

4.3 Awaiting PIN number

Newly registered nurses awaiting their PIN number are not permitted to practice as an accountable registered nurse. In the interim period they must be directly supervised by a registered nurse who will need to countersign all relevant documentation. For this period of time the individual will initially be employed at the pay scale for the relevant level for a Health Care Support Worker in that area until their registration is confirmed.

4.4 Supernumerary period

All periods of preceptorship will commence with preceptees undertaking at least 2 weeks (75 hours) of supernumerary adjustment within their designated workplace. Part-time staff may undertake these supernumerary hours over a longer period of time that will be negotiated with the line manager.

11.4

It may be beneficial to consider the preceptee working 7.5 hour shifts during the supernumerary period to enable them to experience department routines over more days and maximise their exposure to learning experiences. It will also enable the preceptee to reflect and consider their learning needs between shifts and take full advantage of this supernumerary period.

4.5 Preceptor support

It is recommended that:

- The preceptor and preceptee work all shifts together during the supernumerary period. Thereafter a minimum of 12.5 hours per week for the next 4 weeks of employment. Further shifts should be negotiated if required.
- The preceptor and preceptee should have informal monthly meetings for discussion on progress, provision of constructive feedback and reflection on personal and professional development.
- A formal learning contract should be completed by preceptor and preceptee at the beginning of the preceptorship period, at six months and at the end of the preceptorship period. This can be found in the Nurse Foundation booklet which is given to all new preceptees when they commence the NFP. For staff who undertake in-house preceptorship, the booklet is available on the intranet page under Nurse Foundation Programme.

<http://www.cardiffandvaleuhb.wales.nhs.uk/nursefoundationprogramme>

4.6 Preceptorship, the Personal Appraisal Development Review (PADR) Process and Revalidation:

The PADR Process

The PADR process should be utilised to formally assess the preceptee at six months and twelve months. These reviews will need to be linked to the Pay Progression process. The twelve month review will actually need to be undertaken 8-12 weeks before the twelve month increment date to be in line with Pay Progression requirements.

During the supernumerary period the preceptee will need to meet with their PADR reviewer to discuss the PADR and Pay Progression process. They must:

1. Be provided with a copy of their Knowledge and Skills Framework (KSF) outline.
2. Be directed to the 'Pay Progression Toolkit' so that they can familiarise themselves with the core objectives they will need to achieve each year in order to gain pay increments.

<http://www.cardiffandvaleuhb.wales.nhs.uk/padr-pp-toolkit>

3. Work with their reviewer to set clear objectives for their first year in post, which must ensure that the preceptee acquires the essential clinical skills required in their clinical area.

11.4

If the preceptor is also a PADR reviewer it is beneficial if they can also be the preceptee's reviewer. If this is not possible the preceptor will need to provide feedback to the reviewer as part of the PADR process and the preceptee will need to be aware of this. The preceptee will need to be provided with a copy of any feedback that is given to the reviewer.

Revalidation

Activities undertaken during the preceptorship period such as formal study days, reflective activity, experiential learning and development of knowledge and skills through constructive feedback can all be evidenced and contribute to the revalidation process (NMC 2015).

5. Preceptor Criteria

- The preceptor role will be undertaken by first level registered nurses who have been qualified for a minimum of two years.
- Preceptors must have worked in their specific clinical area for at least 6 months before undertaking the preceptor role.
- Preceptors will be prepared by undertaking a Nursing and Midwifery Council (NMC, 2008) approved mentorship training programme. This will be consolidated by mentoring students for a minimum of one year.
- Ideally, preceptors will be sign-off mentors and will be annotated on to the Cardiff and Vale UHB mentor database.
- If staff are unable to complete mentorship training (for example if there are no pre-registration students allocated to the clinical area) then staff must attend the Cardiff and Vale University Health Board 'Clinical Skills Assessor' training programme instead.
- Preceptors will have access to support from their Ward Sisters/Charge Nurse, Midwife, Practice Development Nurses and the Nurse Foundation Programme Lead.
- Any other preceptor preparation will be determined locally.

11.4

6. Key Responsibilities:

6.1 Role of the Preceptor

- Orientation of the preceptee to the clinical area on their first day on duty.
- To demonstrate best practice and act as a role model for the preceptee by adhering to nursing policies, procedures and local UHB guidelines.
- To develop a learning contract in collaboration with the preceptee and ward sister/charge nurse or midwife.
- To help identify ongoing learning and development needs to facilitate competence.
- Assess the preceptees level of attainment and support the achievement of local competencies and the essential clinical skills

competencies that accompany the Nurse Foundation Programme (if applicable).

- Provide positive reinforcement to new registrants on those aspects of performance that are being done well.
- Provide constructive feedback and feed forward on areas that can be improved and develop a plan of action to remedy these.
- Liaise regularly with sister/charge nurse/midwife and PADR reviewer on the progress of the preceptee.
- Ensure that own knowledge and skills are up to date, maintain own personal and professional development, and recognise own limitations
- Raise any concerns about the wellbeing, progress or competence of the preceptee with the ward sister/ Charge nurse/midwife and work with them to implement the required strategy and support.
- To ensure that all new registrants are given the opportunity to discuss any additional learning needs and/or disability which may require reasonable adjustments to be put in place.
- Signpost the individual to the Employee Wellbeing Service resources if required.

6.2 Role of the Preceptee

- To practice in accordance with the NMC code (2015) and adhere to all local policies and procedures of Cardiff and Vale University Health Board.
- To actively participate in the preceptorship process, taking responsibility for own development.
- To attend all relevant study days on the Nurse Foundation Programme or equivalent in-house Preceptorship programme.
- To identify specific learning and development needs and opportunities.
- To meet with the preceptor as soon as possible to develop a learning contract and identify objectives that link in with PADR and pay progression in collaboration with the preceptor and sister/charge nurse/midwife.
- To work at least 12.5 hours a week with your preceptor for the 4 weeks following the supernumerary period in order to assess progress against the KSF foundation outline.
- Accept accountability for your nursing judgement and care of the client/patient.
- To demonstrate an insight into your level of skill and seek advice and guidance on clinical, professional and organisational issues.
- To attend monthly meetings with your preceptor for critical reflection on practice and the provision of constructive feedback on performance and development
- Ensure that a professional portfolio is maintained throughout the preceptorship period. It should contain; KSF outline, reflections and feedback, formal learning contract and records of preceptorship meetings and information from preceptorship programme.

11.4

6.3 Role of the Sister/Charge Nurse or Midwife

- To ensure that the preceptorship process is carried out in accordance with the Cardiff and Vale University Health Board Preceptorship (2017) Policy and Procedure.
- Providing the preceptee with access to Health Board information
- Takes responsibility for ensuring that all preceptees receive at least two weeks (75 hours) of supernumerary status.
- To support the preceptor and preceptee during the preceptorship period, in terms of time and resources (including preparation for the preceptor role).
- To support the preceptee to attend scheduled study days as part of the Nurse Foundation Programme (NFP) Preceptorship Programme (or in-house study sessions).
- Ensuring that the twelve month Personal Appraisal Development Review (PADR) with the preceptee occurs 8-12 weeks prior to the first increment being due.
- At the PADR, review all core organisational objectives and individual performance objectives and check progress against KSF dimensions and levels.
- In the event of planned or unplanned leave identify an alternative preceptor.
- Check that correct documentation is maintained by the preceptor and preceptee.
- Collaborate with preceptor in identifying any deficiencies in preceptee attaining required standards. Commence the capability process as required.

6.4 Role of Senior Nurse

- Monitor the implementation of the preceptorship process.
- Support sister/charge nurse/midwife through capability process if preceptee are not achieving standards required.

6.5 Role of Clinical Board Directors of Nursing

Ensure that there is a preceptorship programme in place for all new registrants working within clinical board.

- Monitor compliance of preceptorship processes and take action if areas not adhering to the requirements of preceptorship.

6.6 Role of NFP Lead

- Plan and deliver the Nurse Foundation Programme (NFP), ensuring it meets the needs of the organisation and new registrants.
- Disseminate relevant information regarding preceptorship to all appropriate staff within the UHB.
- Liaise with clinical experts to ensure NFP content reflects contemporary nursing practice.

11.4

- Review content and structure of NFP and conduct formal evaluations at the end of every programme.
- Utilise constructive feedback to improve and enhance the NFP.
- Feedback evaluations to Nurse Education Manager.

7. Resources:

The following resources are required to support the implementation of This policy;

- A supernumerary period for all Preceptees (minimum of 75 hours – over two weeks for full time staff)
- Release of preceptees for NFP, mandatory training and any additional clinical skills training relevant to the clinical area
- Release of registrants for mentorship training / clinical skills assessor training to enable them to develop skills to become a preceptor.
- Release of Preceptors for any Preceptorship training sessions and updates.
- Protected time for preceptor and preceptee to meet on a monthly basis to discuss progress, feedback and action planning for future learning opportunities.
- Relevant documentation to enable preceptee and preceptor to document progress and achievement of relevant competencies.

References

Department of Health (2010) Preceptorship Framework for Newly Registered, Midwives and allied health Professionals. Department of Health: London.

Nursing and Midwifery Council (NMC) (2006) Preceptorship Guidelines. NMC: London.

Nursing and Midwifery Council (NMC) (2008) Standards to Support Learning and assessment in Practice. NMC standards for mentors, practice teachers and teachers. NMC: London

Nursing and Midwifery Council (NMC) (2015) The Code. Professional standards of practice and behaviour for nurses and midwives. NMC: London.

Nursing and Midwifery Council (NMC) (2015) Revalidation: requirements for renewing your registration. NMC: London

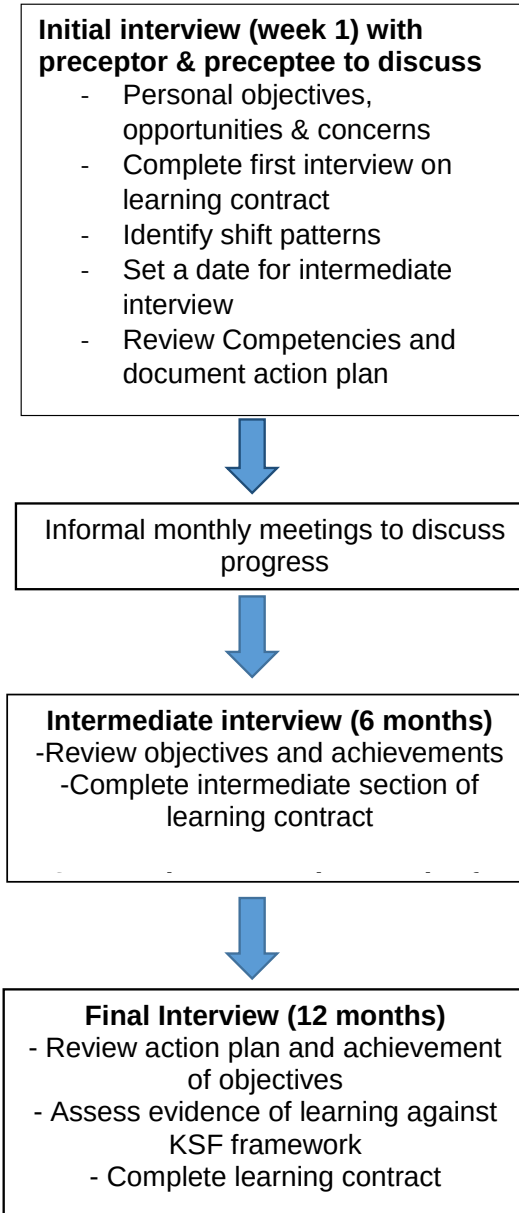
Sharples K and Elcock K (2011) Preceptorship for Newly Registered Nurses. Exeter: Learning Matters.

Welsh Government (2014) Core Principles for Preceptorship shared services partnership.

<http://www.weds.wales.nhs.uk/sitesplus/documents/1076/Final%20Report%20for%20Preceptorship.pdf>

11.4

Appendix 1 Flowchart of Preceptorship Process



11.4

APPROVAL OF THE DISCHARGE FROM HOSPITAL POLICY AND PROCEDURE**Name of Meeting :** Quality ,Safety and Experience Committee**Date of Meeting** 6th December 2017**Executive Lead :** Chief Operating Officer**Author :** Head Of Integrated Care *Phone/ Ffôn:* 029 2074 1778*Email:* Judith.A.Hill@wales.nhs.uk**Caring for People, Keeping People Well :** This report underpins the Health Board's "Sustainability" , "Values" and Delivering Outcomes that Matter to People elements of the Health Board's Strategy.**Financial impact :** Not Applicable**Quality, Safety, Patient Experience impact:** External audit provides valuable feedback and assurance in relation to the quality and safety of services and how well organisations work together to affect the Patient experience. It also provides opportunity to consider the patient, family and carer experience, as well as providing staff the opportunity to input their views into the report.**Health Care Standard Number :** Standard 3.1 5.1,6.1**CRAF Reference Number:** 2.1.1, 6.2.1, 11.2.5.1.**Equality and Health Impact Assessment Completed:** YES**ASSURANCE AND RECOMMENDATION****ASSURANCE** is provided by:

- The implementation of a training and development programme to support the implementation of the Policy by ward based staff.
- Monitoring of compliance against the policy on a regular basis, supported by improvement plans to address recommendations

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the new Discharge from Hospital Policy and Procedure
- **APPROVE** the full publication of the Discharge from Hospital Policy and Procedure in accordance with the UHB Publication Scheme

11.5

SITUATION

The Discharge from Hospital Policy is submitted to the Committee as approval is a decision reserved for the committee in accordance with the [Written Control Documents Development and Approval Procedure or UHB Scheme of Delegation](#).

The Discharge from Hospital Policy is a new policy document which builds on a previous Transfer of Care document.

The Policy clearly emphasis the Home First principle and actively encourages the multidisciplinary planning of discharge soon after admission. The Policy is aimed at providing the Patients with an appropriate discharge plan and ensure that Patients remain in hospital for the minimum period necessary. The Policy is clearly linked to the Health Board strategy of care being provided closer to home and maximising independence.

Whilst there has been improvement in the number of Delayed Transfers of Care (DTOC), there remains a degree of inconsistency in the way discharges are planned. It is anticipated that the implementation and proposed performance monitoring of this policy and procedure will provide support and structure to the development of timely, effective discharge planning

BACKGROUND

The Discharge from Hospital Policy, whilst described as a Cardiff and Vale University Health Board Policy has been developed in conjunction with colleagues from both Cardiff and the Vale Local Authorities.

Recent Welsh Audit Office reviews have described an improved and maturing partnership arrangement and a well developed performance management framework in relation to the management of complex delayed transfers of care. However, the 2016 Delivery Unit, Day of Care Audits identified that there were significant opportunities for more timely discharge in particular relation to simple discharges.

The Discharge from hospital Policy was developed to support the Delivery Unit findings and provide a framework which Staff could utilise to improve the patient experience of discharge and also improve Patient flow.

ASSESSMENT

The Discharge from hospital Policy and procedure was compiled over a period of months and the final draft agreed by the DTOC Operational group in July.

Wide consultation has taken place to ensure that the policy meets the needs of our stakeholders and the Health Board. The consultation undertaken specific to this document was as follows:-

11.5

- The document was added to the Policy Consultation pages on the intranet between August and September 2016;
- The document was shared with the Local Authority stakeholders along with the South East Wales Carers project
- Comments were invited via individual e-mails from all members of the DTOC Operational Group which included colleagues from Housing and Social Services

Where appropriate comments were taken on board and incorporated within the draft document.

Performance Monitoring and Review

Implementation of the Policy and procedure will be monitored and reviewed by the newly formed multiagency Get Me Home Group, as a work stream of the Unscheduled Care Programme Board which replaces the DTOC Operational Group. This will include feedback from regular audits of various aspects of the discharge process.

Publication and Dissemination

The primary source for dissemination of the Discharge Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

A completed Equality and Health Impact Assessment has been completed which suggests that Patients and Carers may experience a positive impact a result of the implementation of the Discharge from Hospital Policy.

Reference Number: TBA Version Number: 1	Date of Next Review: 3yrs Previous Trust/LHB Reference Number: No previous policy
Discharge from Hospital Policy	
Policy Statement To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will work in tandem with Social Care colleagues, and take all reasonable and practicable steps to provide individuals with a mutually agreed safe, effective and timely discharge based on their individually assessed needs.	
Policy Commitment The Health Board is committed to working with patients, their families and partner organisation to support patient's safe and timely discharge from hospital. To ensure this commitment is met the Health Board will ensure that these core principles are implemented • Patients are involved • Patients are informed • Discharges are safe • Discharges are timely • Discharges are coordinated	
Supporting Procedures and Written Control Documents This Policy and the supporting legislations describe the following with regard to Hospital discharge. • Social Services and Wellbeing (Wales) Act 2014 • Mental Capacity Act 2005 • Mental Health Act 1983 • Mental Health (Wales) Measure 2010 • Deprivation of Liberty Safeguards 2009	
Other supporting documents are:	

11.5

Document Title: <i>Discharge from Hospital Policy</i>	2 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:QSE		

- All Wales Framework for Continuing NHS Funded Care
- Discharge from hospital procedure and supporting multi agency choice of accommodation protocol
- Clinical Workstation: Simple /Supported/Complex Matrix
- Standard Operating Procedure for Integrated discharge Service
- Procedure for Requesting Non-Standard Equipment funded by Continuing Healthcare Funding
- Discharge Planning checklist
- Pharmacy Medication for Discharge

Scope

This policy applies to all staff working for Cardiff and Vale University Health Board in all locations including those with honorary contracts.

Equality and health impact Assessment

An Equality and Health Impact Assessment (EHIA) has been completed and found there to be a positive impact. Key actions have been identified and incorporated within this policy/supporting procedures.

Policy Approved by

Quality, Safety and Experience Committee

Group with authority to approve procedures written to explain how this policy will be implemented

Quality, Safety and Experience Committee

Accountable Executive or Clinical Board Director

Chief Operating Officer

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](#).

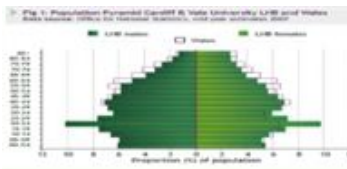
Document Title: <i>Discharge from Hospital Policy</i>	3 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:QSE		

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 <i>[To be inserted by the Gov. Dept]</i>	Version 1 New policy
2			

Equality & Health Impact Assessment for Discharge from Hospital Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Not applicable
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Corporate Operations Team Lead Contact Head of Integrated Care Judith.A.Hill@wales.nhs.uk
3.	Objectives of strategy/ policy	To identify the key principles of discharge understand the links with other policies and how they impact upon the discharge process To provide a standard framework for staff to work within when discharging patients from hospital To clarify roles and responsibilities of key staff associated with discharge Promote a coordinated multidisciplinary team approach to discharge and care planning To promote a positive patient experience by ensuring that patients receive the right care at the right time in the right place Support good communication between clinical teams across the health community, patients and their families/carers

Document Title: <i>Discharge from Hospital Policy</i>	5 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

		Promote early engagement with the patient's GP; locality/neighbourhood team/case manager to ensure that the discharge plan is implemented and there is a safe and timely co-ordinated discharge. To promote IM&T communications i.e. e-discharge and e-bed management through the timely recording of inpatient admission and discharge record keeping on the clinical information systems
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 • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory¹ and the	Cardiff & Vale University Local Health Board (LHB) area is the smallest and most densely populated LHB area in Wales, primarily due to Wales' capital city: Cardiff. 72.1 and 27.9 percent of the LHB area population live within Cardiff and the more rural Vale of Glamorgan respectively  The UHB's usual arrangement with regard to consultation was followed (ie. 28 days on the intranet). All comments were considered and policy altered accordingly. Colleagues within Cardiff & Vale LA Social Services made extensive comments to numerous draft versions of policy. A part of good practice, other policies from different organisations were considered.

¹ <http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf>

Document Title: <i>Discharge from Hospital Policy</i>	6 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

	UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need ² .	• Stakeholders were not engaged in the EHIA and/or policy development • Social Services and Wellbeing (Wales) Act 2014 • Mental Capacity Act 2005 • Mental Health Act 1983 • Mental Health (Wales) Measure 2010 • All Wales Framework for Continuing NHS Funded Care. • Encourage Prudent Healthcare
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The policy applies to all UHB staff involved at any stage in the process of safe, effective discharge including those who hold honorary contracts. There will be an impact on patients their carers as well as local authorities and partner agencies where we are discharging to their care

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

² <http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face>

Document Title: <i>Discharge from Hospital Policy</i>	7 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

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	No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of age Suggest positive impact to have policy that provides a standard framework for discharge planning across UHB	N/A	Delayed Transfers of Care Operational Group and In Hospital working stream
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning	The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy	N/A	Delayed Transfers of Care Operational Group and In Hospital working stream

Document Title: <i>Discharge from Hospital Policy</i>	8 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

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
disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	has been made accessible to staff in both electronic and paper copy. patients discharged from hospital may have disabilities and their individual needs will be considered as part of the same discharge planning process within the framework of the policy		
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	There appears not to be any impact on staff regarding gender. No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where	N/A	Policy put out for consultation within the organisation and ratified by Delayed Transfers of Care Operational Group and In Hospital working stream

Document Title: <i>Discharge from Hospital Policy</i>	9 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

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
procedures. Sometimes referred to as Trans or Transgender	applied cause an adverse impact against any group of individuals in respect of gender. patients discharged from hospital will have their individual needs considered as part of the same discharge planning process within the framework of the policy, irrespective of their gender		
6.4 People who are married or who have a civil partner.	There appears not to be any impact. No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of	N/A	

Document Title: <i>Discharge from Hospital Policy</i>	10 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

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
	individuals in respect of sexual orientation. patients discharged from hospital will have their individual needs considered as part of the same discharge planning process within the framework of the policy, irrespective of whether married or civil partners		
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. patients discharged from hospital will have their individual needs considered as part of the same discharge planning process within the framework of the policy,		Policy put out for consultation within the organisation and ratified by Delayed Transfers of Care Operational Group and In Hospital working stream
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers,	There appears not to be any impact regarding race, nationality, colour, culture or ethnic origin. No documented evidence found from the	Whilst there doesn't appear to be any impact, if a member of staff was known to have difficulties	Policy put out for consultation within the organisation and ratified by Delayed Transfers of Care Operational Group and In

Document Title: <i>Discharge from Hospital Policy</i>	11 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

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
gypsies/travellers, migrant workers	assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of race patients discharged from hospital will have their individual needs considered as part of the same discharge planning process within the framework of the policy,	with the written word, good management would dictate that alternative arrangements be made, such as individual meetings. Members of the public would be supported by staff or family members as appropriate	Hospital working stream
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	It is unlikely to be any impact on staff regarding their religion. There is documented evidence in relation to religion	Staff are able to raise any issues with their line manager/Human Resources.	Policy put out for consultation within the organisation and ratified by Delayed Transfers of Care Operational Group and In Hospital working stream

Document Title: <i>Discharge from Hospital Policy</i>	12 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By:QSE		

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
	patients discharged from hospital will have their individual needs considered as part of the same discharge planning process within the framework of the policy,		
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 or patients. patients discharged from hospital will have their individual needs considered as part of the same discharge planning process within the framework of the policy,		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design	Bilingually patient information leaflets are available for patients. This is in line with our current Welsh Language Scheme and the future Welsh Language Standards. The leaflets are available in one	The policy prompts staff to ask patients which language the patient/service users would like to communicate in, either English or Welsh, in line with the 'Active Offer'	Policy put out for consultation within the organisation and ratified by Delayed Transfer of care group and In Hospital working stream Delayed Transfers of Care Operational

Document Title: <i>Discharge from Hospital Policy</i>	13 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

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	the leaflet should be bilingual in one single document English on one side and Welsh on the other side. The aim of the 'active offer' is that staff should ask for the language choice (of either Welsh or English) of the patient. The language choice should then be integrated into the patients treatment. In other words the patient could request their treatment be in Welsh. If we are unable to provide a fully Welsh language service for	requirements of the Welsh Governments' More than Just Words Strategy appropriate	Group
6.10 People according to their income related group: Consider people on low income, economically	No impact in relation to this policy		Policy put out for consultation within the organisation and ratified by Delayed Transfers of Care Operational Group and In

Document Title: <i>Discharge from Hospital Policy</i>	14 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

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
inactive, unemployed/workless, people who are unable to work due to ill-health			Hospital working stream
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	No impact in relation to this policy Policy is relevant to Cardiff and Vale residents but is also applied to residents from other areas who are currently in UHB beds		Policy put out for consultation within the organisation and ratified by Delayed Transfers of Care Operational Group and In Hospital working stream
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	People who speak other languages other than Welsh or English will be impacted positively as the policy refers to issues of language accessibility. There are no other groups including Carers or risk factors to take into	There have been new statements regarding language accessibility within the policy	Policy put out for consultation within the organisation and ratified by Delayed Transfers of Care Operational Group and In Hospital working stream

Document Title: <i>Discharge from Hospital Policy</i>	15 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

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
	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 and/or those experiencing health inequalities	No impact in relation to this policy		Policy put out for consultation within the organisation and ratified by Delayed Transfers of Care Operational Group

Document Title: <i>Discharge from Hospital Policy</i>	16 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

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 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 management services etc Well-being Goal – A healthier Wales	No impact in relation to this policy		
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	No impact in relation to this policy		

Document Title: <i>Discharge from Hospital Policy</i>	17 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

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 prosperous Wales			
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	For this policy, there will be no impact.		
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	For some individuals there may be positive impact on socialisation as a result of needs based assessment		

Document Title: <i>Discharge from Hospital Policy</i>	18 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

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 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	No impact in relation to this policy		

Document Title: <i>Discharge from Hospital Policy</i>	19 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

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	On reviewing the previous policy and writing the latest version, improvements have been made in people who communicate using the Welsh language, people with a religion or belief or with no religion or belief. Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this policy. All discharges should be planned according to each person's individual circumstances

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

Document Title: <i>Discharge from Hospital Policy</i>	20 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

	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?	On reviewing the previous policy and writing the latest version, improvements have been made in people who communicate using the Welsh language, people with a religion or belief or with no religion or belief. Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this policy.		1 month	Action in accordance with UHB Employment Policies and Procedures.
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?	As there has been potentially very limited impact identified, is unnecessary to undertake a more detailed assessment.			

Document Title: <i>Discharge from Hospital Policy</i>	21 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: QSE		

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- - Decide whether the strategy, policy, plan, procedure and/or service proposal: - continues unchanged as there are no significant negative impacts - adjusts to account for the negative impacts - 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	On reviewing this policy minor positive changes have been made. The EHIA has been consulted. It has been approved by the and will continue to be reviewed every 6 months as part of the groups Terms of Reference. When this policy is reviewed, this EHIA will form part of that consultation exercise. 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).			

DRAFT

11.5

Reference Number: Version Number: 1	Date of Next Review: Previous Trust/LHB Reference Number: new
Discharge from Hospital Procedure	
Introduction and Aim The Hospital Discharge procedure is a document which is intended to support the Cardiff and the Vale UHB Discharge from Hospital Policy. The aim of the Procedure is provide direction, support and guidance to the Policy and is to be utilised by ward based multidisciplinary teams when planning discharge. The Procedure aims to ensure that each member of the Team has a clear understanding of their contribution to the effective, timely discharge and that staff recognise the importance of Patients and /or Carer engagement at the earliest possible opportunity.	
Objectives The objectives of the Discharge from Hospital Procedure are to : • Identify the key principles of discharge and understand the links with other policies and how they impact upon the discharge process • Clarify roles and responsibilities of key staff associated with the discharge process • Promote a co-ordinated multidisciplinary team approach to discharge and care planning • Promote a positive patient experience by ensuring that patients receive the right care at the right time in the right place • Support good communication between clinical teams across the health community, patients and their families/carers • Promote early engagement with the patient's GP; locality/neighbourhood team/case manager to ensure that the discharge plan is implemented in a safe and co-ordinated manner • Promote IM&T communications i.e. e-discharge and e-bed management through the timely recording of inpatient admission and discharge record keeping on the clinical information systems • Encourage a strengths based approach to the assessment of need ; and • Provide key performance indicators	
Scope This procedure applies to all of our staff including those with honorary contracts involved in the discharge of patients from hospital sites of Cardiff and the Vale UHB. The procedure also provides advice on how other statutory organisations support the Discharge Policy.	

CARING FOR PEOPLE
KEEPING PEOPLE WELL



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Document Title: Discharge from Hospital Procedure	2 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

Equality and Health Impact Assessment	An Equality Health Impact Assessment (EHIA) has been completed and found there to be a positive impact
Documents to read alongside this Procedure	Discharge from Hospital Policy Choice of Accommodation Protocol for Inpatients
Approved by	Quality, Safety and Experience Committee

Accountable Executive or Clinical Board Director	Chief Operating Officer
Author(s)	Head of Integrated Care
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			<i>new document</i>

Document Title: Discharge from Hospital Procedure	3 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

Index

1. Introduction
2. Statement
3. Objectives
4. Responsibilities
5. Patient experience
6. Legal Context
7. Safety
8. Effectiveness
9. Timeliness
10. Roles
 - a. ward Nurses/ Care Coordinators
 - b. Ward Sister/ Charge Nurse
 - c. Senior Nurses
 - d. Senior Medical Staff
 - e. Allied Health Professionals
 - f. Directorate Manager/ Lead Nurses
 - g. Clinical Board Management Teams
11. Integrated Discharge Service
12. Discharge Documentation
13. Discharge Information for patients and families
14. Discharge summary and communication with general practitioners
15. Discharge against clinical advice
16. Refusal to leave hospital
17. Continuing NHS Healthcare
18. Fast track Continuing NHS Healthcare
19. Choice of Accommodation
20. Vulnerable Groups
21. Performance measures
22. Review of Policy
23. References
24. Glossary
25. Other Sources of Information

Document Title: Discharge from Hospital Procedure	4 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

1. Introduction

This Discharge from hospital Procedure reflects the principles identified in the Social Services and Well-being Act 2014 (the Act) which was implemented in April 2016. It will ensure that staff actively work towards a strengths based assessment of care needs recognising the importance of an integrated health and social care approach to discharge planning

Supporting the Act's principles is the local Strategy of the Cardiff and Vale University Health Board (UHB): 'Caring for People, Keeping People Well'. This procedure has been developed to provide the framework within which the UHB will support patients to be discharged from hospital at the earliest opportunity and in accordance with their individual ongoing needs as identified on the assessment document. It will include guidance to staff to provide a standardised approach to discharge planning.

The principle of making suitable information, assistance and advice available to patients, and their carers/families at the earliest opportunity is central to the discharge planning process. This should include information in relation to financial assessments and charging for social services and /or accommodation.

2. Statement

A safe discharge is one where the risks associated with the person's ongoing needs are identified and recorded. The UHB cannot prevent or reduce all risks but will work with patients and their families to make the discharge as safe as possible. All risks and discussions about risks should be recorded for those who may be involved in ongoing care.

Working in tandem with social care colleagues, Cardiff and Vale UHB will take all reasonable and practicable steps to provide a mutually agreed safe, effective and timely discharge service for people based on their assessed needs.

This procedure sets out Cardiff and Vale UHB's approach to working with patients, their families and partner organisations to support a patient's safe and timely discharge from hospital.

Central to the policy and procedure are these principles:

- Patients and/or their representative are involved
- Patients are informed
- Using strengths based approach
- Discharges are safe
- Discharges are timely
- Discharges are co-ordinated

Consideration of capacity and the principles and requirements of the Mental Capacity Act 2005, the Mental Health Measure 2010 and the Safeguarding Adult

Document Title: Discharge from Hospital Procedure	5 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

Procedures must underpin the application of this policy which will include recognition of those who hold a Lasting Power of Attorney, a Court appointed Deputy and verification of an Advanced Decision to refuse treatment.

All patients should receive a leaflet with necessary information, detailing the discharge planning processes. This "Planning your Discharge" information leaflet can be found at

http://www.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/PRIMARY_COMMUNITY_AND_INTERMEDIATE_CARE/INTEGRATED_DISCHARGE_SERVICE/USEFUL%20DOCUMENTS%20/PLANNING%20DISCHARGE%20BOOKLET%20-%20DEC%202012.PDF

3. Objectives

- To identify the key principles of discharge and understand the links with other policies and how they impact upon the discharge process
- To clarify roles and responsibilities of key staff associated with discharge
- Promote a co-ordinated multidisciplinary team approach to discharge and care planning
- To promote a positive patient experience by ensuring that patients receive the right care at the right time in the right place
- Support good communication between clinical teams across the health community, patients and their families/carers
- Promote early engagement with the patient's GP; locality/neighbourhood team/case manager to ensure that the discharge plan is implemented in a safe and co-ordinated manner
- To promote IM&T communications ie. e-discharge and e-bed management through the timely recording of inpatient admission and discharge record keeping on the clinical information systems
- Strengths based approach and key performance indicators

4. Responsibilities

The consequences of delayed discharges are well referenced, especially in respect of older people with frailty who are vulnerable to:

- Loss of muscle strength
- General decline
- Loss of confidence and mobility
- Delirium and deterioration of cognitive function
- Increased risk of falls and hospital acquired infections

The Clinical Boards have operational responsibility to implement effective and efficient systems and processes to ensure that all patients receive evidence based person-centred care and treatment within the available resources. This will include

Document Title: Discharge from Hospital Procedure	6 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

ensuring that discharge planning is organised and managed so that patients get the right clinical care under the right clinical teams at the right time, and that they are supported to be discharged from hospital when they are fit for discharge.

5. Patient Experience

- The wishes of patients should inform the development of care plans and the discharge process
- The patient and their family/representative (with the patient's consent) should be engaged at every stage of the discharge planning process and this should be recorded on the discharge plan
- Every effort should be made to take into account cultural, religious, or language differences and sensory disabilities. All staff should be sensitive to special needs arising from these differences

6. Legal context

- Where there is doubt about a patient's decision making abilities in relation to discharge destination, the Mental Capacity Act 2005 must be followed. <https://www.gov.uk/government/statistics/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments-england-2015-to-2016>
- Patients who are subject to the Mental Health Act 1983, must have a robust management plan in place prior to discharge. <http://www.legislation.gov.uk/ukpga/1983/20/contents>
- If there are any concerns that the patient may be an 'Adult at Risk' as defined under the Social Services and Wellbeing (Wales) Act 2014, the assessing professional must follow local safeguarding procedures. If a patient requires care and support at home every effort will be made to carry out the assessment in the patient's own home
- Must be compliant with Human Rights Act Articles 5(Right to liberty) & 8(Right to respect for private and family life)

7. Safety

- All staff should be aware of the increased risks to patients associated with an extended hospital stay
- A Discharge Planning Checklist must be completed for every patient, with information provided, re: follow up appointments, on-going care of wounds, drains, vascular lines, catheter care, continence aids, gastrostomies and NG tubes

8. Effectiveness

Document Title: Discharge from Hospital Procedure	7 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

- Clinical Expected Length of Stay (CELOS) should be set within 48 hours of admission, and discussed with the patient and their family
- Decisions in relation to the discharge of patients should be made each day during ward Board Rounds
- Discharges should be planned to take place every day of the week.
- All staff in contact with patients should be clear to explain to patients and their families that once a patient is 'medically fit' i.e. no longer requires an acute hospital bed, they do not have the right to occupy that bed

9. Timeliness

- Discharge planning should commence on admission in collaboration with the patient and their family with the patient's consent.
- Arrangements for discharge from hospital should ensure there is seamless care, so the person does not experience a gap in care due to hand over from hospital to home.
- Where arrangements for ongoing care are not in place and interim arrangements are made this should not disadvantage the person being discharged, such as where a person agrees to move to temporary accommodation while awaiting grant work in their own property.
- Equipment required for discharge should be identified early in order to be in place when the person is discharged.
- An assessment of the person's needs should be carried out as early as possible and consideration of eligibility for Continuing NHS Health Care should be done by MDT as part of the discharge planning process.

10. Roles

Cardiff and Vale UHB through the Chief Executive as the 'Accountable Officer' - The Accountable Officer is responsible for setting the strategic direction and the policy framework. As part of the strategic direction and the policy framework, care will be provided using collaborative working arrangements across all the agencies responsible for the provision of health and social care for the population served, within Cardiff and Vale UHB.

a. Ward Nurses – Care Coordinator

- Act as care co-ordinator for own group of patients on each shift
- Discharge plans (including Planned Date of Discharge) are discussed with patient and family/carer at intervals throughout their stay in ward area and written discharge information is provided
- Coordinate proportionate, integrated and specialist assessments where appropriate
- Ensure assessments and decision making documents provide evidence of needs and risks that inform discharge plan

Document Title: Discharge from Hospital Procedure	8 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

- Identify constraints in the patient's discharge plan and escalate as appropriate to Ward Sister / Charge Nurse or Deputy
- Ensure reasons for delays or failure in meeting the Planned Date of Discharge are recorded on clinical information systems
- Recording exact time of discharge on Clinical Information systems within 10 minutes of patient being discharged from the ward
- Ensure all the relevant information is available at the Board Round
- Early identification of equipment needs and discussion with appropriate therapist including alternatives for support on discharge e.g. Community Resource Team (CRT) and anticipated delivery date of any equipment required
- Ensure Discharge Planning Checklist is completed for **all** discharges
- Ensure transport arrangements are discussed with family and where necessary book ambulance transport 24 – 48 hours prior to discharge. Transport arrangements must not delay discharge
- Ensure take home medication is requested 24 – 48 hours prior to discharge
- Effective use and early transfer to Discharge Lounge where appropriate

Sisters/Charge Nurses - are responsible for the organisation and management of care provided to patients on their ward. This will include the co-ordination of care to ensure that all patients get the right care by the right professionals at the right time. In so doing they will ensure:

- That all patients have a CELOS set within 48 hours of admission and that this is recorded on the Clinical Work Station (CWS) and noted on the board round board
- That all patients have a care, treatment and discharge plan that is reviewed daily so that patients and their families are kept fully up-to-date as equal partners on all aspects of their care
- That efficient and effective multidisciplinary (MDT) board rounds are held every day, care plans for all patients are discussed and actions such as tests, treatments, assessments and referrals are carried out and all delays chased up
- That every patient has a clear discharge plan that is reviewed daily and all delays escalated appropriately
- That the **Choice of Accommodation Protocol** is properly implemented for **all** patients being discharged to a Care Home
- That all formal MDT meetings are properly co-ordinated and managed so that all information to inform effective decision-making is presented and agreed actions documented and followed up
- There is effective liaison between the ward and Integrated Discharge Service

Document Title: Discharge from Hospital Procedure	9 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

- That a 'live' bed state is maintained on the CWS at all times so that the Patient Access Team are able to co-ordinate the admission of new patients to the most appropriate ward
- b. Senior Nurses – in relation to discharge planning, senior nurses will ensure that this policy is implemented within their area of responsibility. This will include ensuring that:
 - There is an effective board round regularly to assure that all patients are reviewed on a daily basis and meaningful decision are made and executed
 - Any discharge delays that cannot be resolved at ward level are escalated to Lead Nurse
 - They attend at multiagency weekly DTOC meetings to identify and escalate constraints
 - They act on escalated constraints to discharge
 - c. Senior Medical Staff – are responsible for ensuring that there is a clear documented Clinical Plan that has been discussed with the patient, for all patients under their care. The Clinical Plan will include:
 - Differential diagnosis
 - Investigations to confirm / rule out a diagnosis and how to act on results
 - Immediate treatment plans
 - Treatment to be started based on results
 - Any further functional assessment required
 - Anticipated need for therapies input
 - Anticipated need of social input
 - Clinical Expected Length of Stay (CELOS)
 - Post-hospital management plan
 - Relapse signatures and crisis management plan (for Mental Health)
 - d. The responsible Consultant (or their delegated deputy) will attend the daily board round to discuss all clinical plans with the MDT and ensure all decisions / changes to the plan are effectively communicated and acted upon. S/he will also ensure that:
 - All 'to take home' (TTH) medicines, etc., are completed in good time to enable early discharges - for example blister packs for medications are ordered a week prior to discharge
 - Discharge documentation (including Integrated Assessment / Continued Health Care) is legible; outcomes and recommendations are documented and completed in a timely way as a part of the MDT assessment process
 - Electronic discharge summaries are completed on day of discharge
 - A clear plan, including any follow-up care, is in place for patients who are likely to be discharged over the weekend
 - Where a person is not returning to the care of their previous GP the doctor has a responsibility to ensure the receiving GP is provided with appropriate information to provide ongoing care

Document Title: Discharge from Hospital Procedure	10 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

e. Allied Health Professionals, eg Occupational Therapists, Physiotherapists, Dieticians, Pharmacists will:

- Attend the daily board rounds to give professional input and participate in MDT discussion on individual Clinical Plans to ensure timely discharge
- Provide advice, support and training to MDTs in planning safe and timely discharge of patients
- Work with the CRTs to identify patients who can be 'discharged to assess'
- Provide teaching, training and supervision to achieve best practice in discharge planning
- Participate in CHC assessment processes and provide expert advice
- Escalate any discharge delays to the appropriate level
- Ensure that the ward clinical work station is maintained up-to-date so that the Integrated Discharge Service (IDS) and the CRTs are accurately informed about patient progress

f. Directorate Managers /Lead Nurses – will ensure that the Policy and this Procedure are fully implemented within their area of responsibility. This will include:

- Monitoring performance associated with discharge, freeing up bed capacity, reducing length of stay (LOS) and delayed transfers of care (DTOC)
- Ensuring that the ward clinical work stations are kept up-to-date at all times so that IDS and CRT are accurately informed about patient progress
- Escalating any untoward patient delays that are likely to impact on patient flow issues to the appropriate level

g. Clinical Board Management Teams - are responsible for ensuring that the Policy and Procedure are properly implemented within their Clinical Board. This includes ensuring that:

- All staff are made aware of their responsibilities within the Policy and Procedure.
- Adequate training and support is provided to facilitate adequate understanding and implementation of the Policy and Procedure.
- Effective systems are established to monitor the impact of the Policy and Procedure and the discharge planning processes.

11. Integrated Discharge Service IDS

The Integrated Discharge Service, supported by the Head of Integrated Care, will work with clinical teams to support discharge planning processes for people with complex ongoing health and social care needs.

The IDS Team will:

- Use a [Standard Operating Procedure](#) as a framework for a work plan
- Act as a resource to all members of the multi-disciplinary team, to provide expert discharge planning advice

Document Title: Discharge from Hospital Procedure	11 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

- Provide teaching and training, both formal and informal, at ward and departmental level to improve discharge planning
- Support ward teams in the long-term placement assessment process
- Act as a liaison point between ward teams and other agencies
- Escalate any discharge delays appropriately
- Ensure that the IDS activity on the ward clinical work station is maintained up-to-date so that the IDS and the CRTs are accurately informed about patient progress

12. Discharge Documentation

All discharge arrangements should be recorded on the patient's own medical record **and** on the Health Board clinical information systems. If appropriate an accurate contemporaneous record will be available on Social Services client information systems.

13. Discharge Information for Patients and their Families

Patients and their families (where appropriate) will be engaged as equal partners in all aspects of care throughout the in-patient period. On discharge, individual members of the MDT will provide a written summary of the care and treatment while in hospital, including any changes to medication and any further tests, investigations and outpatient clinic appointments, which may be needed.

The patient and their family (where appropriate) will also be provided with any other appropriate information/ contact details relevant to their ongoing care and /or condition.

14. Discharge Summary / Communication with General Practitioners

The patient's Consultant will ensure that an electronic discharge summary is completed for all patients on their day of discharge and forwarded to the patient's GP. The discharge summary will include; the patient's diagnosis and treatment plan and any advice on on-going patient management and follow-up arrangements, details of medication particularly any changes in medication, and the date of discharge.

Where there is a radical change in treatment or medication or where there are complex issues in relation to the ongoing medical care the patient's Consultant is responsible for ensuring the patient's GP is informed by telephone.

A comprehensive discharge summary will be sent to the General Practitioner within 14 working days of the patient's discharge by the patient's consultant.

Discharge against Clinical Advice

Document Title: Discharge from Hospital Procedure	12 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

There are occasions when patients will want to discharge themselves against clinical advice. In these circumstances the ward staff must endeavour to establish the reason for the self-discharge. Where there is no reason to doubt a patient's capacity to make this decision, the ward team must respect the right of the individual to leave the hospital, ensuring that where possible they have been provided with sufficient information to make a fully informed decision. The 'Discharge Against Clinical Advice' procedure must be followed.

http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/EMERGENCY_UNIT_CP/UHW%20EMERGENCY%20UNIT%20DOCUMENTS/CLINICAL%20GUIDANCE/DACA%20PROCEDURE.PDF

15. Refusal to Leave Hospital

If for any reason a patient refuses to leave hospital, every effort will be made to facilitate the discharge to the patient's place of choice. Where difficulties are experienced in transferring care of the patient to the care home of choice, the Multidisciplinary Team will work with the patient and their family/or representative to secure a suitable alternative. This will be done in accordance with the Choice of Accommodation Protocol. Where there are unresolved issues the case should be escalated for consideration to the Clinical Board.

16. Continuing NHS Healthcare (CHC)

For those patients with complex needs their on-going care will be determined following the completion of an 'Integrated Assessment' and, if necessary, the completion of the Decision Support Tool (DST), in accordance with the Continuing National Health Service Care guidance (2014).

http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/PRIMARY_COMMUNITY_AND_IN_INTERMEDIATE_CARE/INTEGRATED_DISCHARGE_SERVICE/USEFUL%20DOCUMENTS%20/CHC%20-%20NATIONAL%20FRAMEWORK%20FOR%20IMPLEMENTATION%20IN%20WALES.PDF

If patients are deemed eligible for CHC or a joint package of care, the patient will be assessed by the MDT supported by the IDS Team and the package of care will be planned and implemented accordingly.

If a patient requires a bespoke/specialist piece of equipment there may be delays in the provision of this equipment so every effort must be made to order this as early as possible. While delays should always be minimised, they should however, be taken into account when planning the discharge and transitional placements used where appropriate.

Document Title: Discharge from Hospital Procedure	13 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

17. Fast Track Continuing Health Care Discharge [Integrated Discharge Service](#)

The 2014 Continuing NHS Healthcare, National Framework for Implementation requires the UHB to have in place a fast track processes aimed at supporting individuals with a rapidly deteriorating condition who are entering a terminal phase of their disease and be in the last weeks or days of life. The fast track process enables them to be supported in their preferred place of care. All staff must ensure that this streamlined process provides enough information to support the rapid approval and arrangement of an appropriate package of care.

All staff involved in the Fast Track process must read the guidance notes carefully and have a clear understanding of the requirements for this process including the need for the Fast Track Care Plan.

Patients and their recognised carers will have provided informed consent to share information about them with community staff who will be providing their care. Patients and their families will be provided with contact details of their Community Key Care Co-ordinator prior to discharge.

It is essential that a timely decision is made in order that the patient receives their care in a setting which they and their families request as long as it can meet their identified needs.

Where a person's home is a residential care home in usual circumstances they would not be able to return with nursing needs however if this is a placement they have been in for some time consideration will be given by the UHB for a return there for end of life care with support from primary care. It is essential that Primary Care services continue to oversee the clinical care and District Nurses are invited to participate in decision making to assure a safe discharge.

18. [Choice of Accommodation Protocol](#)

The Protocol sets out the process for the safe and permanent placement of patients in an appropriate care setting and in a manner which reflects their right to choose their accommodation. This is a significant decision and requires careful consideration by the patient (or their Lasting Power of Attorney, (if applicable), their advocate and their family and/or carers. Obtaining good advice from health care and social care professionals is essential, to ensure that the process is done effectively and efficiently.

Each stage of the discharge planning process should be approached in a supportive manner. The patient (or their LPA where applicable) and their family/carer/advocate should be offered explanations verbally and in writing, there should be counselling and further support throughout the process.

Document Title: Discharge from Hospital Procedure	14 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

19. Vulnerable Groups

Some individuals may require additional support when planning their ongoing care arrangements and may include individuals with a learning disability; people who are homeless; those who have a physical or sensory disability; people who have a mental illness, including dementia; and those who are old with frailty. There should also be due consideration of those adults and children who have existing safeguarding plans in place.

20. Performance Measures

Compliance with this Discharge Policy and Procedure will be monitored as part of Cardiff and Vale UHB's operational performance management process to include:

- Reduction in number of delayed transfers of care
- Reduction in number of bed days lost
- Reduction in number of complaints associated with the discharge process
- Achievement of expected Date of Discharge
- Increased number of discharges achieved before noon
-

The Clinical Boards are accountable for enforcing and supporting this Policy and Procedure and performance of Directorates will be reviewed at Operational Performance Group meetings.

21. Review of Policy

The Policy will be reviewed every three years and will include:

- Regular audit of compliance
- Monitoring of complaints and reported incidents and areas of consistent difficulties
- Feedback from key stakeholders including patients/carers/advocates

22. References

This document needs to be read in conjunction with other resources/ policies. The appropriate links have been made on the electronic version but in the written document they are referred to in the index.

23. Glossary of Terms

Planned Date of Discharge

This is a date identified by the admitting ward team, based on information gained during admittance assessment, as to when the patient is likely to be discharged.

Ready for Transfer

Document Title: Discharge from Hospital Procedure	15 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

Ready for transfer of care date is the date on which a hospital inpatient is ready to move on to the next stage of care. This is determined by the clinician responsible for the inpatient care, in consultation with the multi-disciplinary team and all agencies involved in planning the patient's discharge or transfer to a more appropriate NHS care setting. A patient who continues to occupy a hospital bed after his/her ready for transfer of care date during the SAME inpatient episode experiences a delayed transfer of care

Discharge Fit (Fit for Discharge)

- Is when the patient no longer benefits from on-going hospital based inpatient services, within a tertiary / secondary care setting and where:
- on-going care and social needs have been agreed and can be met in another setting, home or through primary, community, intermediate care or social services.
- on-going care and social care needs can be met more appropriately in a secondary or community care setting closer to the patients' home.
- additional tests and interventions can be carried out in an outpatient or ambulatory setting.

Care Plan

Where hospital staff provide a plan of care that documents the care a person requires how often and the risks to the person if care is not provided in order that all staff responsible for the patient's care are able to provide it consistently and identify any changes in needs.

Plan of Care and Support (POC)

- The documentation the local authority requires to be completed by the social care worker to ensure ongoing care. This is usually commissioned by a local authority.

24. Other sources of information can be found at IDS web site [Integrated Discharge Service](#)

1. Choice Protocol
 2. Simple/Supported/Complex Matrix
 3. Clinical Workstation Operating Procedure
 4. Ticket Home
 5. Discharge Checklist (Draft)
 6. Provision of Equipment
 7. Procedure for requesting Non-Standard CHC Funded Equipment
 8. Procedure for requesting CHC Equipment
 9. The Discharge Pathway
 10. Discharge Lounge Service
 11. Pharmacy
 12. CHC Fast Track Discharge
- Hospital discharge for patients of no fixed abode

Document Title: Discharge from Hospital Procedure	16 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

APPENDIX 1

CARDIFF AND THE VALE INTEGRATED DISCHARGE SERVICE JUNE 2017 STANDARD OPERATING PROCEDURE

The Integrated Discharge Service (IDS) brings together experienced professionals from health and social care into one hospital based team that can support and advise individuals and professionals in non mental health beds of Cardiff and Vale UHB.

Ward teams are required to identify discharge planning for all patients as simple supported or complex. The simple, supported, complex matrix is built in to the clinical workstation (CWS) and there is a requirement for ward teams to update the CWS regularly. The Integrated Discharge Service will support ward teams with discharge planning differently in each category (refer to simple supported complex matrix)

Category	Integrated Discharge Service
Simple Discharge	Support ward team with sign posting to community services that may support the person following discharge Age Connects Discharge Support Officers can spend time with patients and their families discussing their wishes and concerns regarding discharge from hospital and providing a consistent point of contact for families ward team The responsibility for discharge and decision making remains the responsibility of the ward team and the ward need to identify a named coordinator for the discharge planning.
Supported Discharge	A named person from the IDS team will work with the MDT to plan a person's discharge from hospital. This may be • A discharge support officer to work with and support communication with families • A contact officer to work with ward and care agency to restart a care and support package • A social work assistant to restart or amend a care and support package The responsibility for discharge and decision making remains the responsibility of the ward team and the ward still need to identify a coordinator on the ward for IDS to liaise with
Complex Discharge	A named person from the IDS team will work with the MDT and coordinate a person discharge from hospital. The IDS coordinator will work with the ward coordinator for each patient to arrange meetings and ensure • A comprehensive assessment is completed • Discharge planning involves patients and their families • Meetings are action focused, recorded accurately and provide rationale for decision making • Transfers of Care are completed in a safe and timely manner so that there is continuity in the care and support a person receives wherever they may be discharged to • facilitate and support CHC assessments

Document Title: Discharge from Hospital Procedure	17 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

Access to the Integrated Discharge Service

Board Rounds will be attended regularly by a member of the IDS team to provide immediate advice and prompt focus of the board round on discharge planning. Where agreed with Multi disciplinary team the IDS representative will present cases to the IDS team briefing and liaise between IDS and ward team.

Discharge Support Officers Each ward has a named Discharge Support Officer and that Discharge Support Officer will attend each ward at least twice weekly

- to visit patients and families offer information and sign posting as first point of contact
- to liaise with and answer questions any staff may have
- to ensure people referred to CRT are aware of referral and have information about the service

Phone call to Integrated Discharge Service Anyone can ring the IDS department and ask for advice, the only information required is the patients name and ward and what advice is required. The Admin team will direct the request to the relevant IDS team who will respond within next working day.

IDS UHW Tel 029 20742768 or 029 20742098 (discharges from UHW)

IDS Llandough Tel 029 20715522 (discharge from Llandough or Barry)

St David's Hospital please Ring UHW for Hamadryad and Rhydlaver

Ring Llandough for Lansdowne ward

Hours of service: Monday to Thursday 0900 and 1700. Friday 0900 and 1630.

Out of hours Cardiff and Vale Emergency Duty Team. Tel 029 20788570

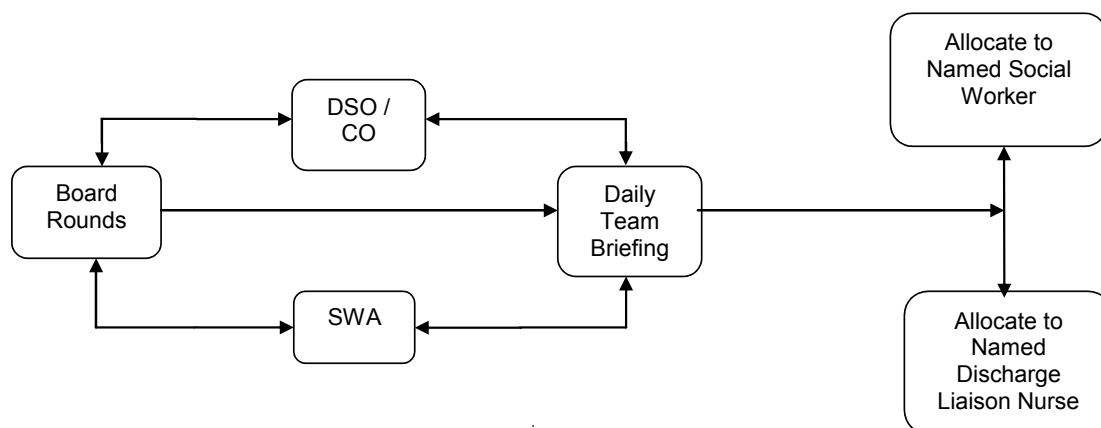
Mobile 07812230073

Fax 029 20226640

email edt@cardiff.gov.uk

11.5

Workflow Integrated Discharge Service



Document Title: Discharge from Hospital Procedure	18 of 18	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality, Safety and Experience Committee		

The IDS team is divided into 5 sub team for working and case load management (see Ids team structure) Each team is made up of contact officers(CO's), discharge support officers (DSO), housing support officers (HSO), social work assistants (SWA), social workers and discharge Liaison nurses. The IDS team will decide which is the appropriate person to work with each patient.

Each day the sub team will have a short tem briefing to review new cases for allocation and action and escalation of existing cases for support from within team. At times of absence of any member of the sub team any other member of the team should be able to liaise with ward and patient or relatives.

Escalation of Constraints and delays to Discharges

DSO, CO, SWA and HSO can escalate delays and difficulties via the daily team briefing for action and to address.

Where each sub team are unable to progress and resolve delays then they should escalate to their respective team managers

Ward teams can escalate delays via their senior nurses

Regular meetings

Daily team Briefing

Weekly DTOC meeting is a forum to identify and share delays in transfers of care and action to avoid delays

Weekly Quality Assurance meeting to present cases complex cases where there is consideration of Continuing NHS Healthcare, joint funding of packages of care or disagreements

Monthly DTOC meeting to review and agree delays reported to Welsh Government prior to submission of DTOC report.

UPDATE ON THE IMPLEMENTATION OF THE REFRESHED PATIENT EXPERIENCE FRAMEWORK	
Name of Meeting :	Quality, Safety and Experience Committee
Date of Meeting:	6 December 2017
Executive Lead :	Executive Nurse Director
Author :	Acting Assistant Director of Patient Experience 029 2074 6108
Caring for People, Keeping People Well :	Deliver Outcomes that Matter to People
Financial impact :	Nil
Quality, Safety, Patient Experience impact :	Improved patient experience
Health and Care Standard Number	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
CRAF Reference Number	
Equality and Health Impact Assessment Completed:	Not Applicable as an update paper

ASSURANCE AND RECOMMENDATION this will provide the basis of the minute
ASSURANCE is provided by:
The evidence of the progression of the Framework
The Quality, Safety and Experience Committee is asked to:
NOTE the progress of the implementation of the Framework.

SITUATION

The Health Board has refreshed the Patient Experience Framework to incorporate all elements of real time, retrospective, proactive/reactive and balancing patient experience across the UHB and primary care. Much of the detail in the framework has been informed by the All Wales Listening and Learning Group which has been established to embed the learning from the Evans Review "The Gift of Complaints" and to share good practice across Wales. This paper will outline the progress in relation to the identified actions to date for year one of the framework.

BACKGROUND

Real Time Short Surveys Used to obtain views on key patient experience indicators whilst patients, carers and service users are in our care (such as in hospital) or very shortly afterwards (such as on discharge or immediately after an out-patient appointment)	Retrospective Surveys post discharge or any clinical encounter in any setting to gain in-depth feedback of service user experience. They can also incorporate quality of life measures and Patient Reported Outcome/Experience measures (PROM/PREM)
Proactive/Reactive Provide opportunities for all service users/families/carers to provide feedback. Includes feedback cards, permanent and temporary online surveys and emerging methods such as text, QR codes and social media.	Balancing Concerns and complaints Compliments Patient stories Focus groups Third party surveys such as Community Health Council and voluntary organisations

In order to capture service user feedback it is recognised that there is no single method that can provide the assurance that Health Boards require and that a number of methods are required for triangulation to verify findings and make improvements. To support this approach The All Wales Framework for Assuring Service User Experience describes four quadrants which group together a wide range of feedback

Patients, families and carers can provide feedback in a wide variety of ways. Some may be specifically designed by organisations to encourage feedback; however there are many other ways in which feedback can be obtained. It is important that patients, families and carers feel that their views, positive, negative or neutral, are welcomed, that notice will be taken of what is said and improvements made where necessary. Organisations should use feedback from all sources to gain a balanced view of experience. There will be a difference between information solicited by surveys and information that has been provided by a user actively sending a compliment or raising concerns.

ASSESSMENT AND ASSURANCE

Key achievements to date

-  Evidence of activity in all 4 quadrants of the framework
-  Internal Carers Group established
-  E datix for Concerns implemented October 2017



Over 100, 000 responses received and able to undertake further analysis

- ✚ Communications team share the results which are very positive via the screens placed in many areas around the UHB



Surveys in use and reports provided to ward area each week- any action points noted



Pilot completed

Changes made in OPA clinic due to information received

Version 2 of the survey under design

- ✚ More targeted and focused placement of volunteers has improved the completion rate for surveys
- ✚ Formal concerns 65% response time has been achieved but there needs to a sustained improvement in place
- ✚ Putting Things Right Training Programme in place with positive evaluation
- ✚ PALS service - Weekly sessions in each of the 3 information centre's KPI's measure the number of concerns processed informally and the informal to formal conversion rate

Measures that require further progression

- ✚ Development of the reporting structures - This needs more work and the Patient Feedback group will become the Patient Experience Framework Assurance Group to monitor themes and actions.
- ✚ 2017-2020 develop and implement the customer care training programme-
- ✚ Programme to be advertised at end of 2017
- ✚ **Happy or not** _ Analyse the data and target more in depth analysis of the themes and trends
- ✚ On line feedback in 5 survey to be launched by end of December
- ✚ QR code underway
- ✚ Thematic analysis of patient stories

Assessment

The framework is on schedule for implementation and an annual report will be produced in April 2018.

Assurance will be provided by Development of the Patient Experience Framework Assurance Group will be in a position to share minutes of the meetings with the QSE committee and to provide assurance of activity from across the UHB in both primary/ community and secondary care settings.

HEALTH AND CARE STANDARDS – PROPOSED APPROACH FOR THE 2017 SELF ASSESSMENT	
Name of Meeting :	Quality, Safety and Experience Committee
Date of Meeting	6 th December
Executive Lead :	Executive Nurse Director
Author :	Patient Safety and Quality Assurance Manager 2074 3681
Caring for People, Keeping People Well :	Offer services that deliver the improvement in health that our citizens are entitled to expect
Financial impact :	None
Quality, Safety, Patient Experience impact :	The framework supports the delivery of effective, timely and quality services.
Health and Care Standard Number	All standards
CRAF Reference Number	5.1.6 Compliance with Health and Care Standards
Equality and Health Impact Assessment Completed:	Not Applicable

ASSURANCE AND RECOMMENDATION
ASSURANCE is provided by: • The progression of work to support continuous ongoing assessment against the standards • Internal Audit Report 2017 The Quality, Safety and Experience Committee is asked to: • AGREE the proposed approach for the assessment of compliance against the Health and Care Standards for the period 2017-2018. •

SITUATION

This report provides the committee with an update of the UHB's approach to assessment of compliance against the Health and Care Standards.

BACKGROUND

The Health and Care Standards set out the Welsh Government's framework of standards to support NHS organisations in providing effective, timely and quality services across all healthcare settings. The current set of Health and Care Standards came into force on 1 April 2015 and incorporate a revision of the "Doing Well, Doing Better" Standards for Health Services in Wales (2010) and the 'Fundamentals of Care Standards (2003).

To further embed the Health and Care Standards and to support a system that promotes continuous monitoring and development of the service

provision underpinning each of the Health and Care Standards, it was proposed that there was a move away from one off annual assessments undertaken by Clinical Boards, and instead, existing committees or groups within the UHB would be aligned to individual standards to provide year round support and strategic direction.

In 2016/17 this approach was taken with standard:

- 2.3 Falls Prevention
- 2.4 Infection Prevention and Control and Decontamination
- 2.5 Nutrition and Hydration
- 2.6 Medicines Management
- 2.7 Safeguarding
- 2.9 Medical Devices Equipment and Diagnostic Systems

The Clinical Boards undertook self assessments against the remaining 16 standards. Corporate leads were aligned to each of these standards in order to validate the self assessments and to identify priorities to support compliance in the following year.

The Process was subject to scrutiny from Internal Audit and was awarded reasonable assurance.

Assessment

The 2017/2018 approach will remain the same as the previous year with a further 6 standards being aligned to groups and committees:

- 1.1 Health promotion, protection and Improvement
- 2.1 Managing Risk and Promoting Health and Safety
- 2.2 Preventing pressure and Tissue Damage
- 2.8 Blood Management
- 3.4 Information Governance and Communication Technology
- 7.1 Workforce

Details of the Standards that are now aligned with UHB Groups and Committees is included at Appendix 1.

It is anticipated that the agendas for these committees will reflect the criteria dictated in the Health and Care Standard with which they are aligned. Monitoring of Clinical Board performance against these criteria will be reported into the committees at appropriate intervals. These standards have been chosen because there is already an established group/committee with a well developed infrastructure to support this development. The remaining standards will be aligned to groups or committees over the next two years (Appendix 2) and in the meanwhile the UHB will continue the current self assessment process against these standards. The aim is that by 2020, there will be no requirement for a one off self assessment to provide assurance on compliance. This will allow time to undertake the necessary preparation with

the chairs of established groups and/or to establish the necessary infrastructure where it is not already in place.

The overall approach and timescales for 2017/18 assessment will be:

Timescale		Activity	Lead
Start	End		
02.01.18	05.02.18	Revision of HCS Driver Diagrams	Corporate Leads
22.01.18	27.04.18	Self Assessment of all standards excluding 1.1 2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 3.4 7.1	Directors of Nursing in Clinical Boards
01.03.18	31.03.18	Internal Audit Assessment	Internal Audit Manager
30.04.18	14.05.18	Corporate Validation of self assessments and completion of SBARs	Corporate Leads
-	14.05.18	Assessment of compliance against standards 1.1 2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 3.4 7.1	Related Group/committee
14.05.18	18.05.18	Executive and Independent member Sign Off	Executive and Independent leads
04.06.18		Paper to QSE	Patient Safety and Quality Assurance Manager

A list of Executive, Independent Member and Corporate Leads is included at Appendix 3.

An update will be given to the committee in June 2018 detailing the overall position of the UHB against the Health and Care Standards and progression towards the further alignment of standards to committees

Appendix 1**Health and Care Standards Aligned to Committees**

	Standard	Group / Committee	Corporate Lead
1.1	Health promotion protection and Improvement	Strategy and Engagement Committee (to be confirmed)	Public Health Consultant
2.1	Managing Risk and Promoting Health and Safety	Health and Safety Committee	Head of Health and Safety
2.2	Preventing Pressure and Tissue damage	Pressure Damage Group	Director of Nursing Surgery Clinical Board
2.3	Falls prevention	Falls Prevention Group	Assistant Director of Therapies
2.4	Infection prevention control and decontamination	IPC Group	Director of Infection Prevention and Control
2.5	Nutrition and Hydration	Nutrition and Catering Steering Group	Head of Dietetics
2.6	Medicines Management	Medicines Management Group	Director of Pharmacy
2.7	Safeguarding	Safeguarding Steering Group	Linda Hughes Jones
2.8	Blood Management	Blood Transfusion Group	Haematologist
2.9	Medical Devices, Equipment and Diagnostic Equipment	Medical Equipment Group	Assistant Director of Therapies
3.4	Information Governance and Communication Technology	Information Technology and Governance sub Committee	Senior Manager Performance and Compliance
7.1	Workforce	Resource and Delivery Committee	Workforce Governance Manager

Appendix 2

Schedule for Alignment of Standards to Committees/UHB Groups

	Health and Care Standard	Timescale for Alignment with a UHB Group/Committee
3.1	Safe and Clinically Effective Care	Apr 2019
3.2	Communicating Effectively	Apr 2020
3.3	Quality Improvement research and Innovation	Apr 2020
3.5	Record Keeping	Apr 2019
4.1	Dignified Care	Apr 2020
4.2	Patient Information	Apr 2019
5.1	Timely Access	Apr 2019
6.1	Planning Care to Promote Independence	Apr 2020
6.2	People's Rights	Apr 2020
6.3	Listening and Learning from Feedback	Apr 2019

Appendix 3

Health and Care Standards Standard Leads

Standard	Executive Lead	Corporate Lead	Independent Member
Governance, Leadership and Accountability Standard	Board Secretary	Head of Corporate Risk and Governance	Audit Committee Chair
Standard 1.1 Health Promotion, Protection and Improvement	Executive Director of Public Health	Consultant in Public Medicine	Strategy and Engagement Committee Chair
Standard 2.1 Managing Risk and Promoting Health and Safety	Director of Planning	Deputy Director of Strategy & Planning	Health and Safety Committee Chair
		Head of Health & Safety	
		Assistant Director Patient Safety & Quality	
		Head of Corporate Risk and Governance	
Standard 2.2 Preventing Pressure and Tissue Damage	Executive Nurse Director	Deputy Nurse Director	Quality Safety and Experience Committee Chair
Standard 2.3 Falls Prevention	Executive Director of Therapies and Health Sciences	Assistant Director of Therapies and Health Sciences	Quality Safety and Experience Committee Chair
Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	Executive Nurse Director	Director of Infection Control	Quality Safety and Experience Committee Chair
		Assistant Director of Therapies and Health Sciences	
		Head of Patient Environment	
Standard 2.5 Nutrition and Hydration	Executive Director of Therapies and Health Sciences	Head of Dietetics	Quality Safety and Experience Committee Chair
Standard	Executive Lead	Corporate Lead	Independent

			Member
Standard 2.6 Medicines Management	Medical Director	Chief Pharmacist	Quality Safety and Experience Committee Chair
Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk	Executive Nurse Director	Deputy Nurse Director	Quality Safety and Experience Committee Chair
		Head of Safeguarding	
Standard 2.8 Blood Management	Executive Director of Therapies and Health Sciences	Consultant Haematologist	Quality Safety and Experience Committee Chair
Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	Executive Director of Therapies and Health Sciences	Assistant Director of Therapies and Health Sciences	Quality Safety and Experience Committee Chair
Standard 3.1 Safe and Clinically Effective Care	Executive Nurse Director	Assistant Director Patient Safety & Quality	Quality Safety and Experience Committee Chair
		Assistant medical Director	
Standard 3.2 Communicating Effectively	Director of Planning	Assistant Director Patient Experience	UHB Chair
		Lead Nurse Patient Experience	
		Board Secretary	
		Equality Adviser	
Standard 3.3 Quality Improvement, Research and Innovation	Medical Director	Assistant Director Patient Safety & Quality	Quality Safety and Experience Committee Chair
		Director of R&D	
Standard 3.4 Information Governance and Communications Technology	Medical Director	Head of Information Governance	Independent Member Information Management and Technology
	Executive Director of Public Health	Head of IT	
Standard 3.5 Record Keeping	Chief Operating Officer	Health Records Manager	Independent Member Information Management and Technology
		Head of Information Governance	

Standard 4.1 Dignified Care	Executive Nurse Director	Assistant Director Patient Safety & Quality	Quality Safety and Experience Committee Chair
		Deputy Nurse Director	
Standard 4.2 Patient Information	Executive Nurse Director	Assistant Director Patient Safety & Quality	Quality Safety and Experience Committee Chair
		Assistant Medical Director	
		Equality Adviser	
		Lead Nurse Patient Experience	
		Mental Capacity Act Manager	
		Mental Health Act manager	
Standard 5.1 Timely Access	Chief Operating Officer	Assistant Director of Operations	Resource and Delivery Committee (TBC)
Standard 6.1 Planning Care to Promote Independence	Director of Therapies and Health Sciences	Assistant Director of Therapies and Health Sciences	Quality Safety and Experience Committee Chair
Standard 6.2 Peoples Rights	Director of workforce	Assistant Director of Workforce	Chair Equality Diversity and Human Rights sub-Committee
		Equality Advisor	
Standard 6.3 Listening and Learning from Feedback	Executive Nurse Director	Assistant Director Patient Experience	Quality Safety and Experience Committee Chair
Standard 7.1 Workforce	Director of Workforce	Assistant Director of Workforce	Resource and Delivery Committee Chair

PATIENT SAFETY WALKROUNDS™

Executive Lead : Executive Nurse Director

Author : Quality and Safety Improvement Manager 2074 3681

Caring for People, Keeping People Well : This report underpins the Health Board's Sustainability, Culture and Values elements of the Health Board's Strategy.

Financial impact : £ zero

Quality, Safety, Patient Experience impact : Senior leaders of the UHB directly influence behaviours and attitudes for improving quality and safety by visiting front line teams, discussing quality and safety matters and empowering them to take appropriate action. Staff are able to share their successful quality and safety improvements. Senior leaders have an action plan to address issues beyond the control of the Clinical Boards.

Health and Care Standard Number WalkRounds™ engage with service users and staff and have the potential to impact on all the Health and Care Standards.

CRAF Reference Number 5 operational and clinical excellence, 8 governance, 9 values and behaviours

Equality Impact Assessment Completed: No

RECOMMENDATION

The Committee is asked to:

- **NOTE** the progress of WalkRounds

SITUATION

WalkRounds™ (WRs) have been carried out in various guises since before the inception of the UHB. They are carried out predominantly by a Board and Independent Member visiting clinical areas together. One WR is scheduled per couple per month. This requires a significant amount of administration and communication.

For the past year specific antimicrobial WRs have been carried out jointly by the Medical Director, microbiology and the infection, prevention and control (IP&C) team.

This paper is to update the committee on recent progress and learning from WRs.

BACKGROUND

Originally WRs were designed by the Institute for HealthCare Improvement (IHI) and introduced to the UK through the Safer Patient Initiatives. They were implemented across NHS Wales from April 2008 through the 1000 Lives Campaign as part of the Leadership improvement stream to get Boards on Board.

They were mandated by Welsh Government in Achieving Excellence, The Quality Delivery Plan for NHS Wales 2012-2016.

WRs provide an opportunity to gain insight and understanding of patient safety and service delivery issues and to identify areas of good practice to share and celebrate. They enable the Board and other senior people in the UHB to demonstrate visible leadership. More recently they provide an opportunity to sense the impact of the work to translate values into action across the organisation.

ASSESSMENT

WRs were designed so that senior leaders get a firsthand experience of clinical areas and engage with staff and patients. The visibility of the Board at the front line is important and valuable to both parties.

Between 1st January 2017 and 30th September 2017 81 WRs were scheduled of which 57 (70%) took place. However, dates were frequently moved:

- Once = 23 occasions
- Twice = 11 occasions
- Three times = 6 occasions
- Five times = 2 occasions
- Total of 73 new dates were required for rescheduling

On some of the above occasions, it resulted in the WRs being completely cancelled. On two occasions, new dates were never received.

Of those that were carried out 33 (57%) WRs were formally recorded. However, there is much variation in the detail.

New Executive and Independent Members have recently been appointed and pairings for WRs have been revised accordingly. Proposals for the new pairings are attached at Appendix 1.

A proposed schedule of visits is attached at Appendix 2. Efforts have been made to ensure that Safety walkrounds to areas do not take place soon before or after scheduled 'observation of care' visits to clinical areas. These are longer and more in-depth than WRs. Reports are always written as part of the inspection process and fed back to the clinical areas visited. They are an additional source of governance and assurance but serve a different purpose to WRs

Key themes from general WRs

Many teams reported that they are proud of the care they provide and team working. Some teams had made local improvements by participating in the Leading Improvement in Patient Safety (LIPS) programme.

The poor condition of some of our older buildings and a wish for more staff were common themes. Conversely – positive comments were made about estates where improvements had been carried out and where roles had been revised to improve service delivery.

Antimicrobial WRs

Appropriate antibiotic prescribing is critical to reducing antimicrobial resistance and treat patients effectively. Since December 2016 the Medical Director has been leading these specific WRs. He is accompanied by the chair of the antimicrobial group, director of IP&C and senior nurse IP&C. These were done on 4 wards which either had concerns surrounding the quality of their antimicrobial prescribing or had recently had a period of increase incidence or an outbreak of *C.Difficile* diarrhoea. As part of the pilot, two wards had follow up visits.

A tool to audit systemic antimicrobial prescribing was designed for junior doctors to carry out. Results are presented and discussed during the WR. This is a positive experience all round. Clinicians welcome the opportunity to discuss associated issues with the Medical Director and identify help required to improve IP&C. Results will be presented at Directorate audit meetings and three times a year at the Infection Prevention and Control Group Meeting.

Similar themes are emerging. Audits highlighted issues with the environment and the cluttering of some wards. It was found to be difficult to comply with bare below the elbow recommendations at the entrance of the ward due to the lack of facilities to leave jackets safely. Other concerns were raised about the lack of staff and the regular need to use bank nurses. Furthermore, documentation of indication and intended duration for antimicrobial prescriptions was found to be lacking and there was poor compliance with the use of the antimicrobial sticker, which was particularly problematic for patients who had been transferred from other areas such as Short Stay Surgical Unit and Surgical Assessment Unit. There was overall a lot of good will to improve own performance even by designing local tailored initiatives to improve antimicrobial prescribing.

Monthly antimicrobial WRs are scheduled up to December 2018. The team is awaiting approval of software development request to Business Informatics Services to allow data entry of systemic antimicrobial junior doctor audit data via clinical workstation. This will enable access to data collection forms across all wards in UHW and UHL. Results will then be reported and analysed via the Consultant and Senior Nurse / Ward Manager dashboards and can contribute to the markers and indicators of quality.

PATIENT SAFETY WALKROUND PAIRS

Board Executive	Independent Member
Len Richards Chief Executive	Susan Elsmore – Local Authority
Bob Chadwick Executive Director of Finance	Chair – Maria Battle
Martin Driscoll Executive Director of Workforce & Organisational Development	Vice Chair -Charles (Jan) Janczewski
Ruth Walker Executive Nurse Director	John Antoniazzi - Estates
Fiona Jenkins Executive Director of Therapies & Health Sciences	Akmal Hanuk - Community
Steve Curry Chief Operating Officer	Eileen Brandreth – IM&T
Sharon Hopkins Executive Director of Public Health	Trade Union representative TBC
Medical Director is carrying out anti- microbial stewardship walkrounds	John Union - Finance
Peter Welsh Director of Corporate Governance	Sarah Moseley – Third Sector
Abigail Harris Executive Director of Planning	Michael Imperato - Legal
Carol Evans Assistant Director of Patient Safety & Quality	University representative

SCHEDULED FOR PATIENT SAFETY WALKROUNDS 2018

Couplet	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Bob Chadwick/ Maria Battle	Gwdihw Ward, UHW	Crisis Recovery Team, UHW	Adult Speech & Language Therapy, UHW	Rookwood 7,8	HMP Cardiff Healthcare Unit, Cardiff Prison	Gynae - cology OPD, UHW	District Nursing, Penarth	Rainbow Ward, CHW, UHW	Community Dental Service, Park View Health Centre, Ely	Pharmacy Clinical Support Unit, UHL	Oak Ward, UHL	Short Stay Surgical Unit, UHW
Martin Driscoll/ Charles Janczewski	Speech & Language Therapy, St David's	East 10, UHL	Llanedeyrn Health Centre, Cardiff	Immunology Outpatients, UHW	Children's Disability Team, St David's	Ward A5, UHW	Pentywn Health Centre CMHT, Cardiff	Ward B6, UHW	MEAU, UHL	Vale Out of Hours GP Service, Barry Hospital	Consultant Led Maternity, UHW	Endoscopy Suite, UHL
Ruth Walker/ John Antoniazzi	Gabalfa Clinic CMHT, Cardiff	West 6, UHL	Ward A1, UHW	Amy Evans Centre, CMHT, Barry	Penguin Outpatients (ENT), CHW, UHW	Llanishen Clinic, Cardiff	Ward East 6, UHL	Mortuary, UHW	Short Stay Surgical Unit, UHW	Community Resource Team, Llanrumney	Poison & Toxicology Laboratory, UHW	Ward A4, UHW
Fiona Jenkins/ Akmal Hanuk	Park View Health Centre, Ely	Pharmacy UHW	Dinas Powys Health Centre	St Barruc Ward, Barry Hospital	East 14, UHL	Surgical Assessment Unit, UHW	Pentywn CMHT, Ely	Ward C7, UHW	Endoscopy UHW	Alder Ward, UHL	Ward West 5, UHL	Ante Natal Clinic, UHW
Steve Curry/ Eileen Brandreth	Orthopaedic Rehab Unit, CRI	Post Natal Ward, UHW	Community Addictions Unit, CRI	Morgannwg Ward, Barry Hospital	Emergency Gynaecology Unit, UHW	Butetown Health Centre, Cardiff	Ward East 18, UHL	Rhiwbina Clinic, Cardiff	Ward C6, UHW	Asylum Seekers Service, CRI	Ash Ward, UHL	Custody Mental Health, Cardiff Bay Police Station
Len Richards/ Susan Elsmore	Neonatal ITU, UHW	Coed-Y-Felin, Iorwerth Jones Unit, Llanishen	East 8, UHL	Cedar Ward, UHL	Physiotherapy & Occ Therapy, CRI	Ward B5, UHW	Ward East 12, UHL	Ward B4 Haematology, UHW	Emergency Assessment Suite, UHL	Ward B1 UHW	Community Wound Healing Team, Lansdowne	Elan Team - Midwifery - Women, UHW
Sharon Hopkins/ Stuart Egan (*New Union Rep from Dec 2017)	Broad Street Clinic, Barry	Critical Care (ITU), UHW	Arthur Bloom Haem Day Unit, UHW	Outpatients, UHL	Ward C5, UHW	Ward B2, UHW	Maple Ward, UHL	Paediatric ICU/HDU, CHW, UHW	Ward East2, UHL	Communications Hub (out of hours), Barry Leisure Centre	Phoenix Community, Cardiff	ALAS, Rookwood
Peter Welsh/ Sarah Moseley	Pine Ward, UHL	Portering, UHL	Renal Dialysis Unit,	The Links Centre, CMHT, CRI	Hazel Ward, UHL	UHW Ward A7, UHW	Nephrology OPD UHW	Ward East 1, UHL	Assessment & Recovery Unit, UHL	Out of Hours Service, CRI	Community Dental Service, Roath	Enhanced Care Unit, UHL
Abigail Harris/ Michael Imperato	Radiology UHL	HSDU, UHW	Physiotherapy, UHL	Neal & Kent Day Hospital, Barry Hospital	Ward B7, UHW	Ward A6 (S), UHW	Stroke Rehab Unit, UHL	Community Dental Service, St David's	T2 Colorectal Unit, UHW	Physiotherapy, St David's	Breast Clinic/Unit UHL	Ward A6, UHW
Carol Evans/ University Rep	OPD UHW	St Alban's Care Home, Splott	ENT OPD, UHW	A3 link	Medical Assessment Unit, UHW	Pine Day Service, UHL	Oral Surgery Dept, Dental Hospital	Audiology Community, Pentwyn	Pelican Ward, CHW, UHW	Sam Davies Ward, Barry Hospital	Ward B4, Neuro, UHW	Haematology Day Centre, UHW
Graham Shortland/ John Union (Anti-microbial WalkRounds)	Anti-microbial WalkRounds											

**UPDATE OF THE IMPROVEMENT PLAN RESULTING FROM INDEPENDENT
REVIEW OF THE MANAGEMENT RESPONSE TO THE ACINETOBACTER
BAUMANNII (AB) OUTBREAKS IN AUGUST AND NOVEMBER 2015**

Name of Meeting : Quality, Safety and Experience Committee

Date of Meeting: 6th December 2017

Executive Lead : Executive Nurse Director

Author : Patient Safety and Quality Assurance Manager :
Alexandra.scott2@wales.nhs.uk

Caring for People, Keeping People Well : Avoiding waste, variation and harm and delivering outcomes that matter to people.

Financial impact : Total capital funding for the Neonatal Unit to date is £45.563m. A business case has been submitted to WG to secure revenue for staffing in line with the South Wales Plan. Investment in the Infection, prevention and control team is recommended within the report and will also need to be considered.

Quality, Safety, Patient Experience impact : The outbreaks had a significant impact on the quality, safety and experience of neonates and their parents. However the development of the new Neonatal Unit, improvement in staffing levels and a renewed focus on infection, prevention and control practice will mitigate many of the issues that contributed to the outbreaks in 2015.

Health and Care Standard Number Standard 2.4

CRAF Reference Number 5.1

Equality and Health Impact Assessment Completed: No

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The development and ongoing monitoring of a robust improvement plan to address the recommendations made as result of the Independent Review.

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the progress made in implementing the recommendations in the Improvement Plan.

SITUATION

The purpose of this report is to present the committee with an update on progress with implementation of the action plan that was developed as a result of the Independent Review of the *Acinetobacter baumannii* (AB) outbreaks on the Neonatal Unit (NNU) in August and November 2015. The Committee has previously received a report in June 2017.

BACKGROUND

Prior to the outbreaks under investigation, several smaller outbreaks involving a number of different organisms occurred on the NNU between 2011-2015. The condition of the neonatal unit (size, cot spacing and staffing) had been recognised as a significant risk and documented on the Corporate Risk Register as 25 since 2012.

AB is commonly found in the environment. It can withstand drying and remain in the environment for weeks and months and it is difficult to eradicate. It is a particular concern because it is usually resistant to antibiotics that are commonly used to treat infection. In this instance the organism was relatively sensitive. The risk of an outbreak may increase when infection prevention and control measures break down or when neonatal units (and other care settings) lack space.

The Executive Nurse Director and Medical Director jointly commissioned an external review of the management of the infection prevention and control outbreaks in the Neonatal Unit (NNU) at the University Hospital of Wales during 2015, from the period from the first AB outbreak in August 2015 to the re-opening of the NNU on 18.12.15, following the second outbreak. The Terms of Reference for the independent review were agreed with Welsh Government and with Welsh Health Specialised Services committee. The external review was undertaken in September 2016.

Following the Independent Review an improvement plan was developed. The updated Improvement plan is included in Appendix 1.

ASSESSMENT AND ASSURANCE

The paper seeks to up assure the committee that action is being implemented in response to the recommendations of the Independent Review



Improvement Plan

Datix ref/ WG SI reference: IN16905/647202DEC15

Executive Directors responsible: Executive Nurse Director/ Medical Director

Date agreed: 9-06-17

Approved by: to be approved at Quality Safety and Experience Committee on 20-06-17

Monitoring arrangements: Quality Safety and Experience Committee

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
1	Secure revenue for staffing a. If this is not done then the full benefits of capital investment for infection control and prevention (and other benefits) to date will not be	Children and Women Clinical Board to secure the necessary revenue to staff the Neonatal Unit (NNU) to required staffing standards.	Clinical Board Director /Director of operations/ Director of Nursing Children and Women	Review September 2017	A business case has been submitted to Welsh Government as part of the South Wales planning arrangements. There has been agreement for the additional funding for 6.6 WTE band 6 posts which will allow the conversion of 2 SCBU beds to 2 HDU beds.	Complete

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
	realised.				The NNU is now staffed in accordance with British Association of Perinatal Medicine (BAPM) Standards.	
2	Secure capital for the remaining beds in the current plan	The UHB will secure planning for completion of the Obstetric and Neonatal Unit project	Executive Director of Planning	December 2016	Final funding was confirmed in December 2016 to complete the entire project which included development of a 50 cot NNU at University Hospital Wales. Estimated completion of the NNU will be December 2018.	This funding has been secured and the capital development is due for completion January 2019. <i>(NB This does not include the revenue to open to 50cots)</i>
3	Share experiences with the Neonatal Network and the broader health economy a. The health economy did not benefit properly from the learning arising from the Singleton ESBL <i>E.coli</i> deaths.	Independent review report to be presented to the UHB Quality Safety and Experience Committee	Executive Nurse Director	June 2017 By September 2017 June 2017		An update from Welsh Health Specialised Services Committee is pending.

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
	b. The Neonatal Network would benefit from closer working arrangements with the maternity network and the commissioners .	Independent review report to be presented to the National Quality and Safety forum	Executive Nurse Director	By September 2017	There is a dedicated neonatal transport team for South Wales known as CHANTS which has been commissioned for over 5 years. Currently the service is provided in a partnership arrangement by Aneurin Bevan, Abertawe Bro - Morgannwg, Cardiff and South East England for 12 hours per day/ 7days a week/365 days per year. Most transfers are carried out within these hours.	
	c. The 12 hours dedicated neonatal transport service should be extended to 24 hours. If another serious outbreak were to arise, additional transport services may need to be commissioned short term.	Report to be shared with the neonatal network and UHB to work with and support the Neonatal Network with any required action. There should be a review of the current dedicated neonatal transport service to consider whether an extension of the service to 24 hours is	Executive Nurse Director TBC (? Neonatal Network and partner organisations?)		Out of hours transfers, when necessary and appropriate, will be carried out by a Cardiff and Vale Consultant with a Neonatal Unit nurse who is caring for the child, by WAST transfer.	

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
		required.				
4	Engagement of medical staff in IPC at all levels of the organisation During clinical work all doctors need to follow IPC measures at all times including effective hand hygiene and bare below the elbow.	All medical staff in the NNU will be reminded of the need to follow IP&C measures at all times including effective hand hygiene and bare below the elbow. A job specification for an Anti-Microbial Resistant (AMR) stewardship post in each Clinical Board has been agreed and is currently being piloted in Specialist Services The Medical Director and Executive Nurse director are currently piloting a zero	Medical Director Medical Director Medical Director/Executive Nurse director	Completed Review September 2017 Review September 2017	All medical staff in the NNU now wear uniform and are bare below the elbows at all times. There is appropriate challenge in place now for those staff who are observed as not complying with acceptable standards of IP&C practice in the NNU. On an organisational basis the Medical Director supports work on delivery of the Antimicrobial Delivery plan including regular Anti-microbial Walkrounds with the Director of IP&C. All medical staff at induction are reminded of the need for robust IP&C practice.	All Clinical Boards have adopted a zero tolerance policy for Bare Below the Elbow and this is reflected in the audit results. Hand hygiene audits are reported on the performance dashboard monthly and are raised in the monthly Clinical Board Performance Reviews. IP&C performance is presented weekly in "Big Room" and discussion is lead by the Medical Director.

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
		tolerance policy for Bare below elbow and hand washing in Specialist Services with a view to rolling this out across the organisation				
5	Improve methods for linking isolates and identifying outbreaks a. Implement electronic methods for linking isolates, for example IC Net. b. Implement a system that is not reliant on one person. c. The IPC Team should have access to information about isolates so they can look it up for	a)The UHB will implement ICNet b)Identify further resource within the team c)Implement ICNet as above	Director of IP&C	Review end July 2017	IP&C team are currently receiving training to use the system. When in place, it will help in terms of increasing the resilience in the system.	IP&C ICNET was introduced in June 2017 to the IP+C team with further rollout expected over the coming months To date no further resource for the IP&C team has been identified, however discussions are ongoing

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
	themselves.					
6	Document meetings, risk assessments and completed actions more effectively	The UHB will review strengthen it's current processes for the management of serious incidents to include guidance on the recording of meetings and the consideration of risk assessment throughout the process.	Assistant Director Patient Safety and Quality	September 2017	The Patient Safety and Quality department now records all Serious Incident meetings to allow for more accurate minutes. In addition audio files are stored as required.	Complete
7	Maintain multiple ways of staff to raise concerns	The UHB will continue to promote the ways in which staff can raise patient safety and quality concerns.	Executive Nurse Director	Review September 2017	There are a number of mechanisms in place for staff to raise concerns about care: Electronic incident reporting Freedom to Speak up process Safety Valve process –which gives staff direct access to the UHB Chair Safety Walkrounds Staff can also raise concerns directly with their line	Complete

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
					managers, other senior managers and with executive colleagues directly.	
8	Review cleaning practices a. Training and competence assessment b. Methods c. Review of methods (is Actichlor being used effectively).	The UHB will review the processes in place for: Training and competence assessments for Operational Services staff Methods of cleaning practice The effective use of Actichlor	Director of Capital and Estates Head of Facilities	Completed by end September 2017 Review end Sept 2017	There is a training package in place for all new staff and robust competency assessment, forms part of that. Refresher training is aimed primarily at staff when there is a concern, or to all staff when there is a change in practice All efforts are made to maintain the same cohort of staff on the NNU, all of whom have been specifically trained and competency assessed. Best practice is applied across the NNU, in that every specific area, is allocated a single mop and bucket. These are never transferred between areas within the NNU. Additional cleaning time is already allocated to the NNU following IP+C outbreaks prior to the Acinetobacter	Complete

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
					outbreaks. There is now daily HPV cleaning of equipment in the NNU. Actichlor is now used as a cleaning agent across the UHB and this issue with regards to incorrect dilution was addressed at the time, with all staff being updated with Actichlor tool box talks. These issues are all under constant review as part of work falling out of the Association of Healthcare Cleaning Professionals (AHCP) working group Cardiff and Vale UHB is represented on the All Wales HCSW group looking at standardised training for cleaning. High level results presented to IPC as part of Senior Nurse report	
		Introduce joint audits so that Credit for	Senior Nurse IPC/ Head of Facilities	Review end Sept 2017		
			Senior Nurse IPC/ Head of Facilities	Review end Sept 2017		

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
		Cleaning scores and environment audits results are more representative of environmental conditions. Participate in the review of the All Wales Cleaning Standards			Cardiff and Vale staff will influence the new standards to capture environmental issues within the new standards	
9	Consider quantitative assays of cleaning effectiveness	The UHB will explore the options for introducing a robust system for evaluating the effectiveness of cleaning.	Director of Infection, Prevention and Control/Head of Facilities	Review September 2017	Review completed and decisions made	Complete
10	Maintain close monitoring of infections at all levels of the organisation	The UHB will continue with and improve upon its current processes for the close monitoring of infections at all levels	Executive Nurse Director	Review September 2017	There are already robust arrangements in place for the close monitoring of infections at all levels of the organisation. This includes: A robust IP&C group with strong Clinical Board	ICNET was introduced in June 2017 to the IP&C team with further roll out over forthcoming months

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
		of the organisation The UHB will continue to strengthen it's approach to Root cause analysis of IP+C incidents.	Director of IP+C/Assistant Director Patient Safety and Quality.	Review September 2017	engagement An Anti-microbial group (sub group of the Medicine Management Group) IP&C rates are monitored at Professional performance reviews and at Clinical Board Executive Performance reviews Clinical Board monitoring is carried out through QSE arrangements There are regular IP&C reports to both the QSE Committee and to Board Introduction of ICNet end June/July 2017 will improve monitoring by enabling the development of standardised reports.	
11	Ensure robust ways for the Health Board to become aware of troublesome isolates a. Review arrangements with PHW about	The UHB will work with Public Health Wales to review current arrangements for information flow between the laboratories to health care facilities in the	Director of IP&C	September 2017	Work has already been undertaken with PHW on the definition of Multi-drug resistant organisms to be captured on the ICNet system. Reporting of these will be robust and consistent across Wales.	An All Wales MDRO procedure is currently being developed. It will be out for consultation by the end of 2017

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
	information flow from the labs to health care facilities in the Health Board.	Health Board				
12	Assure capacity and capability of IPC team a. The IPC team is too small, banding of staff is extremely low for a major teaching hospital and lacks a middle tier between DIPC and operational staff. It should be recognised that the DIPC role is not full-time and that the post holder had additional external responsibilities.	The UHB will review the structure of the IP&C team to ensure that it is resourced to meet the size and complexity of the organisation including Primary Care and Community.	Executive Nurse Director	Review end September 2017.	Review completed and recommendations made.	Complete

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
13	Improve hand hygiene audits	The UHB will continue to monitor, report and address areas where poor hand hygiene is identified and take steps to ensure that all clinical teas are carrying out their hand hygiene audits. (see also actions for R4)	Executive Nurse Director	Continue to review on a monthly basis	Hand hygiene rates are reported monthly through the Health and care standards monitoring audit. These are monitored at both Clinical Board professional Performance reviews and Executive Performance reviews. There is high compliance with the NNU with hand hygiene scores consistently >95%. A high presence of IP&C support has been maintained in the NNU. Across the UHB, the IP&C team conduct as many audits as possible but specifically in areas where there is an outbreak. The UHB participated in Hand Hygiene day on 5th May 2017. An IP&C multi-professional interest group has been established with the support of	Complete

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
					the IP+C team. There are very active IP&C link practitioners in place who attend 3 study days a year and act as pro-active IP&C champions in their clinical areas.	
14	Improve hand hygiene practice and personal ownership	As above (R13) Implement standardisation of signage at ward entrances	As above (R13) Executive Director of Nursing	As above (R13) Review September 2017.	As above (R13)	Complete
15	Review whether the risk register is useful: the Neonatal Unit was rated as 25 out of 25 for 4 years. What is the point of the risk register if an intolerable risk can be carried for	Proposals for review and renewal of the Risk Management Process to be presented to the Board. Meet all Clinical Boards and Corporate areas and support them in review/amendment of their registers.	Director of Corporate Governance Head of Corporate Governance	Complete May 2017 January 2018	A Board development session on Risk Management and the Risk Register was held on April 27 th 2017. Clinical Boards were in attendance First of these meetings is to take place on 08/06/17, with Capital Estates & Planning	Complete Further meetings have been held with Dental Clinical Board & Public Health. A Risk Pamphlet is near completion.

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
	so long?	Define our objectives and risk appetite at all levels (via the meetings/support described above). Produce more visual, less text based standardized reports that reflect all risks not only extreme ones. Standardize agendas for key groups in Clinical Boards to ensure the risk register is included and analysed. Have one system of capturing risk and providing reports.	Head of Corporate Governance Head of Corporate Governance Head of Corporate Governance Head of Corporate Governance Head of Corporate Governance	January 2018 September 2017 June 2017 April 2018 November 2017	Testing a new approach with report for June 2017 QSE Committee E-module purchased for the risk register on Datix	Work continues, and the findings are to be presented at January Board. Reports now include heat maps, format will continue to change as review progresses. The approach is being tested in the Capital Estates & Planning. A template Board/Committee Report is under development. Potential to be explored with Patient Safety & Quality in 2018. Review underway.

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
		Review and revise the Risk Management Policy and Risk Assessment and Risk Register Procedure.				
16	Develop ways for nurses to be reassessed in cleaning skills	Explore options for the assessment of nurses in cleaning skills	Deputy Executive Nurse Director	Review end September 2017		Complete
17	Recognise tremendous work by cleaners, nurse, DIPC team and neonatal doctors, particularly Dr J Calvert	This will be highlighted as part of the report to the QSE Committee in June 2017	Assistant Director Patient Safety and Quality	June 2017	The work by everyone in the team of the NNU was highlighted in the feedback session following the review and was extended to staff at the time. Thanks was extended to staff by the Executive Nurse Director throughout the management of the outbreak. She also visited the NNU to offer support and thanks to staff.	Complete
18	Highlight	This will be	Assistant Director Patient Safety and	June 2017	The work of Dr E Davies and the IP+C team was highlighted	Complete

May 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
	exceptional work done by Dr E Davies and recognise the value of that work by strengthening the IPC team	highlighted as part of the report to the QSE Committee in June 2017	Quality		in the feedback session following the review and was extended to staff at the time.	

May 2017

INFECTION PREVENTION AND CONTROL, CURRENT POSITION AGAINST TIER 1 INFECTION REDUCTION EXPECTATIONS FOR HEALTHCARE ASSOCIATED INFECTIONS

Name of Meeting : Quality Safety and Experience

Date of Meeting: 6th December 2017

Executive Lead : Executive Nurse Director

Author: Senior Nurse Infection Prevention & Control, Acting Deputy Executive Nurse Director 029 2074 6167

Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.

Financial impact: There are no financial implications currently quantified with the within this report.

Quality, Safety, Patient Experience impact: The work outlined below will provide assurance to the committee that we will achieve the expectations set by Welsh Government whilst providing quality and safe care to our patients.

Health and Care Standard Number 2.4 Infection Prevention and Control and Decontamination

CRAF Reference Number

Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is given because:

- It is unlikely that the Health Board will achieve the required reductions in cases to meet Infection Prevention and Control Tier 1 targets, however work is underway to mitigate any further deterioration.

The Quality, Safety and Experience Committee is asked to:

- NOTE** the contents of the report and the actions therein.

SITUATION

A rise in the number of *C.difficile* and *S.aureus* cases within the Primary Community and Intermediate Care Clinical Board has been observed, compared to previous months.

This was noted at a previous Quality Safety and Experience (QSE) Committee meeting and has led to the Chair requesting an update on the current position against the Tier 1 Infection reduction expectations set by Welsh Government and question what plans are in place to address the problem.

Cardiff and Vale UHB has made good progress against the 2012-13 baseline numbers with an overall 52% reduction in *C.difficile* cases and over 21% reduction in *S.aureus* cases.

Six months into the 2017-18 reduction expectation period Cardiff and Vale UHB is not on trajectory to meet the reduction expectation targets. However it should be noted that the Health Board had fewer cases of *C.difficile* in April – September 2017 compared to April – September 2016.

C. difficile

- The rate *C.difficile* rate for September 2017 is 30.94 per 100,000, 13 cases over the reduction expectation for the time period.

***S. aureus* bacteraemia**

- The *S.aureus* bacteraemia rate for April – September is 35.83 per 100,000 population.

***E. coli* bacteraemia**

- The *E.coli* bacteraemia rate for April – September 2017 is 74.09 per 100,000 population.

BACKGROUND

Healthcare associated infections (HCAIs) cause avoidable harm and remain a key patient safety issue and result in significant financial cost to NHS Wales. Since April 2014, the Welsh Government has been committed to halving the population rate of *C.difficile* and *MRSA* bacteraemias and expectations against the 2012-13 baselines.

For 2017-18 Health Boards are required to continue to drive down all preventable HCAIs and specifically within the Tier 1 targets:

- *C.difficile*, a new all Wales rate of 26/100,000 population is to be delivered by end March 2018.
- *S.aureus* bacteraemias, a new rate has not been set but Health Boards are expected to achieve an all Wales rate of 20/100,000 population by end March 2018.
- Health Boards are also required to strengthen efforts to tackle *E.coli* bacteraemias - the most common organism found in blood samples in Wales. Cardiff and Vale UHB are expected to achieve a rate of 61:100,000 population by end of March 2018 (WHC/2017/011).

Assurance

Cardiff and Vale UHB is currently not on trajectory to achieve any of the Tier 1 Infection reduction expectation for Healthcare Associated Infections (HCAI).

Chart 1. Cardiff and Vale University Health Board maximum cumulative monthly numbers of C. difficile to achieve the 2017/18 reduction expectation and current cumulative monthly numbers for Apr to Sep 17

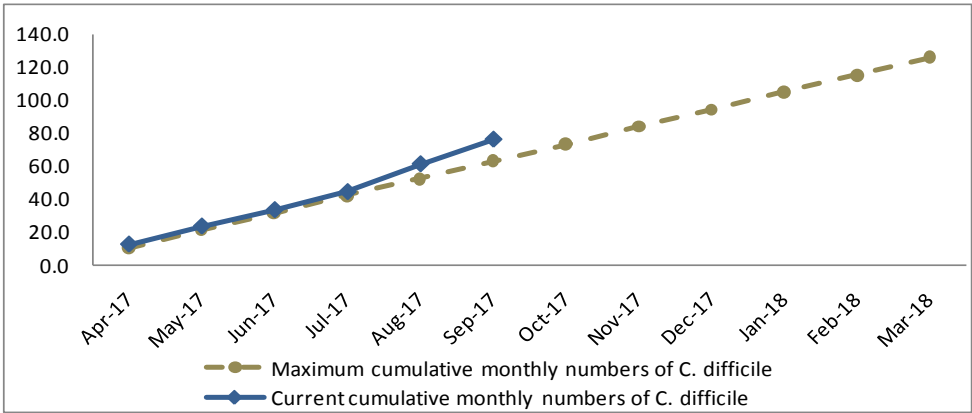


Chart 2. Cardiff and Vale University Health Board maximum cumulative monthly numbers of S. aureus bacteraemia to achieve the 2017/18 reduction expectation and current cumulative monthly numbers for Apr to Sep 17

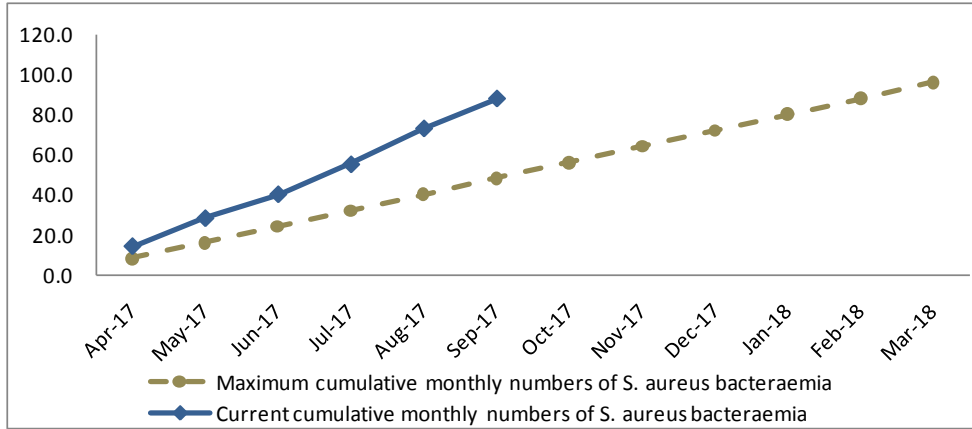
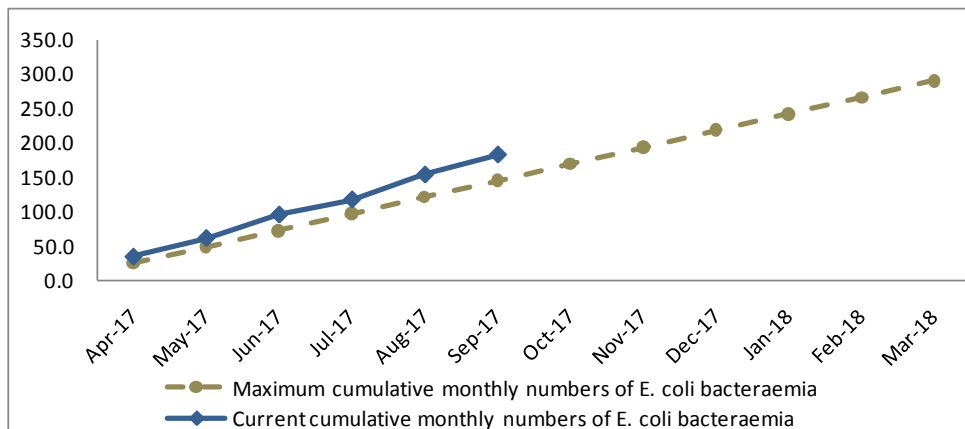


Chart 3. Cardiff and Vale University Health Board maximum cumulative monthly numbers of E. coli bacteraemia to achieve the 2017/18 reduction expectation and current cumulative monthly numbers for Apr to Sep 17



Although the UHB is currently not on trajectory to achieve the reduction expectation there is much work and progress being made across the Health Board. This work is outlined below:

***S. aureus* and *E. coli* bacteraemias**

Implementation of Peripheral Venous Cannula (PVC) insertion packs and Aseptic Non Touch Technique (ANTT) across the Health Board

- PVC packs are in use in most areas where PVC insertion is undertaken (apart from theatres and anaesthetics). There is ongoing Health Board wide training and education regarding their use and their insertion and usage in line with ANTT principles.
- Primary and Community Intermediate Care (PCIC) Clinical Board are participating in the All Wales collaborative work to reduce *E. coli* bacteraemias with development of the 'Reduction in *E. coli* Quality Improvement Working Group'. Membership includes staff from PCIC, pharmacy and the Infection Prevention and Control (IPC) team. The group will focus initially on Urinary Tract Infections (UTI) diagnosis and management and will work with a General Practice (GP) cluster in the Vale of Glamorgan. Once agreed the Central Vale Cluster staff will support implementation of Urine dip sticking guidance, Catheter Associate Urinary Tract Infections (CAUTI) Bundle and All Wales Patient Urinary Catheter Passport.

Effective learning from Root Cause Analysis (RCA) process with resultant interventions to reduce the burden of bacteraemias and *C. difficile* cases.

- Clinical Boards have established review systems, but current figures suggest that the learning is not translating into further reductions. Examples of good practice are in General Practice where they are undertaking RCAs using an amended shortened tool for *C. difficile* cases and reviewing themes identified. All acute clinical boards now have better systems in place to undertake reviews.
- PCIC are also currently developing a shortened RCA tool for bacteraemias to encourage completion by GPs and lessons learnt.

Pre admission and admission screening for MRSA is being reviewed to include *S. aureus* in some key areas i.e. Renal/transplant, haematology, elective orthopaedic surgery. However work continues to understand the cost implications and this is currently being reviewed.

Antimicrobial stewardship - implementation of the Antimicrobial Delivery Plan

- A local plan has been agreed by the Antimicrobial Group. The Medical Director uses his monthly patient safety reviews to focus on antimicrobial stewardship issues in areas where *C. difficile* outbreaks or periods of increased incidence have been reported.
- Unfortunately lack of antimicrobial pharmacist posts is severely impairing the ability of the Health Board to take forward improvements in antimicrobial stewardship. However a business case to increase antimicrobial pharmacist time/numbers has been developed and submitted to the Clinical Diagnostic and Therapies Clinical Board. A decision is expected in the New Year.

Implementation of Carbapenemase Producing Enterobacteriaceae (CPE) / Multi-Drug Resistant Policy (MDRO) and accompanying screening protocol.

- MDRO procedure has been agreed but full implementation requires further discussion due to the concerns regarding cost-pressure of screening.
- A roll out programme has been developed by the IP&C team.
- Screening is being undertaken when 'at risk' groups are identified on admission or transfer to inpatient areas. Patients who are identified as positive are isolated and contact precautions initiated immediately.

Continue to address findings of the All Wales Decontamination of Endoscopes Audit and engage with repeat audit.

- Very good progress has been made to improve decontamination facilities and procedures within the Health Board following the All Wales Decontamination audit of endoscopy units.
- The most recent All Wales Hospital Surgical Decontamination Unit (HDSU) audit included the health board and the final report is awaited. However, in general the feedback was pleasing and a full action plan will be developed to meet the recommendations once the full report is received.

Water Safety Plan

- The Water Safety Plan is in place; at the most recent Water Safety Group assurance was provided that changes have been made following a case of Legionella. For improvement, further actions regarding flushing to be taken at ward level to reduce the risk of Legionella. A new flushing proforma is currently being developed and will be ready for roll out by the end of the year.
- Both the Water Safety Plan and Policy will be uploaded to the Health Board intranet side by mid December 2017, whilst the changes in flushing requirements will be circulated to Clinical Boards as soon as possible.

CLEANING UPDATE PAPER NOVEMBER 2017	
Name of Meeting : QSE	Date of Meeting: 6 th December 2017
Executive Lead : Director Capital, Estates & Facilities	
Author : Head of Estates & Facilities	
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "For Our Population" elements of the Health Board's Strategy.	
Financial impact: N/A	
Quality, Safety, Patient Experience impact: Safety Impact – Infection and Patient Experience Impact.	
Health and Care Standard Number 2.1 Managing Risk 2.4 IPC	
CRAF Reference Number: 5.1 5.1.5 6.2 6.4.8	
Equality and Health Impact Assessment Completed: Not Applicable	

ASSURANCE AND RECOMMENDATION

LIMITED / REASONABLE ASSURANCE is provided by:

- Audit Report Draft Report – September 2017
- Actual Cleaning Scores for Very High & High Risk Area Scores vs Target

The Quality Safety and Experience Committee is asked to:

- **AGREE** that update content is appropriate and proportional.

SITUATION

The UHB monitors its cleanliness using the all Wales "Credits 4 cleaning" system, deployed across all sites. Areas and departments are categorized as being very high risk, high risk, significant risk or low risk based on the potential consequences to patient outcomes. For example the intensive care unit is a very high risk area.

Cleanliness audits are undertaken weekly, with the 4 week average being used to determine for each clinical area, and as a UHB as a whole, whether the acceptable level of cleanliness has been achieved.

The required cleaning standards are generally being met in the significant and low risk areas.

The UHB has set a priority therefore for high risk and very high risk areas in the main hospitals (UHW & UHL) to ensure we get up to WG standard and meet targets as soon as possible. This has in the main, been achieved in the last 12 months.

WG Standard "Very High Risk" Areas	98%
WG Standard "High Risk" Areas	95%

This report is to provide the QSE Committee an update on the current arrangements for cleaning and provide an update in C&V results in improved cleaning scores within priority areas of late.

There are however Internal Audit concerns regarding the independent strategy in meeting the National Standard for Cleaning in NHS Wales. An IA report is subsequently due to be published in November 2017.

BACKGROUND

Ensuring our estate is clean, is essential to achieving both good clinical outcomes and patient satisfaction within their environment of care.

Working in a clean, smart environment improves the morale of staff and can influence in general, behavior, culture and attitudes.

Any perception of lower standards of any of the UHB's estate and services does reflect badly on the reputation of the UHB and has an overall negative impact on patients, visitors, staff and overall culture and image.

One of the challenges to improving the environment is the ongoing pressure with the ongoing demand for beds and as a result, the clinical boards are not being provided with the opportunity to close facilities for cleaning, improvements and repairs to be made.

A further risk to the delivery of our service lies with the ability to recruit on time and in full. Work is however underway to try and develop a bank of housekeeping staff to ensure continuity and numbers on the front line are maintained.

Our cleaning costs on benchmarking are low compared to others in Wales NHS. This is substantiated in EFPMS (2015/2016) where C&V are £26.68 per m² and the average of All Wales is £30.72 m². In light of the financial constraints, the cleaning resource is focused on the high risk patient areas.

A RRT (Rapid Response Team) has also been trialed and deemed a success in tackling immediate and urgent cleaning issues. Priorities are now known and the RRT are helping sustain and gain small advantages in reaching standards.

Waste Management and the Rapid Response Teams are working closely together to offer a de-clutter of each ward area before the RRT undertake a deep clean.

Whilst it is recognised that storage is a problem on most wards it is evident by de-cluttering this creates opportunity for areas to be full cleaned and maintained. The initial feedback from Ward Managers is that cleaning standards are improving.

All Very High Risk and High Risk areas, as defined by the National Standards for Cleaning in NHS Wales, continue to be monitored on a weekly basis until the levels of

cleanliness attain the levels required by the National Standards. In order to deliver against this requirement it is imperative that the monitoring is carried out as a joint exercise involving ward staff and operational services supervisory staff. Unfortunately clinical time has proven difficult to support this and audit has picked this up as an issue recently.

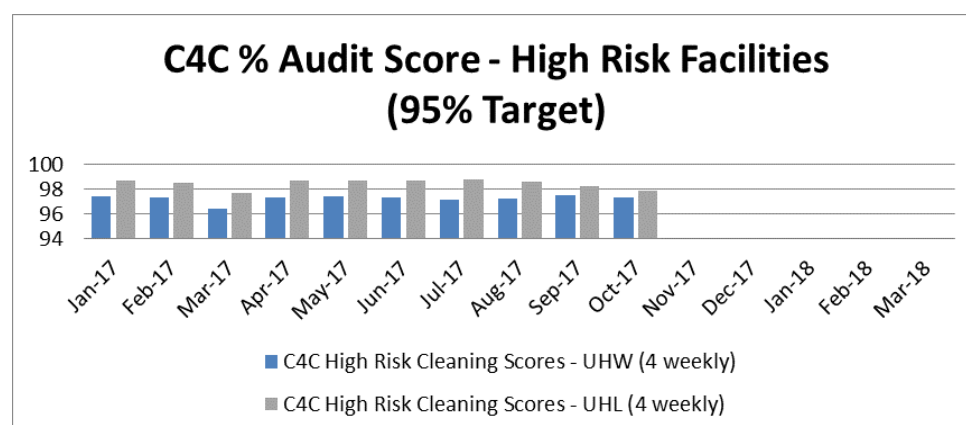
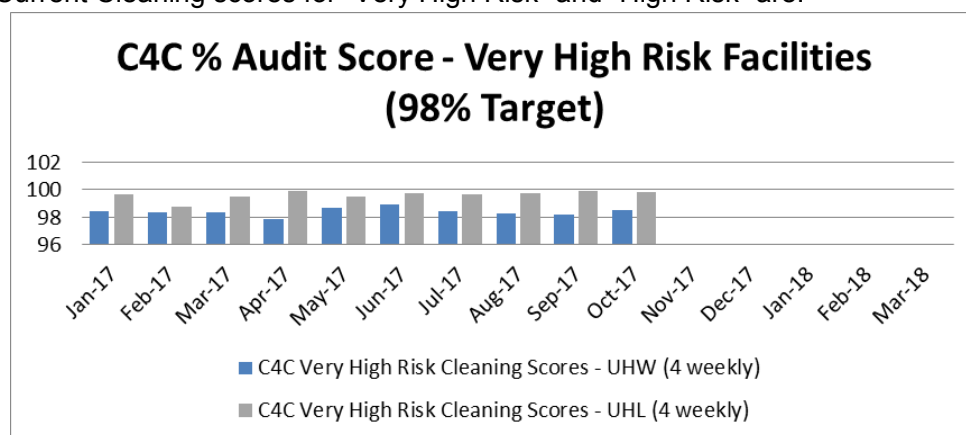
Clinical Boards are supplying ward equipment so that this can undergo the Hydrogen Peroxide Vapour (HPV) cleaning treatment. Further work is underway to establish a programme utilising the spare equipment the UHB funded to increase the use of machines and the disinfection of ward equipment.

ASSESSMENT AND ASSURANCE

1. General Progress

A Capital Ward Bathroom programme is ongoing which addresses issues on a prioritised need basis. This is a planned and weighted programme now in place.

Current Cleaning scores for “Very High Risk” and “High Risk” are:



NB Please note that we do not prioritise or specifically resource areas of “Significant or low risk”.

2. Internal Audit

An Internal Audit (IA) report is due November 2017 which provides two assurance levels of:

Assurance Summary					
1	Risk of infection for patients / health and safety risk for the public and staff			✓	
2	Areas of poor performance are not identified or addressed		✓		

Priority	H	M	L	Total
Number of recommendations	2	4	0	6

A Management response has been submitted to IA.

The following areas of good practice (for QSE Assurance) were noted as being:

- Review of Organisational Charts shows that the Health Board has clear management, supervisory and staffing arrangements in place for environmental cleanliness which has been split across the two sites - University Hospital Wales (UHW) and University Hospital Llandough (UHL).
- The Health Board has Standard Operating Instructions in place for cleaning services and these are used across both UHW and UHL which ensures that the expected standard of cleaning is consistent across both sites. Additionally there is a cleaning training manual in place and this also details how areas are to be cleaned.
- Patient views are obtained via '2 Minutes of you Time' patient feedback and feedback obtained from National Surveys which includes the question "Thinking of the place you received your care, how clean was it?" We note from our review of feedback received that the majority of respondents noted that they found the premises to be very clean - which was the highest rating available.
- Areas to be cleaned have been broken down into risk based functional areas (Very High Risk; High Risk; Significant Risk and Low Risk) in line with the requirements of the standards. Our sample testing of 10 functional

areas confirmed that the assessed level of risk was in line with the standards.

- The Health Board uses the C4C system and as such the items to be cleaned have been accounted for in terms of the 49 generic elements set out in the standards. This has been confirmed from our review of the C4C Cleaning Audit Score Sheet report.
- Both sites have a stand-alone 'Rapid Response' team which sits within the Portering Services.

However the following recommendations were stated:

Recommendation 1

The Health Board should ensure that there is a Multi-Disciplinary Group in place in line with the requirements of the 'National Standards for Cleaning in NHS Wales' or that the Healthcare Environment Steering Group referred to in the Cleaning Strategy is reconvened.

Recommendation 2

The Health Board should ensure that a consistent approach is used for reporting the technical audit scores across the 2 sites and that accurate scores are reported for all completed audits.

Recommendation 3

An appropriate member of the Ward staff should sign off the technical audits undertaken by the domestic supervisor.

Recommendation 4

The Health Board should carry out managerial audits on a quarterly basis in line with the requirements of the Standards.

Recommendation 5

Management should update the Cleaning Strategy and develop an Operational Cleaning Plan in line with the requirements of the Standards.

Recommendation 6

Management should ensure that technical audits are completed on all high / very high risk areas as per required timescales.

HEALTH AND CARE STANDARD UPDATE: 2.9 MEDICAL DEVICES, EQUIPMENT AND DIAGNOSTIC SYSTEMS

Executive Lead: Executive Director of Therapies and Health Science.
Author : Deputy Director of Therapies and Health Science
Caring for People, Keeping People Well: Medical Equipment is used in nearly every care pathway across all Cardiff and Vale UHB sectors and underpins the delivery of the majority of the UHB's service priorities. The effective life cycle management of Medical Equipment also supports several components of the UHB's strategy. It will enable clinical services to deliver outcomes that matter to people; it will improve service efficiency and sustainability, and the optimal use of the appropriate medical device supports prudent healthcare.
Financial impact: Effective System level Medical Equipment life cycle management processes are costly. The UHB does not have sufficient capital or revenue funds to consistently deliver medical equipment management processes to the required standard.
Quality, Safety, Patient Experience impact: Having fit for purpose medical equipment available to deliver effective care when needed is a fundamental tenet of good healthcare.
Health and Care Standard Number: 2.9 Medical Devices, Equipment and Diagnostic Systems
CRAF Reference Numbers: 5.1, 5.1.6, 6.6, 8.1, 8.1.4 & 8.2
Equality Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The UHB's Medical Equipment Group as part of the Medical Equipment Management Governance Framework

The Quality Safety and Experience Committee is asked to:

- **NOTE** assessment of corporate level compliance to Health and Care Standard: 2.9 Medical Devices, Equipment and Diagnostic Systems
- **SUPPORT** the improvement actions to be included in the Medical Equipment Group (MEG) work programme for 2017/2018.

SITUATION

The management of medical equipment is not a corporate function in the same way as other system wide enablers such as Estates or IT. It relies on a diffuse system level network of risk management structures, functions and processes. The UHB has made solid progress in strengthening the effective life cycle management of medical equipment through the further development of the UHB's medical equipment governance framework. However local compliance is still variable between clinical areas. Some Departments have good quality management systems and are accredited to ISO, UKAS or other external quality assurance standards. These areas generally provide good levels of assurance that medical equipment risks are effectively managed.

Others however are still reactive to medical equipment management issues and provide only limited assurance. Funding for both capital and non-capital items is still recognised as the major risk to sustainable service delivery, optimal performance and assured patient and user safety.

BACKGROUND

The assessment of compliance with Health and Care Standard 2.9 Medical Devices, Equipment and Diagnostic Systems was compiled by the Clinical Board Medical Device Safety Officers and coordinated through the UHB's Medical Equipment Group.

The UHB continues to make good progress in the effective life cycle management of medical equipment through the further strengthening of the UHB's system level medical equipment management governance framework (appendix 1 and 2). However compliance to national standards is still inconsistent across clinical areas and much work is further required to standardise life cycle management processes.

Notable improvements during 16/17 include:

- Publication of the Ultrasound Risk Management Policy and Procedure.
- Pathology Laboratories meeting ISO accreditation standards which include standards for equipment management
- A successful national endoscope decontamination re-audit noting significant improvements with several clinical areas now leading the way in Wales.
- Introduction of fluorescent prion protein testing for surgical instruments (first in Wales).
- 5 gamma cameras have been replaced including a significant increase in functionality for 3 cameras which now have CT scanning capability

The following were suggested as improvement actions necessary to improve compliance to Health and Care Standard 2.9 and will be included in the Medical Equipment Group's work programme for 2017/ 2018:

- Develop a medical procurement officer role business case
- Develop an ultrasound governance competence framework.
- Develop a ECG policy and procedure
- Progress project to consolidate endoscopy decontamination onto a single facility for the UHW campus.
- Develop a UHB wide integrated medical equipment risk register
- Develop a local audit framework for decontamination
- Replacement of aging MRI scanners.

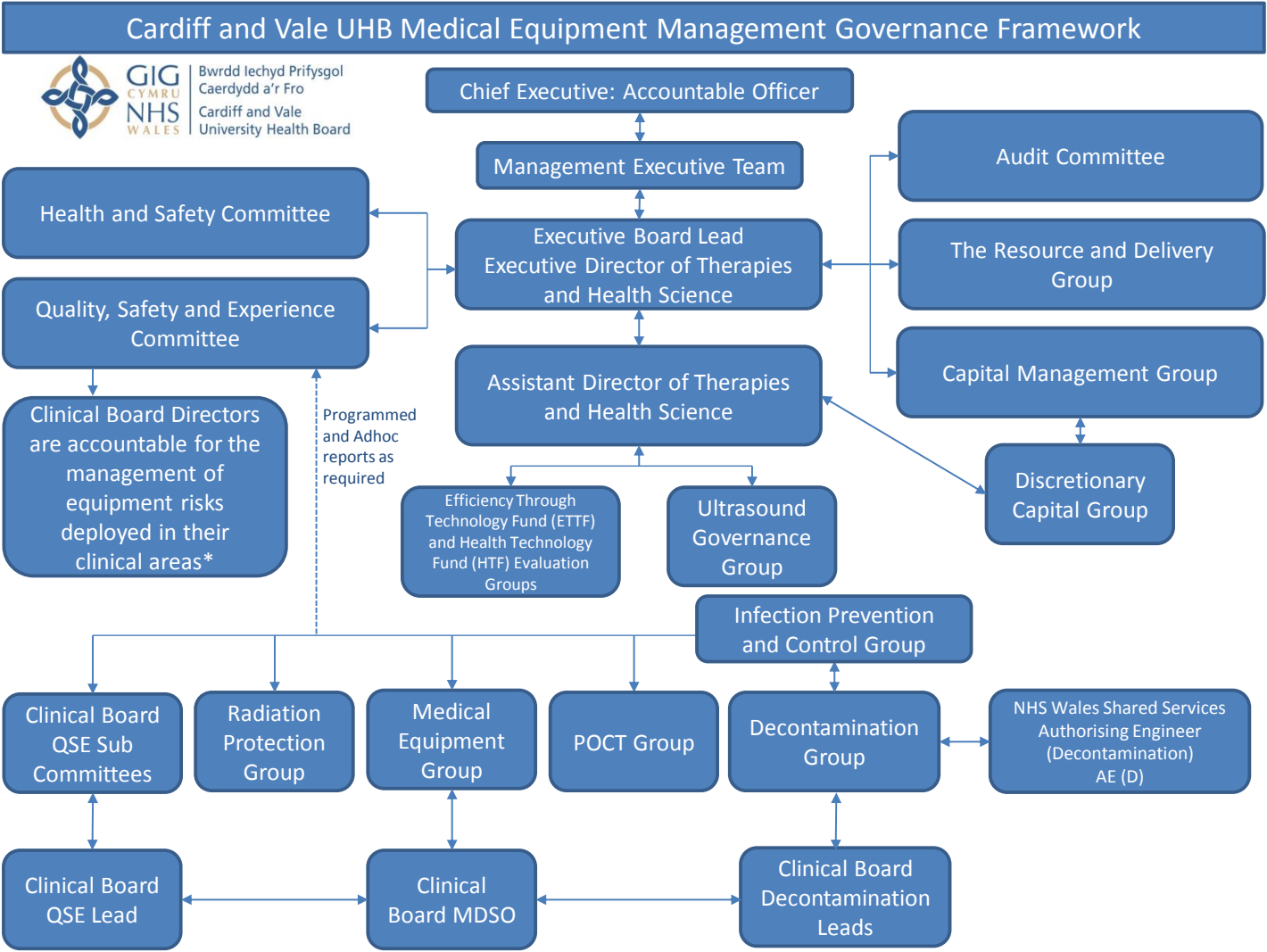
ASSESSMENT

There is not a pervasive culture of compliance which can make it difficult to influence behaviours and effectively implement change. Work continues to strengthen this through the development of the medical equipment management governance framework through the development of medical equipment risk management policies and procedures and oversight groups (Appendix 1 and 2.) Therefore on balance a fair assessment the corporate level of compliance would be 'Getting There'.

Medical Equipment Life Cycle Risk Management Process: “Choose it right; Buy it right; Use it right; Keep it right”



Appendix 2.



CORPORATE RISK AND ASSURANCE FRAMEWORK UPDATE REPORT	
Name of Meeting:	Quality, Safety and Experience Committee
Date of Meeting:	6 December 2017
Executive Lead:	Director of Corporate Governance
Author:	Head of Corporate Governance sian.rowlands@wales.nhs.uk
Caring for People, Keeping People Well:	This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact:	Where a risk is financial this should be clear from the Corporate Risk and Assurance Framework (CRAF) and known by the Executive Lead and/or Risk Owner.
Quality, Safety, Patient Experience impact:	The CRAF includes a number of risks that impact on quality, safety or patient experience.
Health and Care Standard Number:	2.1
CRAF Reference Number:	Not applicable
Equality and Health Impact Assessment Completed:	Not applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Assignment of risks to a Lead Executive and Committee
- The CRAF being a standard agenda item at Board and its Committees
- The review of the CRAF that is currently taking place recognises that this area can be strengthened to provide better assurance and is aimed at achieving this.

The Quality, Safety and Experience Committee is asked to:

- **CONSIDER** the CRAF Update Report and the potential for change to risk reference 6.4.12.
- **NOTE** proposed next steps in the CRAF review.

SITUATION

Each risk contained within the CRAF is assigned to Board or a Lead Committee for oversight.

BACKGROUND

The review of the overall Risk Management process, including the CRAF that is maintained, published and provided to the Board and its Committees continues.

Next steps

- An integral part of the review is engagement with the Clinical Boards and Corporate areas and a program of further visits to ensure all areas are covered and all registers reviewed with key individuals is planned.
- Existing systems in other organizations have been reviewed and a new template register is being developed to include an “open date” for risks, together with initial and current ratings and a target risk score. Smart capturing of existing controls and further mitigating actions together with due dates, review dates and key indicators are to be included to make the CRAF the live document it should be with more meaningful, measurable content.
- The revised CRAF will align with our current strategic objectives as set out in our IMTP.
- Once the proposed new format has been consulted on with Clinical Boards, Corporate areas and Board members, it will be presented at the April Board Development Session with launch to take place the same month.
- A risk pamphlet is near completion to share with all areas and help structure review of the current registers and CRAF content to achieve transfer to the new system.
- A template report for Board/Committee/Group reporting on risk is being developed to assist risk owners in providing updates and assurance to these meetings-this is to be tested with a report to the Health and Safety Committee on risk 6.4.5 “Compliance with fire safety requirements” which is currently scored at 20.

ASSESSMENT AND ASSURANCE

The latest version of the full CRAF (updated 13 November 2017) showing the detail of all risks can be found at:

<http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/248865>

It is to be noted that the overall CRAF format and content remains unchanged other than being updated to reflect information being provided by our areas.

There has been no change in the profile of risks currently assigned to the Committee.

Of note:

- Risk reference 5.1.3 “Improve neonatal, SCBU and Foetal medicine capacity and standards” has been reduced by Strategy and Service Planning to a score of 5 (previously 16) due to current capital developments having been delivered in line with local commissioned capacity and completion of the first phase with full commissioning to 28 cots. This also relates to risk reference 6.4.12 “Risks to neonates and high risk mothers as a result of providing on-going care to neonates in a clinically unsuitable environment” which is assigned to this Committee. These risks remain on the CRAF scored at 16 and 15 respectively pending clarification with Children and Women Clinical Board (as the other risk owner) given the update provided by Strategy and Service Planning.

UHB SELF ASSESSMENT AGAINST HEALTH AND CARE STANDARD 2.6 (MEDICINES MANAGEMENT) – MID YEAR UPDATE

Name of Meeting : Quality, Safety and Experience Committee

Date of Meeting: 6th December 2017

Executive Lead : Medical Director

Author : Director of Pharmacy and Medicines Management (029 2074 4331)

Caring for People, Keeping People Well : This standard underpins the UHB strategy in relation to “Avoid harm, waste and variation”

Financial impact : Not applicable

Quality, Safety, Patient Experience impact : Impacts on safe use of medicines

Health and Care Standard Number 2.6 Medicines management

CRAF Reference Number ...5.1 Deliver safe, effective and efficient care
5.1.7 Patient harm resulting from inadequate management of medication

Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Action plans are being managed via the corporate Medicines Management Group

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the mid year update on self assessment against Health and Care Standard 2.6 (Medicines Management).

SITUATION

Standard 2.6 Medicines management (Corporate)
Self-assessment completed May 2017 (*updated Oct 2017*)

Overall rating: Getting there

BACKGROUND

The overall conclusion is that the Health Board is **Getting there**.
The rationale for this response is that, whilst there are some areas of robust and innovative practice in relation to safe and effective medicines management and very good governance processes, this is not yet consistently evidenced either within Clinical Boards or across the Health Board.

Notable improvements over the past year include the continued use of e-Datix to report, investigate and share learning from medication errors, continued development and implementation of medicines-related treatment pathways, development of a Governance Framework to facilitate the training and competency assessment to support supervised medicines consumption by healthcare support workers, widespread implementation of MTeD (electronic discharge) on all wards, except Mental Health and some specialised day units (where a “discharge on demand” functionality has been requested). Continued progress with electronic prescribing for outpatients (COPPS) with all initial target clinics now implemented.

Dissemination and actions related to Patient Safety Notices and internal communication of medication safety issues is led by the Medicines Safety Executive (reporting to corporate Medicines Management Group). Effective sharing of lessons from medication-related incidents is supported through this process, including a widely circulated monthly medicines safety briefing. Assurance that messages are reaching frontline staff has been audited but remains a challenge.

Systems to manage the UHB joint formulary and manage the entry of new medicines are now embedded.

Medicines-related procedures have been updated to align with the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal published November 2015 and a single UHB Medicines Code will be launched in November 2017. A Health Board wide audit of all inpatient areas relating to storage and security has been undertaken supported by Clinical Board nurses and the Nurse Advisor.

Antimicrobial stewardship across primary and secondary care continues to be an exemplar of best practice, regularly audited and providing positive outcomes in relation to HCAI. Aim to put resource support on a sustainable footing has been included in 2018-19 IMTP.

A patient helpline to support provision of information and advice on medicines (after hospital discharge or outpatient consultation) is available.

ASSESSMENT

Medication chart (prescribing and administration, including omitted and delayed doses) audits need to be fully implemented and reported with supporting remedial action plans across all sectors (including district nursing and domiciliary care). A plan to complete this audit for 2017/18 is in place.

Recent NICE guidance on management of controlled drugs in hospitals (May 2016) has been used to support review of all related processes across primary and secondary care, via the Local Intelligence Network.

Training and revalidation of staff (including HC SW) involved in medicines administration (including intravenous therapy) is a key development area and supports the continued implementation of the MARRS policy noted above.

Supporting e-learning has been developed and will be available before the end of 2017.

A review of the Non Medical Prescribers register held within pharmacy was completed to ensure all information and scope of practice was up to date for each individual non medical prescriber. A UHB forum for Non-Medical Prescribing has been re-established.

Medical and non-medical prescribing training and reduction in unwarranted variation in prescribing behaviour was a focus for 2016-17 and is continuing in 2017-18.

Following on from a successful LIPS project in the Surgery Clinical Board, an administration of insulin session and associated competence assessment has been added to the UHB Medicines Management Programme and Medicines Skills Assessment for Nurses and Midwives has been rolled out across the UHB.

Key performance metrics for medicines management to be agreed and reported through Clinical Board and corporate Medicines management groups.

Improved access to the GP-record of a patient's medication has been implemented, and facilitates safe admission processes including medicines reconciliation. MTed supports safe transfer of care at discharge.

With the aim of achieving "Meeting the Standard", progress with each of the actions noted above will be monitored through the corporate Medicines Management Group.

Specific areas for focus in 2017-18 are:

- Strengthen medicines-related audits (i.e. >95% achievement of prescribing and administration standards, to address ongoing concerns in specific areas raised by HIW about documentation and oxygen prescribing (and provide a baseline prior to EPMA implementation)
- National prescribing and medicines-related performance indicator reports used to inform improvement actions
- Medicines storage, security and destruction compliant with UHB standards
- Specific support to patients/carers in presence of sensory loss
- Support for non-medical prescribers and agreement of UHB strategy.

This assessment will be signed off by the Executive Medical Director and Independent member (Prof Elizabeth Treasure) and through the corporate Medicines Management Group.

DEVELOPMENT OF A PAEDIATRIC SINGLE POINT OF ENTRY	
Name of Meeting :	Quality, Safety and Experience Committee
Date of Meeting:	6 th December 2017
Executive Lead :	Chief Operating Officer
Author :	Assistant Chief Operating Officer, 029 2074 4574
Caring for People, Keeping People Well :	This proposal supports the Health Board's strategy of reducing waste, harm and variation and promoting home first principles
Financial impact :	To be determined
Quality, Safety, Patient Experience impact :	Increased equality of access to services for children and young people
Health and Care Standard Number:	2.7, 3.1, 3.2, 4.1, 5.1, 7.1
CRAF Reference Number:	2.4, 3.1, 5.1, 6.4
Equality and Health Impact Assessment Completed:	No

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The establishment of a multi-disciplinary project to develop a sustainable model for paediatric unscheduled care services
- The project is progressing as per the original plan with regular updates to Management Executive

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the work being done to agree a model for a Single Point of Entry

SITUATION

The care of acutely unwell children in the Cardiff and Vale area is currently delivered at UHW, in two geographically separate areas: the Paediatric Emergency Unit (PEU) and the Children's Assessment Unit (CAU).

PEU operates 24 hours a day, seven days per week and is situated adjacent to the main adult emergency department. The CAU is located within the Noah's Ark Children's Hospital for Wales and is funded for operation between 08:00 and 22:00, seven days per week.

It is widely accepted that this arrangement is sub-optimal and a Single Point of Entry (SPE) for paediatric unscheduled care patients would offer a number of advantages.

BACKGROUND

The PEU was opened over 15 years ago, it consists of four trolley spaces, two cubicles and a minor injury treatment room. There are constraints in respect of both overall space and patient flow, with both clinical and waiting areas being out of view of the main reception / base.

CAU moved into a refurbished area (previously Island ward) in Nov 2015. The unit consists of 8 beds, 2 cubicles, a triage and treatment room. Provision was made to accommodate an additional 4 short stay beds, however these have not officially been commissioned.

Two distinct streams of patients and several referral pathways exist within both departments. These are not always easy to define or navigate for patients, doctors referring patients into hospital and the ambulance / transport service as children with particular conditions may in practice present through either stream. Operating a system of two separate clinical models is sub-optimal and inefficient and there is duplication / dilution of resources as a result.

Attendances within PEU currently exceed 30,000 per year. CAU receives an average of 6,700 primary care referrals per year. These patients have been assessed by their GP and require assessment by the specialist paediatric team. In addition there are in excess of 200 children who have been given 'open access' to the CAU following previous acute admissions or as part of their complex need / chronic condition care pathway.

ASSESSMENT AND ASSURANCE

With the support of Noah's Ark Charity a 0.5wte project manager was appointed in May 2017, for a period of 12 months, to lead the development of a proposal for a paediatric SPE.

In the six months the project has been running, the following has been achieved:

- Project board established, chaired by the Assistant Chief Operating Officer, and meeting bi-monthly
- Project plan developed with key milestones
- Agreement reached that co-location with the emergency department is the preferred option, validating the previous options appraisal
- Top 10 clinical presentations identified and patient pathways profiled accordingly

- Benchmarking tool developed and benchmarking visits undertaken to Leicester and Derby
- Service model developed
- Infrastructure requirements developed in outline
- Project aligned to emerging infrastructure plans in support of the Major Trauma Centre proposals
- Project newsletter produced monthly and circulated within UHB
- Ongoing meetings / communication with stakeholders including Clinical Boards, Directorate teams, community and primary care, support services etc

The key next steps in the development of the plans are:

- Development of a workforce model for the SPE once established
- Agreement on the interim model ahead of a capital solution to establishing a single point of entry

PATIENT SAFETY SOLUTIONS - ALERTS AND NOTICES – UPDATE ON OUTSTANDING AREAS OF NON-COMPLIANCE

Name of Meeting: Quality Safety and Experience Committee

Date of Meeting : 6th December 2017

Executive Lead: Executive Nurse Director

Author: Patient Safety Facilitator, Contact number 029 2074 6548

Caring for People, Keeping People Well: This paper underpins the 'reducing waste, variation and harm' element of the University Health Board's strategy.

Financial impact: Whilst there are no financial implications associated directly with this report, failure to fully implement patient safety alerts and notices has the potential to impact financially on the University Health Board (UHB) in relation to failure to manage clinical risk.

Quality, Safety, Patient Experience impact: The work outlined within this report reflects the significant activity taking place to improve patient safety and experience leading to improved quality and care outcomes for patients.

Health and Care Standard Number: 2.1, 3.1, 3.3

CRAF Reference Number: 5.1, 5.1.5, 5.6, 5.7

Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

ASSURANCE is provided by:

- The UHB is currently 90% compliant with all existing Patient Safety Solutions (PSS). Work is underway to address the requirements of recently issued PSS and to declare compliance with historical alerts.
- The actions that are being undertaken to address the outstanding areas of non-compliance.

The Committee is asked to:

- **CONSIDER** the update provided within the 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, as well as one outstanding notice from the now disbanded National Patient Safety Agency (NPSA).

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 content of the document. 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 was presented to the Quality, Safety and Experience Committee in April 2015 to compliment the UHB's Safety Notices and Important Documents Policy and ensure the UHB complies with necessary Welsh Government requirements. The flowchart is currently being revised in line with a review of the Safety Notices and Important Documents Policy.

The UHB participated in an event hosted by Welsh Government and the Delivery Unit in November 2016 where challenges and opportunities for improvement in relation to the safety solutions process were reviewed, and was also well represented in a follow up event which is being held in November 2017.

ASSESSMENT

Since the last report to Committee in September 2017, the UHB has declared compliance with:

- PSA 002 – The prompt recognition and initiation of treatment for sepsis for all patients.
- PSN 034 – Supporting the introduction of the National Safety Standards for Invasive Procedures (NatSSIPs).
- PSN 035 – Risk of death and severe harm from ingestion of superabsorbent polymer gel granules.

This means that current UHB compliance overall is 90% i.e. the UHB is compliant with 43 out of 48 patient safety solutions.

Details of the PSS where the UHB remains non-compliant are given below (Table 1). This includes our position in comparison with our peers across Wales.

A summary of overall UHB compliance status is included at **Appendix 1**.

An action plan to address outstanding areas of non-compliance is included at **Appendix 2**.

Table 1 – PSS where the UHB is currently non-compliant

Patient Safety Solution	How do we compare with our peers
PSA003 – Update to National Patient Safety Agency (NPSA) alert for safer spinal (intrathecal), epidural and regional devices	Cardiff and Vale UHB is one of 3 Health Boards reporting non-compliance. The alert is not applicable to 3 Health Boards / Trusts and 4 have reported compliance.
PSN026 – Positive patient identification	Cardiff and Vale UHB is the only Health Board reporting non-compliance. This is because of the links to No. 24 Standardising wristbands improves patient safety.
PSN030 – The safe storage of medicines: Cupboard	The UHB is one of 7 Health Boards which have reported non-compliance with this notice. Only Velindre NHS Trust and Public Health Wales have reported compliance.
PSN037 – Resources to support the safety of girls and women who are being treated with Valproate	Benchmarking data to other Welsh NHS organisations is not yet available.
No. 24 – Standardising wristbands improves patient safety	Cardiff and Vale UHB is the only Health Board reporting non-compliance. All other Health Boards in Wales to which the notice applies are already reportedly using electronically printed ID wristbands.

Appendix 1 – Summary of Compliance Position with Patient Safety Solutions for Cardiff and Vale UHB

Patient Safety Alerts				
PSA Ref.	Date Issued	Title	Date for response to WG	Compliance Status
PSA 008	May 2017	Nasogastric tube misplacement: continuing risk of death and severe harm	30/11/2017	(Not yet due for response – work underway)
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	Non-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
PSN038	October 2017	Risk of severe harm and death from infusing Total Parenteral Nutrition too rapidly in babies	08/12/2017	(Not yet due for response – work underway)
PSN037	April 2017	Resources to support the safety of girls and women who are being treated with Valproate	06/10/2017	Non-compliant
PSN036	November 2017	Reducing the risk of oxygen tubing being connected to air flowmeters	04/08/2017	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 or delayed in patients with cranial diabetes insipidus	08/04/2016	Compliant
PSN026	April 2016	Positive Patient Identification	13/05/2016	Non-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				
NPSA Ref.	Date Issued	Title	Date for response to WG	Compliance Status
SPN002	June 2009	Risk to patient safety of not using the NHS Number as the national identifier for all patients	18/09/2009	Compliant
16	July 2007	Early identification of failure to act on radiological imaging reports	28/02/2008	Compliant
No 24	July 2007	Standardising wristbands improves patient safety	18/07/2009	Non-compliant

Appendix 2 - Action plan to address outstanding areas of non-compliance with Patient Safety Solutions

Reference	Title	Action required to secure compliance	By whom	By when
PSA003	Update to National Patient Safety Agency (NPSA) alert for safer spinal (intrathecal), epidural and regional devices	A small number of additional controlled drugs cupboards are needed to be installed in selected ward areas. The applicable Clinical Boards have been approached to progress this.	Medication Safety Executive group/Medicines management Group/Local Neuroaxial Implementation Group	End December 2018
PSN026	Positive Patient identification	Review and revise Positive Patient Identification Policy Secure investment and implement an electronic solution for the production of wristbands from the Patient Management System (see No.24 below)	Patient Safety team Patient Safety team	Aiming for ratification February 2018 The patient safety team are working with procurement, Information management & technology department and other internal stakeholders to assess the available options. A visit was arranged to a neighbouring Health Board to view an electronic wristband solution,

				however it was established that this did not meet the requirements of the patient safety notice. Contact is being made with other Health Boards to gain further information about the systems in use within Wales in order to inform our option appraisal by January 2018.
PSN030	The safe storage of medicines cupboards	The UHB is awaiting the publication of revised guidance form WG which is being issued due to widespread non-compliance across Wales with the requirements of this Notice. NB –the UHB has robust mitigation in place for the safe and secure storage of medicines which is subject to annual audit across the UHB, and to regular scrutiny during pharmacy visits and	WG	Keep under review until revised guidance is issued. This issue is being taken forward at an all Wales level by the Medicines Administration, Recording, Review, Storage and Disposal Group (MARRS)

		unannounced internal and external inspections		
No. 24	Standardising wristbands improves patient safety	Secure investment and implement an electronic solution for the production of wristbands from the Patient Management System Establish a task and finish group to oversee implementation of the electronic wristband system Implementation of the system across the UHB	Patient Safety team Patient Safety team Patient Safety team/ Information management & technology department	As above (see PSN026) January 2018 Aim April 2018 depending on funding stream and procurement procedures
PSN037	Resources to support the safety of girls and women who are being treated with Valproate	Paper and Action plan to be approved at the end November 2017 Medicines Management Group	Medicines Management Group	End November 2017

REPORT FOLLOWING COLORECTAL CANCER PEER RE-REVIEW	
Name of Meeting :	Quality, Safety and Experience Committee
Date of Meeting:	6 December 2017
Executive Lead :	Medical Director
Author :	Lead Manager Cancer Services, Telephone 02920 746682
Caring for People, Keeping People Well:	This report underpins the Health Board's "Sustainability" elements of the Health Board's Strategy.
Financial impact :	Nil applicable
Quality, Safety, Patient Experience impact :	The work outlined within this paper reflects the significant activity taking place to improve patient experience for patients with cancer leading to improved performance, quality and care outcomes.
Health and Care Standard Number ...	3.1 Safe and Clinically Effective Care
CRAF Reference Number	5.1 Deliver safe, effective and effective care
Equality and Health Impact Assessment Completed:	Not Applicable

ASSURANCE AND RECOMMENDATION

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

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.
- **NOTE** that the NHS Wales Peer Review Framework WHC 17 037 has been received and will be considered by the QSE in February 2018.

SITUATION

The purpose of this report is to present the Committee with an analysis of the findings and actions required following the Peer Review processes reported to Welsh Government and the South Wales Cancer Network following the review, re-review of each of the cancer tumour sites within the Health Board.

This report outlines the findings of the re review of Lower Gastro intestinal cancers, the initial review having taken place in 2014.

BACKGROUND

Peer review of cancer services in Wales is a quality assurance programme that reflects the quality of the service being delivered against a framework of standards of care, by multi-disciplinary teams and health boards in Wales. It combines self- assessment with independent expert review to ensure structures and processes are in place to deliver high quality care, and that clinical teams are working effectively together with the aim to improve service delivery, treatment outcomes and patient experience. In Wales, peer review of cancer services began in 2012 and is delivered by the Cancer Networks in partnership with Health Inspectorate Wales (HIW). A three yearly re-review process has been developed by the cancer network. Actions plans are expected to be developed and implemented to address the concerns raised at each peer review and re-review.

ASSESSMENT AND ASSURANCE: Summary of Peer Re-review Report for Lower Gastro Intestinal Cancers

Good Practice/Significant Achievements:

- Good team dynamics with evidence that the multi-disciplinary team value each other's contribution.
- 3 nurse endoscopists now in training which demonstrates a willingness to explore new ways of working
- Only HB engaging in routinely reporting issues whilst waiting (SUIs) nationally.
- 18 months strategy for capacity and demand of the service is being developed.
- Outcome data e.g. laparoscopy, 1/2 year mortality for surgery is very good
- Nurse led follow up needs to be commended but concerns regarding the impact on nursing time are acknowledged
- Evidence that the team have responded to previous report with input now from the oncology nurse from Velindre

Serious Concerns noted:

Cancer Pathway Waiting Times

Concerns noted were:

Service improvement delays
 Business meetings
 Patient experience
 Radiology/Pathology
 Endoscopic Ultrasound (EUS)

Where appropriate, overarching actions have been identified and an action plan has been formulated and implemented to address the concerns outlined above. It will be noted that some of the issues identified have now been addressed. Further detail is provided in the full action plan appendix 1.

APPENDIX 1

Lower GI Cancer Peer Review Action Plan 2017
University Health Board

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
1	Serious concerns					
	Cancer Pathway Waiting Times The percentage of USC referrals treated within 62 days has dropped to 58.9% (65% in 2013).	Seek UHB support with pathway analysis and improvement, specifically with data quality, feedback and administrative support for data analysis and submission to WG, CANISC and NBOCA Tentacle needs fully incorporating into the pathway. Discuss with CD and DM to develop a bid for a data manager post across both UGI and LGI services	High High Med	UHB MDT Lead/MDT Cancer Services MDT Lead/CD/DM	End Jan 2018 Mid 2018 Mid 2018	uHB lower GI pathway work ongoing, facilitated by improvement department
	Concerns					
2	Service improvement delays	Notwithstanding the austere financial times, senior management must support service improvement. ➤ Through administrative facilitation of data and pathway analysis ➤ Through appropriate resourcing to effect recommended changes	High	Clinical Board/ HOD/CD and Cancer Executive	End Jan 2018	Consider as part of lower GI pathway work
3	Lack of regular business meeting distinct from the MDT meeting.	Regular business meetings with the the MDT and management to be set up to: ➤ review its functioning,	Med	MDT/ CB HOD/CD/DM	Jan 2018	

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
		➤ evaluate breaches, ➤ pathway developments, ➤ validate data for national submission ➤ complete appropriate audits and improvement work all of these are necessary to provide a high quality forward-looking service.				
4	Patient experience No evidence of any patient experience surveys being undertaken. Lack of HNA assessment due to CNS lack of time /capacity	➤ Liaise with UHB Lead Cancer Nurse to undertake a review of CNS pacity/workload, noting Cardiff has a single CNS performing all roles including 'virtual clinics' (800 patients pa) and cancer follow up (1000 patients pa) ➤ consider ways of increasing staff numbers to meet national levels benchmarked across Health Boards ➤ explore the role of stoma care in support of patients and overlap with CNS working ➤ consider the risk of potential WG decision regarding funding for stoma care from Industry and make contingency plan to ameliorate this. ➤ explore different ways of addressing patient survey and HNA assessment e.g. consider postal survey or completion by other AHPs to undertake.	High	MDT Lead/UHB Lead Cancer Nurse DM /CD Lead Nurse Surgery UHB Lead Nurse/ UHB Lead AHP/Lead Nurse Surgery	Mid 2018 Ongoing	Dependent on bid for CNS expansion to benchmarked levels across S. Wales

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
5	Specialist Radiology/Pathology provision	Arrange meeting with HOD for CD&T to discuss the need for succession planning to sustain the service and look at expansion to meet inexorable demand for imaging and pathology reporting.	High	HOD CD&T/CD/DM/MDT Lead	End Jan 2018	Initial progress as part of pathway work initiated Nov 2017
6	Endoscopic Ultrasound (EUS) Single handed service leading to a vulnerable service with no contingency in place.	Noting that current (Autumn 2017) there is no EUS staging available to Cardiff patients a regional service option needs to be considered and explored. WCN to arrange a meeting across UHBs to assist in finding a way to develop a service mode that will provide sustainable access to this service in the future.	High	WCN/appropriate representatives for each of the UHBs involved.	Mid 2018	
7	Reporting times for radiology are slow due to insufficient radiology reporting capacity, growing demand and limited numbers of reporting and MDT radiologists.	An option appraisal needs to be undertaken exploring all possible solutions to reduce reporting turn around times. These should include ➤ new appointments, insourcing and outsourcing options. ➤ Consider using more representative measure of quality, namely time from request to result reporting	High		Mid 2018	
8	Capacity & demand for endoscopy service Demand has overtaken capacity – surveillance waiting times are long.	Seek input from the Service Improvement Team to look at capacity and demand modelling for the service as this would be beneficial in planning the service in	High	HOD for Surgery/CD/DM	Mid 2018	Some crossover with lower GI pathway work

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
		order to maintain & improve the diagnostic pathway.				
9	Poor recruitment to clinical trials	Improve resource at UHW for recruitment to trials. Need to improve communication between UHW and Velindre Cancer Centre regarding support for trials	Med	Work with Velindre/ oncology service to coordinate	Mid 2018	

MORTALITY DATA AND MORTALITY REVIEW	
Name of Meeting :	Quality, Safety and Experience Committee
Date of Meeting	6th December 2017
Executive Lead : Medical Director	
Author :	Quality and Safety Improvement Manager. Email joy.whitlock@wales.nhs.uk Phone 029207 45099
Caring for People, Keeping People Well :	This report underpins the Health Board's "Delivering Outcomes that Matter to People" and "Being a great place to work and learn" elements of the Health Board's Strategy.
Financial impact :	None
Quality, Safety, Patient Experience impact:	This provides an opportunity for organisational learning and improvement.
Health and Care Standard Number	3.1 – safe and clinically effective care
CRAF Reference Number	5.1 Safe, effective and efficient care.
Equality and Health Impact Assessment Completed:	Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Monitoring of Mortality measures reviews
- Mortality Data

The Quality, Safety and Experience Committee is asked to:

- **AGREE** the ongoing proposed plans for mortality reviews.

SITUATION

Monitoring mortality data is one of the important ways in which the Quality, Safety and Patient Experience Committee is assured about patient safety and quality of care. This paper seeks to provide an update about current issues and key data, building on the paper from [June 2017](#).

The Committee is asked to note that there is currently an Internal Audit being conducted on how the organization is using the various systems of Mortality review. This should be available to report on at the next regular six-monthly review of Mortality Data at the Quality, Safety and Patient Experience Committee (June 2018).

BACKGROUND

An all-Wales mortality and harm collaborative was established to develop a systematic approach to casenote reviews. This resulted in a two stage mortality review structure which has been in place for some time. A Universal

Mortality Review tool (UMR) was developed and is used for stage 1 reviews across NHS Wales. The aim is to determine cases that need a more in-depth second stage review. There is no current standardisation in the tool or method for stage two reviews at present.

Population statistics demonstrate significant disparities in health outcomes between people with learning disabilities and the rest of the population. Following the report into the deaths of people with Learning Disabilities and Mental Health problems at Southern Health NHS Foundation Trust there is a recommendation that all Health Boards now establish systems and capacity for routinely undertaking Mortality Reviews for all specialist mental health and learning disability services. Work to progress this in the UHB is described in more detail below.

The Electronic Mortality Audit Tool (EMAT) was developed in Cardiff and Vale University Health Board (UHB) and launched in September 2014. This IT system enables us to record death certification and mortality review data which now sits alongside the Patient Management System information in the clinical information repository. It provides useful information at individual patient level which can be aggregated to provide information for directorates, clinical boards and the UHB. This provides an initial summary of any concerns which have been described in previous papers at Quality, Safety and Experience.

ASSESSMENT AND ASSURANCE

Medical Examiner role

The aims of the Medical Examiner Role are to strengthen safeguards for the public, make the process simpler and more open for the bereaved, and improve the quality of certification and data about causes of death. The Department of Health started their consultation process for the introduction of the Medical Examiner role in March 2016 and Welsh Government followed in Dec 2016. There has been little development due to several reasons:

- General election and planning for Brexit
- Turnover of civil service staff in the Department of Health

The current implementation date of April 2018 may be extended. A formal announcement has yet to be made.

The current focus of the mortality and harm collaborative across NHS Wales is to become 'Medical Examiner Ready'. It is expected that Health Boards will be responsible for appointing MEs and collecting fees. Logistical challenges will need to be addressed – particularly where there are no pre-existing bereavement offices and in rural areas.

Stage two Casenote Reviews

A Wales-wide workshop was held on 12th July 2017 to critique stage two review tools in use and to agree a standard tool for use in Wales which would

also support the Medical Examiner (ME) role when it is introduced. A comparative analysis of the tools has been undertaken. A number of the tools have elements from the SAFER II tool. This was developed for the second phase of the Harm Study at Cardiff University (<https://www.ncbi.nlm.nih.gov/books/NBK424600/>). The Wales mortality review steering group is overseeing the development of a standard second stage two review tool. There is the need within a new tool to align it to serious incident review processes and to ensure that there are clear instructions about whom/ how the case note review should be conducted. A robust training structure for carrying out mortality reviews will need to be in place to ensure a consistent approach.

The Mortality Review Steering Group is developing an information sheet on Mortality Reviews for Bereavement Services to share with families ahead of the ME role.

Learning Disabilities and Dementia

1000 Lives Improvement, the NHS Delivery Unit and Health Inspectorate Wales jointly lead an improvement programme on '*Sharing the Learning from Untoward Incidents*' in Mental Health, Learning Disability and related NHS services. The UK National Steering Group (NSG) for the improvement programme recommends that all UHBs now establish systems and capacity for routinely undertaking Mortality Reviews for all specialist mental health and learning disability services, across NHS inpatient and secondary care community services.

To support this work the NSG has adapted Mortality Review tools currently used in NHS physical healthcare inpatient services in Wales and developed new tools with proposals for their piloting in all HB's responsible for Mental Health and Learning Disability service during 2017. In addition to testing the utility of the Mortality Review tools, the pilot aims to identify potential implementation issues, including how easy or difficult it is to integrate within wider UHB Mortality Review processes.

Mental Health Clinical Board has commenced the introduction of the Learning Disabilities pilot.

Two extra fields on EMAT will be added to capture patients with learning disabilities and dementia who were cared for in physical health inpatient wards at the end of life. The paper based data collection form for mortality reviews and death certification has similarly been amended. Patients with LD will automatically be escalated to a level two review. We will be able to count the number of patients with dementia at the time of death that may not yet have a code on PMS. At this stage patients with dementia will not automatically be escalated to stage two reviews unless there is another trigger.

The PARIS IT system has been developed to record stage one mortality reviews for mental health patients. Further amendments will be necessary to accommodate the LD pilot of mortality reviews.

Information Management

The UHB regularly updates on a three monthly basis for publication its public website details of mortality statistics. The latest updated information on hospital deaths is shown in appendix one. There is much more detailed information, including community mortality statistics available on: <http://www.cardiffandvaleuhb.wales.nhs.uk/our-safety-systems>

The Health Board is able to monitor the % of patients who have a mortality review (figure 1) recorded.

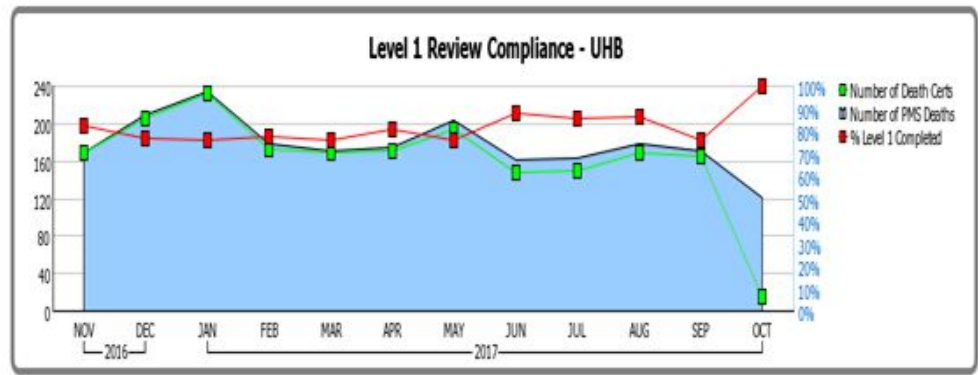


Figure 1 - % patients having a level 1 mortality review – note October 2017 data inputting is incomplete.

About 40% patients currently trigger a level two review. On further investigation a significant proportion of the triggers are due to the disease processes at the end of life impacting mostly on Medicine Clinical Board. A revised process involving a discussion with the Consultant about the cause of death and quality of care at stage one is being tested in order to over-ride some level two triggers. Figure 2 shows the % patients where a level two is triggered/

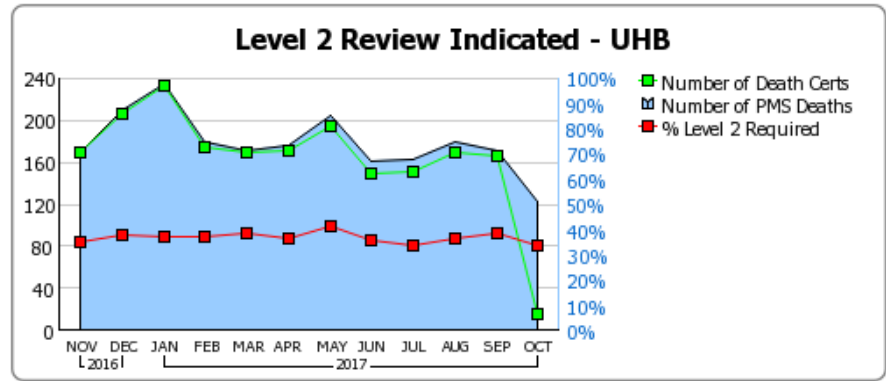


Figure 2 - % patients who trigger a level two review

EMAT has been developed in order to highlight an unexpected rise in the number of deaths so that an enquiry can be carried out promptly – figure 3.

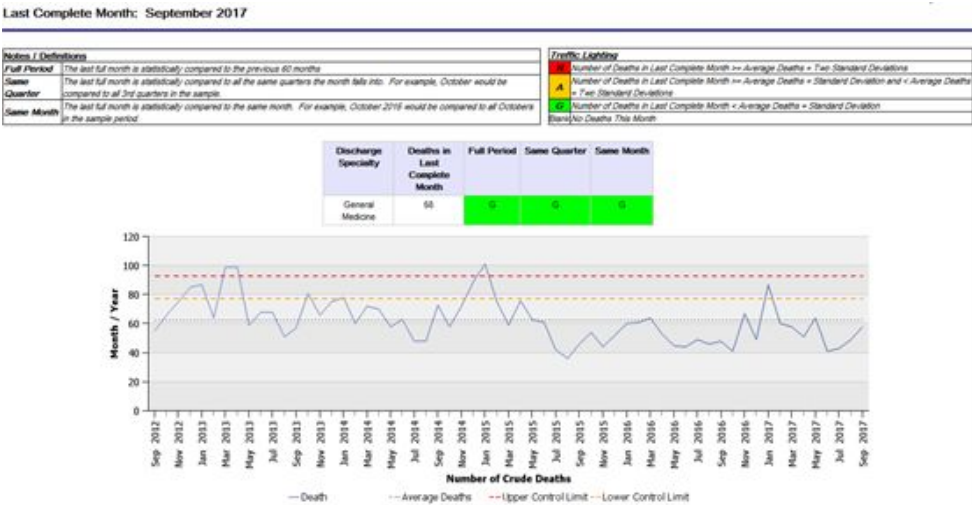


Figure 3 – monitoring the number of deaths to determine unexpected rise

EMAT enables the UHB to count the triggers for level two and prioritise areas for improvement. Figure 4 below show sepsis as the biggest trigger. Many of these are due to the aforementioned disease process at the end of life – but many are not. The UHB has invested in a substantial improvement programme for sepsis.

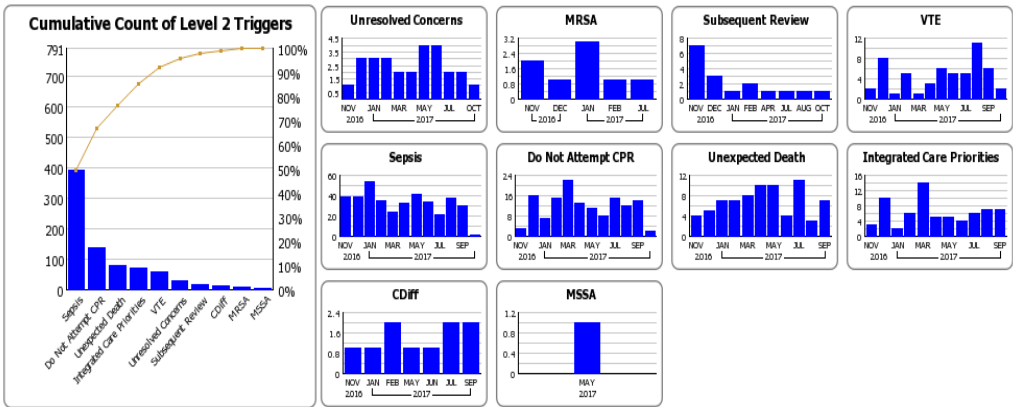
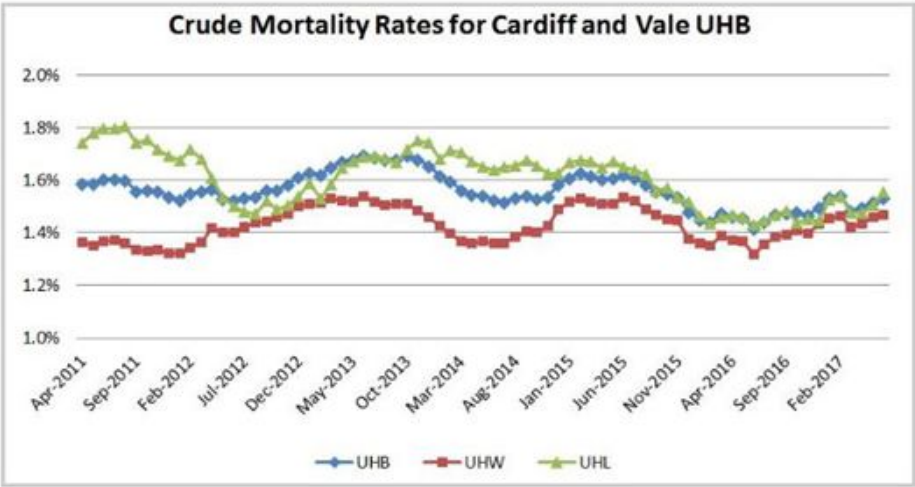


Figure 4 – triggers for level two reviews

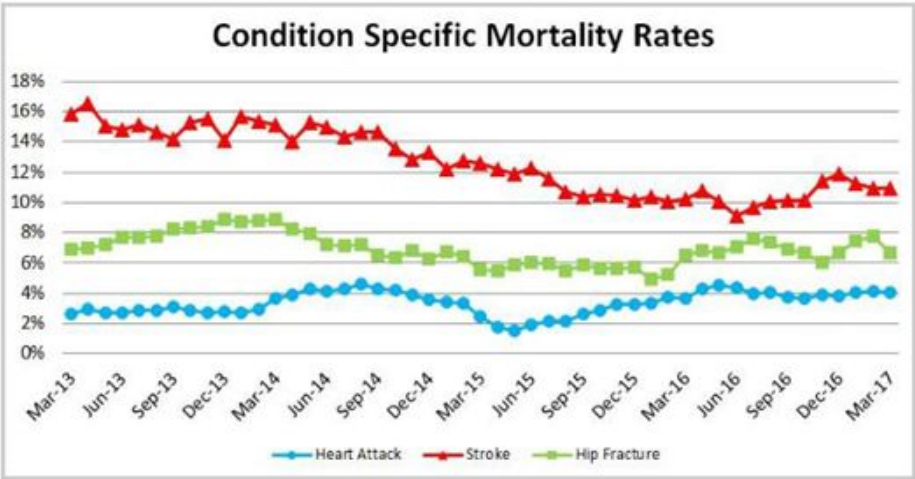
Percentage of crude mortality and condition specific mortality (stroke, heart attack, hip fracture) and mortality rate in A&E are publicly reported quarterly on the UHB internet site Appendix One. The mortality rate in the Emergency Unit has steadily continued to improve while the other data show stable situations for the past year (Appendix One) More recently the Royal College

of Physicians Sentinel stroke National Audit Programme (SSNAP) report April 2016 – March 2017 has published their figures (Appendix Two)

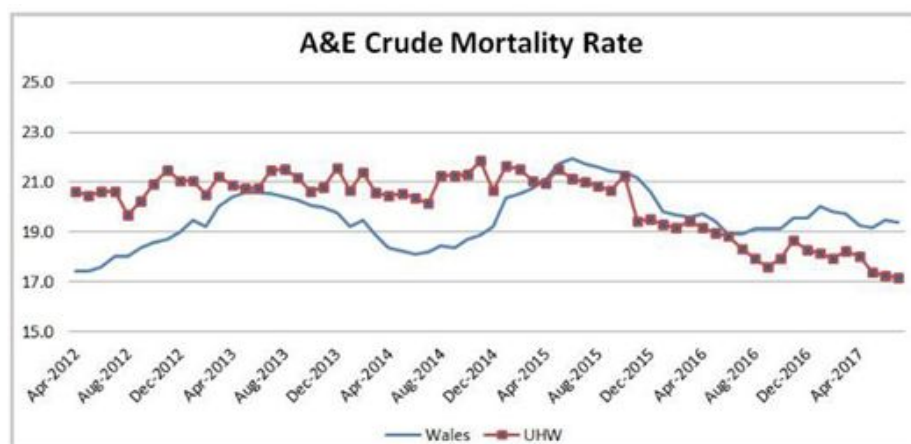
Appendix One.



% crude mortality



% condition specific mortality



A&E mortality rate per 10,000 attendances.

Appendix Two

Appendix Two Stroke Mortality Data – for routinely admitting sites Royal College of Physicians Sentinel stroke National Audit Programme (SSNAP) report April 2016 – March 2017

Heath Board	Site	2016/17		2015/16
		SMR	Crude Mortality %	Crude Mortality % (SMR)
ABU	Nevill Hall	*	*	11 (1.00)
	Royal Gwent	1.09	12	13 (1.23)
ABMU	Morriston	1.14	16	15 (1.16)
	Princess of Wales	1.06	11	11 (0.94)
BCUHB	Glan Clwyd	1.11	14	16 (1.16)
	Wrexham	1.08	15	14 (1.05)
	Ysbyty Gwynedd	1.18	16	16 (1.12)
Cardiff and Vale	UHW	0.86	11	11 (0.9)
Cwm Taf	Prince Charles	0.83	13	16 (1.02)
	Royal Glamorgan	*	*	*
HDdUHB	Bronglais	0.76	9	12 (0.8)
	Prince Phillip	1.37	20	16 (1.25)
	Withybush	0.78	12	11 (0.84)
	Glangwili	1.16	14	18 (1.18)

Welsh average (Crude Mortality rate): 13.6%. (Rate for 2015/16: 13.8%)

Welsh mean SMR = 1.04

SMR = Standardised Mortality Ratio

(* Nevill Hall and Royal Glamorgan are no longer routinely admitting sites)

**HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2017) - TABLE OF INSPECTIONS**

	<i>Practice Name</i>	<i>Inspection Date</i>	<i>Summary</i>	<i>R A G</i>	<i>UHB Actions</i>	<i>Update</i>
36	Greenfield Dental Care	16/10/2017 (not yet published – draft report rec'd 07/11/2017)	Overall a positive report <i>Improvements Required</i> - Medical emergency equipment / drugs - Cannula* had use by date had expired [<i>* this is not a mandatory equipment in kit</i>] - Regular checks are completed on the emergency drugs and equipment - Update adult safeguarding policy - appropriate safeguarding team contact details - Ensure medical history forms are signed by the patient and countersigned by the dentist at each visit - Immunisation levels - review hepatitis B level for 1 member of staff; retain immunisation outcomes for all staff		HIW issued satisfactory assurance	
35	Bupa Dental Care (Pentwyn)	07/09/2017 (not yet published – final report rec'd 31/10/2017)	Overall a positive report <i>Improvements Required</i> - More health promotion information in waiting area - Verification of inoculation immunity check status required for three staff - Amend infection control policy to refer to WHTM 01-05 (and not the HTM 01-05) - Review access to stock room area and decontamination room		HIW satisfied with outcome of Action Plan submitted by practice	
34	Cyncoed Dental Practice	17/08/2017 (not yet published – draft report rec'd 27/09/2017)	Overall a positive report <i>Improvements Required</i> Language Services - information in language / format meeting needs of patients; formal arrangement in place to access interpreting		HIW satisfied with outcome of Action Plan submitted by practice	

**HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2017) - TABLE OF INSPECTIONS**

			services - Complaints procedure - compliant with NHS 'Putting Things Right'; develop private patients' complaints procedure; review complaints handling processes and record keeping - Five yearly electrical wiring certificate - Patient records improvements required - recording oral cancer screening; recording valid consent; written treatment plans; justification and clinical findings of radiographs			
33	{my}dentist (Countisbury Avenue, Llanrumney)	17 th July 2017 (published – 22 nd June 2017)	A reasonable report overall <i>Improvements Required</i> - Review storage of hazardous and non hazardous waste - WHTM 01-05 Issues (decontamination training) - DBS certification for all dentists Review storage and access of patient records Administrative (centralised training records)		HIW satisfied with outcome of Action Plan submitted by practice	
32	Restore Dental Group (215 & 354 Whitchurch Road)	28 th June 2017 (published — 29 th September 2017)	An overall poor report, with a significant number of areas of improvement identified being described below: - System checking medical emergency equipment and drugs - Health promotion information to be available for patients - Private patient's price list displayed - Patient information provided in language/ format meeting needs of patients - Review NHS complaints procedure to : - Compliance with NHS 'PTR' - Complaints handling processes - Recording and audit trails - System for recording views of patients - Five yearly electrical testing certificate		- HIW satisfied with outcome of Action Plan submitted by practice - Letter sent to practice (29/8/17) by UHB to seek written assurances on issues outlined in Action Plan with a request to follow up the process with a meeting within six months. - Response received 19/09/17	Re categorised as Amber

**HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2017) - TABLE OF INSPECTIONS**

			• Fire risk assessment review • Review access to stock room and decontamination room • Decontamination training required for relevant staff. • Review resuscitation policy for both premises • Review stock control processes: - Materials - Anaesthetics • Child protection/ POVA training needed for relevant staff • Review location of X-Ray isolation switches • Review appropriate IR(Me)R training for dental nurses • Formalise QA arrangements • Patient records: - Patient medical histories - FP17s for banded NHS COTs - Justification and reporting of radiographs - Treatment plans and options • Clinically Issues: - Clinically necessary treatment carried out under private arrangements - Frequency of BW radiographs • DBS required for five dentists • Staff appraisals on an annual basis. • Practice management and leadership in this practice need to be reviewed and strengthened		
31	Dental Surgery (G O'Keeffe & J Jones)	18 th July 2017 - published	A reasonable report overall <i>Improvements Required</i> • Review of complaints process to include trail of complaint • Review system for capture of informal comments		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan once Report has been formally published.

**HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2017) - TABLE OF INSPECTIONS**

			• Review storage of hazardous and non hazardous waste • Storage of sterilised instruments in line with WHTM 01-05 • OOD Emergency equipment to be replaced & system for Regular checks to ensure they remain in date. • Radiography (Critical examination reports missing and System for X-ray QA audits required) • Peer review system recommended • Patient Record system needs reviewing • Review storage and access of patient records • Formal induction for Agency staff Administrative (Centralised training records, Staff appraisal system, Formally document team meetings)			
30	Hillcrest Dental Practice	21 st June 2017 - published 27 th September 2017)	A positive report overall <i>Improvements Required</i> • Review the NHS complaints policy and procedures • Electrical wiring Certificate • Gas maintenance certificate • Review its environmental risk assessment • WHTM 01-05 Issues (hand washing sink and dual sink arrangement) • Dentist requires inoculation immunity check • Staff to complete decontamination training. • Review of the cleaning schedule. • Residual works to cabinetry, decorative works to surgery		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan once Report has been formally published.	
29	Calgary Dental Practice (Llantwit)	8 th May 2017 - published 9 th August 2017	A positive report overall <i>Improvements Required</i> • OOH number for private patients		• Review undertaken • Letter to practice outlining good practice and areas	

**HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2017) - TABLE OF INSPECTIONS**

	Major)		- Update complaint process to include "Putting Things Right". - Surgery floor needs to be appropriately sealed - Update Adult and Child Safeguarding policies - Explore relocation of isolation switch for X-ray unit & radiograph processing audit - QA Audit - Immunisation Records need to be retained - Updated DBS certificates for HIW registered dentists.		picked up in HIW Action Plan once Report has been formally published.	
28	myDentist (Quay Street)	21 st March 2017 (published 22 nd June 2017)	Report found on HIW website – July 2017. Not notified. A positive report overall <i>Improvements Required</i> - Environment Review: Dental Unit and equipment need to be in satisfactory condition. - Patient Record Issues (Storage/ Stationary) - Patient Record Issues (Treatment plans/ NHS or Private/ NHS PRW Forms) - Ensure all policies are kept up to date and reviewed in correct time frames		- Review undertaken - Letter to practice outlining good practice and areas picked up in HIW Action Plan - Response requested for ongoing work.	
27	Gwena Dental Care	2 nd March 2017 (published 5 th June 2017)	Report found on HIW website – June 2017. Not notified. A positive report overall <i>Improvements Required</i> - Update Complaint policy to reflect correct timescales. - Complaint policy on the website - Methods for regular checks of Emergency Drugs - IR(Me)R Training for all relevant staff - Patient records quality		- Review undertaken - Letter to practice outlining good practice and areas picked up in HIW Action Plan - Response requested for ongoing work.	
26	Wilton House Dental	28 th February 2017 (published	Report found on HIW website – July 2017. Not notified.		HIW issued satisfactory assurance	Practice being sold - 1/12/17 - Working

**HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2017) - TABLE OF INSPECTIONS**

	Practice	31 st May 2017)	A number of areas of improvement were identified, with the main issues being described below: • Separate NHS and Private complaints procedures needed • Private Price List • WHTM 01-05 Audits • WHTM 01-05 (dirty to clean workflow signs, instruments to be cleaned and sterilised properly, single use items not reused on same patients) • Checks on Emergency Drugs expiration dates • Radiographic Audit • Patient Record Improvements • Implement Resuscitation Policy • POVA Training • Child Protection Training		• Practice written to by UHB to seek assurances on issues outlined in Action Plan	with incoming owners
25	The Orthodontic Centre	5 th January 2017 (published 6 th April 2017)	Report found on HIW website – August 2017. Not notified. An overall positive report. <i>Improvements Required</i> • Ensure that surgery floors are kept clean and tidy • Ensure the surgery floor is sealed appropriately • Ensure work surfaces are sealed appropriately • Ensure all instruments and equipment are in suitable condition • Ensure compliance with WHTM 01-05 for storage of sterilised instruments • Patient records Issues (Updating and countersigning Medical History, Oral health of patient, Extra oral findings) • Process for audit of equipment and materials BBE		• HIW issued satisfactory assurance • Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	

**HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2017) - TABLE OF INSPECTIONS**

24	Cathedral Orthodontics Ltd	5 th December 2016 (published 6 th March 2017)	Report found on HIW website – August 2017. Not notified. A positive report overall <i>Improvements Required</i> • WHTM01-05 Issues (Performing tests and procedures on autoclave machines/ Maintaining logbooks of the tests and procedures on autoclave machines) • Ensure patient records completed are maintained in accordance with standards • Radiographs (Ensure X-rays have full justifications and reports)		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	
23	Oasis Dental Care (Canton)	24 th November 2016 (published 27 th February 2017)	A relatively positive report overall with some significant areas of concern <i>Improvements Required</i> • Website to comply with GDC standards for advertising. • Deep Cleaning Schedule to be implemented • Remedial work to Cupboard/ Dental chair and stool • Electrical wiring certificate to be updated • Fire Exit Access query • Environmental Risk Assessment • Inoculation Records • CPR training evidence for all staff • DBS Checks to be updated # • Position of X-ray switch review • IR(M)ER Training for all staff • Records Keeping Improvements (MH Updates/ Smoking Cessation Advice)		• Practice written to by UHB to seek assurances on issues outlined in Action Plan (22/8/17) • Response received (17/10/17)	Recategorised as Yellow
22	Wilson Road Dental Surgery	18 th November 2016 (published 20 th February 2017)	Notified to UHB – 15th May 2017 A positive report overall <i>Improvements Required</i> • Clinical/hazardous waste storage needs to be		• HIW issued satisfactory assurance • Review undertaken • Letter to practice	

**HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2017) - TABLE OF INSPECTIONS**

			safely stored • Review of cleaners handling clinical waste • Review clinical facilities to ensure safety and condition. Specific attention: worktops and handles/ Flooring sealed in the surgeries/ Repairing or replacing the light unit, suction pipe, upholstery/ Rusting or damage to the dental chair. • WHTM 01-05 Compliance (Separation of clean/dirty areas, Dental impressions and disinfection, Autoclave data logger not being used correctly) • Confirmation letter to HSE • IR(ME)R training certificates obtained and kept on file • Patient records administration • Radiography: • Review of policies		outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	
21	Cardiff Smile Centre	15 th November 2016 (published 16 th February 2017)	Report found on HIW website – August 2017. Not notified. A positive report overall <i>Improvements Required</i> • Review location of clinical waste bin. • Website to comply with GDC standards for advertising. • Patient records: - Comprehensive patient information to be recorded - Specific Attention: - Addresses - Cessation advice - Consent - OCS • Justification and reporting of radiographs needs		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	

**HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2017) - TABLE OF INSPECTIONS**

			to be recorded - Review of all policies and procedures needed to ensure the correct organisations and/or appropriate guidance is listed. - Policies and procedures need to be consistent with version and review dates mentioned within documents - Review of staff training needed.			
20	Ellen Davies Dental Practice	27 th October 2016 (published 30 th January 2017)	A positive report overall <i>Improvements Required</i> - Informing patients and visitors of the CCTV in operation - Ensure full compliance with WHTM 01-05 - Resuscitation equipment needs to be checked - First Aider : Certificates obtained held/first aid box needs to be checked regularly - IR(M)ER for dental nurses - Patient records: - Medical histories countersigned - Medical histories are updated - Soft tissue examinations - Justification for x-rays - Review of all staff training needs required and courses - Policies and procedures need to be consistent with version and review dates		- Review undertaken - Letter to practice outlining good practice and areas picked up in HIW Action Plan - Response requested for ongoing work.	
19	Nicola Taaffe @ West Grove	26 th September 2016 (published 29 th December 2016)	A weak report overall <i>Improvements Required</i> - Practices' complaints procedures need updating - Compliance with WHTM 01-05 in respect of: - Autoclave tests - Procedures on Ultrasonic Bath - Maintaining records		- HIW satisfied with outcome of Action Plan submitted by practice - Practice written to by UHB to seek assurances on issues outlined in Action Plan. - Assurances received	- Action plan submitted by practice to HIW and acceptable. - Recategorised as Yellow

**HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2017) - TABLE OF INSPECTIONS**

			• Ensure floors are appropriately sealed between the cabinets and walls • Implement system regular checks on the emergency equipment • Review storage of emergency drugs and equipment in one location for easy access • Review safeguarding procedures: • Ensure staff complete training • Patient records issues: - Medical histories - Use of templates - Treatment planning - Consent - Radiographic reports • Review of all policies, procedures and demonstrate implementation • Training certificates for all clinical staff • Confirmation of the Hepatitis B immunisation for all staff		from practice.	
HIW Immediate Assurance Letters (received since last update)						
Members should note that Immediate Assurance letters for Primary Care are <i>issued</i> to the Practice for response and <i>copied</i> to the UHB for Information and to feed into the broad Performance Management of the practice.						
	<i>Practice Name</i>	<i>Inspection Date</i>	<i>IA Letter Date</i>	<i>Summary</i>	<i>UHB Actions</i>	
1	No Immediate Assurance Letters since last update					
HIW Concerns Raised (received since last update)						
	<i>Practice Name</i>	<i>Contact from HIW</i>	<i>Follow Up</i>	<i>Summary of Concerns</i>	<i>Summary of UHB Actions</i>	

**HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2017) - TABLE OF INSPECTIONS**

1	No Concerns raised by HIW since last update

**HIW GENERAL PRACTICE INSPECTION PROGRAMME
FOLLOW UP ACTIONS (November 2017) – APPENDIX 1 – TABLE OF INSPECTIONS**

HIW Inspection Reviews				
<i>Practice Name</i>	<i>Inspection Date</i>	<i>Summary</i>	<i>RAG</i>	<i>UHB Actions/ Update</i>
Meddygfa Albany Surgery	23 rd February 2017	1. Non clinical staff made aware of what's expected if they are required to act as chaperone. 2. Manage concerns/complaints with accordance to Putting Things Right 3. Recording outcome of house call consultations 4. Receive annual appraisals in the near future and on an ongoing basis		1. Primary Care Team have checked and a Chaperone Policy is in place. Training is being rolled out to practice staff. 2. Putting things right leaflet and poster in practice. The practice scored themselves Level 2 on the Clinical Governance Tool Kit . Primary Care team to review at Annual Practice Development Visit in January (APDV) 2018 3. The practice has confirmed that GP's have been reminded of the importance of keeping contemporaneous clinical records. 4. The practice is reviewing their HR policies and process and will provide detail in their Annual Practice Plan and will be reviewed at the APDV in Jan 2018
Cloughmore Medical Centre	31 st January 2017	1. Non clinical staff made aware of what's expected when they are required to act as a chaperone. 2. Obtain patient consent to clinical procedures 3. Manage concerns/complaints with accordance to Putting Things Right		1. Chaperone Policy is in place and has been discussed in Team Meeting. The Practice had training for October 2017.

**HIW GENERAL PRACTICE INSPECTION PROGRAMME
FOLLOW UP ACTIONS (November 2017) – APPENDIX 1 – TABLE OF INSPECTIONS**

		- Describe action taken to address the absence of staff health and safety risk assessments - New staff have access to appropriate induction		The Practice has rated themselves as Level 4 on the Clinical Governance Tool Kit. - The practice has new consent forms which are being embedded into practice. - A new protocol and patient leaflet has been developed. The Practice scored themselves as level 3 for complaints on the on Clinical Governance tool kit. The Primary Care team will review with the practice during the Annual Practice Development visit in Jan 2018 - The practice have undertaken risk assessment on all workstations and staff received E learning training in April 2017. - Chairs have been replaced. - The practice has developed a new Induction checklist and embedded into practice.
Four Elms Surgery	18 th January 2017	- The practice is required to describe the action taken/ to be taken in order to address the absence of staff (DSE) Health and safety risk assessments. - Ensure Sharps containers are relocated and secure in patient areas		- A training DSE training session occurred in March 2017. Training is diarised in staff calendars. Workstation risk assessments have been completed - All sharp containers are securely wall mounted.

**HIW GENERAL PRACTICE INSPECTION PROGRAMME
FOLLOW UP ACTIONS (November 2017) – APPENDIX 1 – TABLE OF INSPECTIONS**

HIW Immediate Assurance Letters (received since last SBAR update)			
<i>Practice Name</i>	<i>Inspection Date</i>	<i>Summary</i>	<i>UHB Actions</i>
The City Surgery	24 th January 2017	1. Strengthen review of patient test results 2. a) Inform HIW of actions taken for flexible registration appointments, b) also treating patients with respect 3. Protocol in place for patients without appointment but in need for medical advice 4. Ensure action taken to obtain patient views and act on them accordingly 5. Ensure Sharps containers are relocated and secure in patient areas 6. Action to provide minimum emergency/resuscitation equipment 7. Content of medical records is comprehensive enough and carry out audit to improve 8. Ensure med notes are summarised, to assist in clear clinical decision making 9. Access to current policies and procedures to meet requirements	1. Patient results are now checked daily by Senior GP and actioned. The practice Manager audited the new system in May 2017 and has concluded that the new system is effective. 2. a) A more flexible registration process now exists with registration appointments available daily. b) Practice manager confirmed Dignity and Respect Policy is in place and was reviewed at team meeting. 3. A new protocol is in place for registered and non-registered patients who attend the practice outside of normal consulting hours with a need for medical advice. An Emergency/Temporary Appointment Request Form has also been developed and embedded in practice. 4. The Practice Manager has developed a patient Questionnaire. To be reviewed at Practice Development meeting 2017/18 5. Wall brackets for sharps containers are in place in all clinical areas 6. The practice have purchased relevant equipment 7. Information regarding GMC and NMC standards is available to the practice and has been signposted to relevant record keeping courses.

HIW GENERAL PRACTICE INSPECTION PROGRAMME
FOLLOW UP ACTIONS (November 2017) – APPENDIX 1 – TABLE OF INSPECTIONS

			GP's to discuss record keeping in their annual appraisal and provide Form 4 to Quality & Safety Director. 8. The practice GP's have refined their summary and care planning process. The practice will share outcome of audit Feb 2018.

PRIMARY CARE GENERAL MEDICAL SERVICES AND DENTAL GOVERNANCE	
HIW PRACTICE INSPECTION UPDATE REPORT – NOVEMBER 2017 UPDATE	
Name of Meeting :	Quality, Safety & Experience Committee
Date of Meeting :	6 th December 2017
Executive Lead : Executive Nurse Director	
Author :	Quality and Safety Manager, Primary, Community and Intermediate Care 02920 335654
Caring for People, Keeping People Well :	This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact :	Not applicable.
Quality, Safety, Patient Experience impact :	Gives assurance and confidence on quality, safety and patient experience.
Health and Care Standard Number	2.1, 2.4, 2.7, 2.9, 3.1, 3.4, 3.5, 4.2.
CRAF Reference Number	Not applicable.
Equality and Health Impact Assessment Completed:	Not Applicable.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The processes in place to monitor the outcomes of HIW inspections in primary care
- Overall positive findings

The Quality, Safety and Experience Committee is asked to:

- **CONSIDER** the report and the findings of the inspections

SITUATION

The routine Welsh Government practice and performer inspection programme has been commissioned from Healthcare Inspectorate Wales (HIW) from August 2014. The UHB Primary Care Team needs to provide assurance that Inspection Reports have been received, reviewed and acted upon. The purpose of this report is to provide an update on inspection activity since the last report to the Committee in February 2017.

BACKGROUND

All General Practices and General Dental Services/Personal Dental Services are inspected on a three-yearly rolling cycle to ensure that appropriate standards of premises, systems and care are in place. The inspections are announced and are undertaken by an HIW Inspection Manager, at least one external reviewer (Qualified Dentist, GP or Practice Manager with recent experience of GMS) and where possible a member of the local CHC. The HIW inspection leads produce an Action Plan which is assessed and followed up on by HIW. The UHB then ensures ongoing compliance with the outcomes of the inspection and the action plan.

ASSESSMENT AND ASSURANCE

The process for the inspection is as follows:

1. The practice is inspected by HIW
 - a. Any significant issues are sent to practice and the UHB in the form of an Immediate Assurance letter.
2. The initial report is written and checked and sent to the practice with the HIW action plan.
3. The practice replies with details of their responses for each element of the action plan.
4. HIW acknowledge whether they are content with the feedback.
5. Once feedback from the practice is received and HIW approves the actions undertaken, the report is released to the UHB.
6. The UHB Clinical Director for Clinical Governance for PCIC (CDCG PCIC) and Primary Care Dental Advisor reviews the Inspection Report and Action Plan and produces a 1-page summary with a RAG-score and any additional actions for the UHB to undertake.
7. The findings of reports and actions taken are discussed at the Clinical Board Dental group and reported to the PCIC Quality, Safety and Experience Group.
8. The report and action plan is then formally received at C&V UHB QSE Committee

Any responses from the practice which HIW are not satisfied with are escalated internally and a more detailed response and actions requested from the practice. This communication is copied into the UHB. The outcome of the action plan is assessed by HIW and satisfaction with steps taken or proposed by the practice are included in the final report.

The Primary Care Team undertakes a full in-depth review of each practice report and any potential actions for follow-up required. These steps are in addition to any satisfaction HIW have with the outcome and so are managed with sensitivity. This 1-page summary is logged on the practice file and the follow-up actions undertaken. The Review and summary of reports as well as actions taken is included at **Appendix 1** – General Dental Services and **Appendix 2** – General Medical Services.

Overall, reports are positive. However some practices have a number of areas for improvement. A visit to Wilton House Dental practice in February

2017, highlighted a number of areas for improvement. A comprehensive action plan was submitted by the practice owners. The Practice is being sold and the UHB is in discussion with the new owners with regards to the issues that were raised at the time of the inspection.

In June 2017, a visit to Restore Dental Practice raised a significant number of areas for improvement. HIW confirmed that they were satisfied with the action plan submitted by the practice. The UHB sought written assurances from the practice and there is a plan to have a follow up meeting early in the New Year. The status of the practice has been re-categorised to Amber and will continue to be monitored.

HEALTHCARE INSPECTORATE WALES ACTIVITY	
Name of Meeting :	Quality, Safety and Experience Committee
Date of Meeting	6th December 2017
Executive Lead :	Executive Director of Nursing
Author :	Assistant Director Patient Safety and quality
Caring for People, Keeping People Well :	Offer services that deliver the improvement in health that our citizens are entitled to expect
Financial impact :	None
Quality, Safety, Patient Experience impact:	External inspections provide valuable feedback and assurance in relation to the quality and safety of services. It also provides opportunity to consider the patient, family and carer experience, as well as providing staff to input into the report.
Health and Care Standard Number	All standards
CRAF Reference Number.	5.1 and 5.1.6
Equality and Health Impact Assessment Completed: A specific Equality Impact Assessment is not required. Delivery of care which is dignified, respectful and compassionate will ensure equality for all patients receiving care from the UHB.	

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The development, implementation and monitoring of improvement plans to address recommendations.
- Progress reports through the Clinical Board Quality, Safety and Experience Committee(QSE) , as well as through the Health board QSE Committee

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the findings following the Children's Hospital for Wales inspection
- **NOTE** the level of HIW activity across a broad range of services
- **AGREE** that the appropriate processes are in place to address the recommendations and to receive future assurance reports as the findings of the Thematic reviews are published.
- **AGREE** that a more detailed report, outlining the UHB position against the findings of the All Wales HIW report is received at the February 2018 committee

SITUATION

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview of the inspections carried out by Healthcare Inspectorate Wales (HIW) since the last over-arching report to the committee in June 2017.

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 will be undertaken.

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 and ASSURANCE

Unannounced inspections

In June 2017, HIW undertook an unannounced follow up inspection to 4 wards in the Noah's Ark Children's hospital. The previous inspection was undertaken in October 2015.

The purpose of the follow-up inspection was to see what improvements had been made since their last inspection to focus on the specific areas for improvement that were previously identified as well as focusing on what the Health Board said that they would do in response.

The inspection team revisited the following areas:

- Pelican zone,

- Island
- Gwdihw
- Paediatric Critical Care

The report was published in September 2017.

There were no immediate assurances required from this inspection and the inspectors concluded that the service provided safe and effective care. They found the following issues were being performed particularly well:

- Parents told them that they were happy with the care of their child received from nursing, play staff, doctors and a variety of other health care professionals
- Additional furniture and a TV had been added to the visitors' room within PCCU in direct response to what relatives had highlighted with a monthly patient experience survey
- The six week induction available to new employees had resulted in very positive comments from staff in terms of the support they received for named mentors

They advised that the UHB needed to improve

- The availability of sufficient theatre time for surgical improvements
- Aspects of medicines management
- Recording of care within patients' notes

A number of actions have been taking including the following:

- An established 'Line' list has been put in place to ensure all children have vascular lines inserted in a timely way
- A CEPOD list is currently operating twice weekly in Children's theatres in the Children's Hospital for Wales and work is underway to consider options to expand this further.
- Processes in relation to the recording of controlled drugs have been revised
- The UHB has developed a Medicines Code to support All Wales Medication Administration, Recording, Review, Storage and Disposal Policy (MARRS)
- A process in relation to the recording and monitoring of fridge temperatures have been strengthened
- Staff have been reminded of their responsibilities with regards to the safe storage and security of medication
- The findings with regards to record keeping have been fed in to the work programme of the Documentation Development team

The full report and action plan can be accessed via the following [link](#)

Thematic Reviews

The following thematic reviews have been underway during the year

- Thematic Review of Patient Discharge from Secondary care to Primary care NHS Healthcare

This commenced in February 2017 and concluded in the UHB in September 2017. This has involved the submission of a self-assessment questionnaire, relevant evidence and the interview of staff. The final report is awaited

- Thematic Review of Community Mental Health services

This commenced in June 2017 and has now concluded. This too has involved the submission of a self-assessment questionnaire, relevant evidence and the interview of staff and service users. The final report is awaited.

- Thematic review of Services for young people in Wales – Transition

This commenced in September 2017. The UHB has submitted a self-assessment questionnaire and awaits guidance on the next phase of the review

Ionising Radiation (Medical Exposure) Regulations (IR(MER) 2000) – compliance monitoring inspection – Cardiology Department at University Hospital of Wales

This inspection took place on October 2nd, 3rd 2017. The following areas were visited:

- Cardiac Catheter Laboratories (A,B and C)
- Cardiac pacing Room
- Cardiac day ward

This involved the submission of a self-assessment questionnaire, questionnaires and discussions with service users, site inspections and interviews with staff.

The draft report has been received. Overall HIW found that the cardiac service delivered safe and effective care to patients. This was in accordance

with the Ionising Radiation (Medical Exposure) Regulations and the Health and care Standards. They did identify the need for improvement to some administrative aspects of the service. These included issues in relation to the security of patient records, the recording of informal training and the general quality of training records. The UHB has developed an improvement plan to address the recommendations and is awaiting final publication.

Primary Care announced inspections

In addition, there have been a number of announced inspections to Primary Care contractor premises and these are described in a separate report to the Committee.

HIW All Wales Annual Report

HIW published their All Wales Annual report in September 2017. This can be viewed via the following [link](#).

The report commented that, 'Almost without exception, we found that patients' and relatives' experience of healthcare during our inspections was positive; people telling us that they were treated with kindness, courtesy and politeness. Patients and relatives who completed a HIW questionnaire also expressed their satisfaction with the cleanliness of ward areas'

Areas of concern across Wales related to:

- Absence of patient identification wristbands
- Compliance with Mental Capacity Act (2005) legislation
- Effective and prompt application of the Deprivation of Liberty Safeguards
- Aspects of Medicines Management
- Monitoring and treatment of patients in non-clinical areas of emergency departments such as corridors.

The report has been shared with all Clinical Boards and also with the Mental Health and Capacity Legislation Committee and the Medicines Management Committee. A more detailed report, setting out the UHB position in relation to the All Wales findings will be submitted to the February 2018 QSE Committee.

The Cardiff and Vale UHB annual HIW report was presented previously to the September 2017 QSE Committee.

HEALTHCARE INSPECTORATE WALES OPHTHALMOLOGY THEMATIC REVIEW	
Name of Meeting :	Quality, Safety and Experience Committee
Date of Meeting :	6 th December 2017
Executive Lead : Executive Nurse Director	
Author : Patient Safety and Quality Assurance Manager: Alexandra.scott2@wales.nhs.uk	
Caring for People, Keeping People Well : Offer services that deliver the improvement in health that our citizens are entitled to expect	
Financial impact : £ none	
Quality, Safety, Patient Experience impact : External inspections provide valuable feedback and assurance in relation to the quality and safety of services.	
Health and Care Standard Number All standards	
CRAF Reference Number 5.1 and 5.1.6	
Equality and Health Impact Assessment Completed: Not Applicable	

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The development, implementation and monitoring of an improvement plans to address recommendations that resulted from the Thematic Review.

The Quality, Safety and Experience Committee is asked to:

- NOTE** the progress made in implementing the recommendations in the Improvement Plan.

SITUATION

The purpose of the report is to present the Committee with an update on implementation of the improvement plan following the Healthcare Inspectorate Wales Ophthalmology Thematic Review [Report](#) which was published on 31st January 2017. The Committee has previously received a report in February 2017.

BACKGROUND

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator for all healthcare in Wales. The core role of HIW is to review and inspect NHS and independent healthcare organisations in Wales so that independent assurance can be given to patients, the public, the Welsh Government and healthcare providers that services are safe and of good quality.

The review set out to look across the boundaries of primary and secondary care to examine how providers were delivering and developing services, and to define the care and support required by patients. Due to the risks associated with any delay in treatment for patients with 'wet' Age Related Macular Degeneration (AMD), it was decided that the review would be based around the 'wet' AMD pathway.

The aim of the review was to assess how effectively health boards have been utilising service integration as a means of making the best use of the breadth of expertise and resources available.

Following the inspection an improvement plan was developed which is being monitored by the Ophthalmology Directorate. The updated action plan is included in Appendix 1.

ASSESSMENT AND ASSURANCE

The paper seeks to assure the Committee that action is being implemented, monitored and progressed in response to the findings

Appendix 1**Thematic Review: Improvement Plan****CARDIFF AND VALE UHB****Department : Ophthalmology****Date of inspection: September 2016**

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	December 2017 Update
1	Issues relating to patient referral process (Patient Referrals - Referral Process)	All parties (Welsh Government, NWIS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	A)The UHB requested NWIS select Specsavers Cardiff as their pilot site for e-referrals as this our highest referrer to secondary care services (rather than Boots who were selected by NWIS and who are a very low referrer and are not engaged with the programme) NWIS have declined this request (20 Jan 17) . Therefore the UHB is exploring another option to access to WPRS (27/1/17), if successful we plan to offer this option to Specsavers Cardiff. B) In addition work has been commenced by the national eye care steering group to look at developing an EPR for eyes, though implementation is not expected until 2018.	Technical development Manager / Executive Director of Therapies National eye care steering board	National Work stream 2018. A local system using e-advice has been developed. The pilot has started with 2 optometric practices with a roll out plan to 15 more by December. If successful optometric practices will be able to send e-referrals into the UHB

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	December 2017 Update
2	The CHC's National Ophthalmology Review highlighted that some patients felt they had not been provided with sufficient information regarding the reason for their referral. (Patient Referrals - Referral Process)	Health Boards via Local Eye Care Groups should work with optometrists to ensure that patients are provided with adequate and accessible information regarding the reason for their referral to secondary care and ensuring that all patients feel listened to and involved in decisions made around their care.	Optometric Advisor will provide feedback and training to optometrists within C&V. Leaflets are available from the College of Optometrists for common eye conditions to assist this process	Optometric Lead	Written information is being developed for use in all optometric practices to be given to patients at point of referral. An online educational package is being designed by WOPEC to advise optometric practices on informing patients regarding referrals and pathways.
3	Quality of referrals being sent to rapid access pathway (Patient Referrals – Quality of Referrals)	A) Health Boards should consider methods to refine referrals to ensure patients enter the most appropriate care pathway in a timely and efficient manner, avoiding unnecessary visits. B) Health Boards should consider providing educational events/material to raise awareness among optometrists and other relevant staff of local referral pathways.	A) This issue has been discussed and agreed as part of the wet AMD pathway for C&V B) An educational workshop has been run between C&V and WOPEC for local optometrists for the cataract pathway, further events will be planned as our pathway work continues with AMD.	Service Improvement Manager / Optometric Adviser Optometric Adviser Optometric Adviser	Pathway redesign and audit is being undertaken as part of Big 3 service improvement. Communication has been distributed to all C&V optometrists highlighting correct pathways, quality of referral information and correct paperwork to be used. The Optometric Adviser has commenced a programme of education working with WOPEC and AMD consultant. Educational events initiated from summer 17 A new feedback mechanism within PMS allows all letters to

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	December 2017 Update
		C) Health Boards should ensure feedback is provided to optometrists when required relating to quality of referrals sent to ensure learning.	C) C&V optometric advisor has undertaken an audit of cataract referrals and provided feedback to local optometric practices. This improved the quality of referrals from 30 to 80 % of appropriate referrals. There are plans to widen the scope of this work to other sub specialities.		be sent to optometrists and copied to GP. The roll out of this letter will start imminently
4	Lack of feedback provided to optometrists following referral and discharge of patients. (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information)	A) Health Boards should ensure feedback of diagnosis and a treatment plan is provided to referring optometrists following every referral B) Optometrists must use the appropriate referral form and ensure that their name and practice address are clearly legible C) Health boards/welsh	The UHB PMS has been upgraded which enables the Clinic Co-ordinators to ask patients if their discharge letter can be sent to the Ophthalmic Practice. Currently all discharge summaries are sent to the GP and available on both the Cardiff Clinical Port and the Welsh Clinical Portal. We are now able to send with the patients consent the discharge summary via the Royal Mail to the appropriate Ophthalmic practice. (rather than just GP) to give timely feedback.	Database Development and Server Manager/ Technical Development Manager/ ENT and Ophthalmology Directorate Manager	A) Exploring potential for Patient Management System (PMS) to enable communication back to referring optometrist, to give timely feedback. B) Optometric Advisor has commenced a programme of education C) WG leading on enabling

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	December 2017 Update
		government must ensure that systems are introduced to improve the amount of information available to optometrists in relation to patients who have been discharged from secondary care			procurement and deployment of EPR.
5	CHC reports concerns around lack of information provided within secondary care prior to treatment (Patient Referrals – Communication Following referral)	Health Boards must ensure that patients are provided with adequate information about their condition and proposed care plan prior to any investigation or treatment. This should conform to the principles outlined in GMC guidance on informed consent	C&V UHB has good information for patients. However Audit will be undertaken to ensure that patients feel informed about their care plan and treatment and this conforms to GMC guidance on informed consent	Ophthalmology consultants via their audit programme	
6	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets)	A) The Welsh Government should ensure that Patient Administration Systems are capable of providing data on clinician recommended follow-up interval and actual follow-up interval by care pathway.	A) Ophthalmology to work with IT team to determine whether PMS can deliver this functionality	ENT and Ophthalmology Directorate Manager & Database Development and Server Manager Executive Medical Director	A) PMS IT system has a follow up tracking capability, which is available to ophthalmology, however, Data needs to be consistently inputted by clinical and OP admin teams. The directorate is leading work to ensure a standard operating procedure is developed to

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	December 2017 Update
		B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available. C) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan	Bi) Work being led by Medical Director on a national basis, to address this recommendation with regard to prioritisation. Bii) In addition developing ODT and nurse led initiatives to increase capacity for consultants to see those patients in most clinical need of seeing a consultant C) Being captured through Consultant outpatient module of PMS, but also requires additional outpatient service improvement	ENT and Ophthalmology Directorate Manager & PCIC ENT and Ophthalmology Directorate Manager / Directorate Manager Medical Records	support this, and data quality is monitored Bii)ODTC option is being developed with Orthoptists with 7,795 patient slots available
7	Lack of incident reporting relating to WG patient harm policy (Incident Reporting)	A)Health Boards must ensure that there are mechanisms in place to review incident reports to identify potential	Remind staff of incident reporting requirements and ensure incidents are reviewed as part of quality and safety agenda for Ophthalmology directorate	Lead Nurse Surgery and ENT and Ophthalmology Directorate Manager Assistant Director Patient Safety and	Complete The Clinical Board has been

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	December 2017 Update
		B) Health Boards must ensure on the occasions where any incidents occur, in line with the WG policy related to patient harm, that these are reported as Serious Untoward Incidents (SUI's).	Ensure ophthalmology incident reporting to WG complies with SUI policy	Quality	reminded of its responsibilities with regards to this requirement. Further work is required to monitor trends in the reporting of ophthalmology related incidents.
8	Lack of capacity/Fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity)	A) Health Boards must proactively develop workforce plans which set out to address any shortfalls in the current service capacity and available facilities to mitigate the risks to patient care. These plans should seek to maximise capacity by making most effective use of the skills of medical and non-medical staff available, as well as available space/facilities. B) Health boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to	A) Workforce plans are being developed in line with IMTP plans for eye care and also as part of national work on eye care workforce planning – looking to adopt prudent workforce principles) B) Developing plans for ODTc and maximising primary care element of pathways as part of eye care plan implementation and BIG 3 workstreams. consideration to be given to opportunities related to ODTc shared care services, wet AMD	PCIC and Surgery Clinical Board workforce leads PCIC and Surgery Clinical Board management teams	A) Complete B) There is regular and sustained engagement between primary and secondary care in several fora, including managers and clinicians. There is strategic leadership from Executive and Clinical Board level to ensure on-going relationship

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	December 2017 Update
		undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.	shared care and referral refinement		development.. A working group has been established between primary and secondary care, of which the purpose is the delivery of the revised eye care delivery plan, HIW report and CHC report. This group meets monthly.
9	Health boards should learn from the experiences following progress made in other areas (Treatment – Initiatives to improve Capacity)	A) Health Boards must ensure that they fully engage with the Ophthalmology Planned Care Board to aid shared learning from/with staff in other areas. B) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical injectors.	C&V now have senior attendance at National Planned Care Boards including CB representation by the Director of Operations and Clinical Board Director and optometric advisor B) WG action, but will be addressed by national planned care board eye health group where all LHBs are represented. Possibly also an action for OSAG	ENT and Ophthalmology Directorate Manager /Director Operations and Delivery Surgery Clinical Board/ Optometric Adviser	A)Complete B)This National work stream is ongoing
10	Importance of the AMD Coordinator	Due to the demands of the role and the importance of		ENT and Ophthalmology	This is now complete and an AMD co-coordinator is

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	December 2017 Update
	role (Service Support Staff – AMD Coordinators)	providing continuity of cover, consideration should be given by Health Boards as to whether one AMD Coordinator is sufficient for the eye care service		Directorate Manager	employed. Additional resource have been provided to ensure continuity during times of leave.
11	ECLO – lack of utilisation of the role from other staff (Service Support Staff – Eye Care Liaison Officer)	Health Boards must ensure that all staff are aware of the availability of the local ECLO service. Ensuring patients have access to relevant advice and support.	Good engagement with ECLO, the office accommodation is situated within the main outpatients setting.	ENT and Ophthalmology Directorate Manager	This is now complete
12	ECLO – Limited capacity/cover (Service Support Staff – Eye Care Liaison Officer)	Health Boards should ensure that there is ECLO for their eye care clinics at all times and consideration should be given as to whether one ECLO is sufficient for the eye care service.	2017-18 Possible funding for ECLO from ophthalmology endowment funds being considered. Review on ongoing funding of ECLO	Ophthalmology consultants / ENT and Ophthalmology Directorate Manager	Funding has been agreed for ECLO post on an ongoing basis
13	Concerns raised by staff in relation to a lack of processes in place to submit comments/suggestions to health board management. (Service Support Staff – Eye Care Liaison Officer)	Health Boards must ensure that there are methods in place to allow all staff to raise any concerns/suggestions about improvements to service provision they may have. This process should ensure that feedback is routinely provided to	UHB has a programme of staff engagement (Values into Action” which has gathered input from 3000 sources. Feedback sessions are in place as well as tools to aid speaking up. In addition the BIG 3 principles include engagement with clinicians and encouraging feedback to improve services.	ViA feedback lead by UHB OD team. Assistant Director of Organisational Development Ongoing engagement via Surgery clinical board, Director of Operations and Delivery Surgery	There are regular and sustained team meetings to work collaboratively to implement the action plan

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	December 2017 Update
		individuals		Clinical Board / ENT and Ophthalmology Directorate Manager	
14	More clarity required in relation to evolving role of optometrist (The role of optometrist)	To enable more effective utilisation of optometrists, Welsh Government must provide clarity to health boards relating to Indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	WG action. And UHB implementation	WG	Await WG Timescale
15	Additional utilisation of optometrists is required to increase capacity (HDHB example) and reduce the burden on secondary care. (Utilisation of optometrists)	Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Board will need to ensure that issues are clarified around Indemnity, resource & finance arrangements, training and communication, for optometrists.	A) UHB developing plans for optometric led services. B) clarity being sought from WG re indemnity As part of IMTP and Eye care sustainability plan, capacity and demand planning completed and skill mix reviewed.	Surgery clinical Board and PCIC Executive Director of Therapies	Most prudent development of ODTC at this stage is to use LHB employed Ophthoptists for ODTC work. Using optometrists as part of other pathway work and good uptake of cataract follow ups
16	Patients not always being referred for their initial low vision assessment by secondary care staff. (Utilisation of optometrists)	Health Boards must ensure that staff are reminded of the importance of referring all eligible patients are referred to an accredited optometrist for a low vision assessment.	As part of demand and capacity and service redesign work is underway with the optometric lead to develop further the use of optometrists in the service The service is already in place in primary care (Welsh Low Vision	ENT and Ophthalmology Directorate Manager / Consultant Ophthalmologist	Low Vision Service Wales and C&V Optometric advisor will be delivering an education session to ophthalmologists highlighting the service and referral pathways

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	December 2017 Update
			Service) this section needs a directive to all clinical staff to ensure that they are aware of the service and are referring effectively.		
17	Issues in relation to poor relationships between primary and secondary care staff impacting on progress to service developments (Primary and Secondary Care Relationship)	Health boards must ensure that relevant staff engage with the local Eye Care Group. The group should meet regularly and be chaired by a member of the executive team. A key objective is to improve the working relationships between primary and secondary care staff to foster joint working initiatives.	Regular meetings, minuted and attended by both Primary and Secondary care Exec Chair of the C&V eye care group is also Chair of the national group.	Executive Director of Therapies/ PCIC and Surgery Clinical Boards and partners	There is regular and sustained engagement between primary and secondary care in several fora, including managers and clinicians. Strategic leadership from Executive and Clinical Board level to ensure on-going relationship development.
19	Concerns raised about different criteria being used by different consultants, which subsequently means some patients are being followed up unnecessarily or treated with little chance of benefit. (Discharging Patients – Criteria)	Health Boards must ensure their AMD service has a policy setting out criteria for discharging 'wet' AMD patients in line with Royal College Guidance. The aim being to ensure that patients do not remain within the service longer than required. Maximising capacity for patients most likely to benefit. Adherence to the policy could form part of the annual	BIG3 AMD workshop being held on 20/01/2017 looking at pathway redesign. These criteria will be discussed.	Service Improvement manager	AMD revised pathway commenced March 17

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	December 2017 Update
		service audit.			
20	Inadequate IT systems to capture useful data. Limited awareness of capacity and demand data. (Information Management Systems - planning)	Improvements must be made to information management systems within health boards to enable accurate capturing of capacity and demand (performance) data to allow for more informed workforce planning and to ensure resource provisions are based on patient need.	Review of PMS ability to track follow ups will be undertaken. A significant part of the issue is NHS Wales coding requirements for outpatients – this needs further exploration via the planned care board	ENT and Ophthalmology Directorate Manager / Database Development and Server Manager	PMS IT system has a follow up tracking capability, which is available to ophthalmology. Use of WPRS to enable e-referral will support improvements in capturing demand. However this requires optometry to be enabled to refer electronically, which is being picked up in the electronic referral process
21	Issues in relation to information sharing (Information Management Systems –sharing information)	Improvements must be made on improving the access to/sharing of patient information within health board areas to improve efficiency of services	Specific issues will be highlighted by clinicians, and issues that cannot be resolved and needing IG sharing advice to be raised with corporate information governance.	Consultant Ophthalmologist/ Head of Information Governance and Assurance	Ongoing
22	Lack of public awareness in relation to general eye care (Public Awareness)	Welsh Government , Public Health Wales and Health Boards need to consider how the general public can be made more aware the importance of regular eye checks, general eye care issues, as well as the symptoms to look out for which are associated with the	Health board Eye Care Collaborative Groups and public health lead School Nurses Orthoptists Optometrists Optometry Wales Third Sector Welsh Government Communications team C&VUHB continue to work with local Public Health Teams as part of their	Eye Care Steering Board	Passed from WG to HBs in Oct 17

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	December 2017 Update
		more serious eye conditions and the importance of seeking healthcare advice quickly. More information needs to be provided on the different services/professionals available to see/treat patients in relation to their eye care conditions.	T&F group Latest public awareness campaign through social media for World Diabetes Day and ahead of Halloween re use of contact lenses		

Health Board Representative:

Name (print): Fiona Jenkins

Title: Executive Director Therapies and Health Science and Chair Cardiff and Vale Eye Care Group

Date: 25/1/17

LEARNING DISABILITIES SPECIALIST, SECONDARY CARE AND PRIMARY CARE SERVICES	
Name of Meeting : Quality, Safety and Experience Committee	
Date of Meeting: 6th December 2017	
Executive Lead : Executive Director of Therapies and Health Sciences	
Author : Lead Nurse N&W Locality, Lead Nurse Surgery, Head of Outcomes Based Commissioning ,Patient Safety and Quality Assurance Manager	
Caring for People, Keeping People Well : Offering services that that deliver the improvements in population health that our citizens are entitled to expect.	
Financial impact : none	
Quality, Safety, Patient Experience impact : the detail outlined in this paper reflects the ongoing work to assure quality of care delivery	
Health and Care Standard Number 3.1 – Safe and clinically effective care 6.1 - Planning care to promote independence	
CRAF Reference Number 5.1 – Effective and efficient care 2.1 – Failure to embed a commissioning approach to ensure services are based on evidence and population needs to include the quality of commissioned care 2.5 - Have robust governance/SLA arrangements in place (including quality standards) with all external service providers 8.1.3 - Compliance with Mental Capacity Act and consent policies	
Equality and Health Impact Assessment Completed: Not applicable.	

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Ongoing work to progress the integration and governance of Learning Disability Services

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the progress made against the joint Care and Social services Inspectorate Wales and Health Care Inspectorate Wales Improvement Plan.

SITUATION

The purpose of this paper is to report to the Committee the progress made around the joint Care and Social services Inspectorate Wales (CSSIW) and Health Care Inspectorate Wales (HIW) improvement plan and to report the progress made in implementing the 1000 Lives, Improving Hospital care of Patients Who Have a Learning Disability (LD) care bundle.

BACKGROUND

A Confidential Inquiry into premature deaths of people with learning disabilities in England (CIPOLD 2013) was commissioned to provide evidence about contributory factors to avoidable and premature deaths in this population; it established that 22% of people with a learning disability were younger than 50 when they died and the median age of death for both male and female individuals with a learning disability was significantly lower than the general population. A number of recommendations were identified in the government response to the inquiry. The report can be accessed [here](#).

The recommendations include:

- The clear identification of people with learning disabilities in all health care record systems.
- Ensuring that people with a learning disability have access to the same investigations and treatments as the rest of the population but recognising that these assessments might need to be delivered differently to get the same outcomes.
- Standardisation of annual health checks with resulting health action plans.
- Improved systems in place nationally for the collection of standardised mortality data about people with a learning disability.

In 2014 the 1000 Lives, Improving Hospital Care of Patients Who Have a Learning Disability was launched detailing a care bundle to ensure effective care of patients with a learning disability in hospital. The paper can be accessed [here](#).

In December 2015 NHS England published the Independent Review of Deaths of People with a Learning Disability or Mental Health Problem in Contact with Southern Health NHS Foundation Trust April 2011 to March 2015. It was established that there had been inadequate investigation and reporting of unexpected deaths and as a result missed opportunities for learning. This report can be accessed [here](#).

In 2015-16 HIW undertook a thematic review of NHS health services for people with learning disabilities in Wales. It completed announced inspections to seven community learning disability health teams (one in each health board area) and unannounced inspections to 25 specialised NHS residential services for people with learning disabilities. The report can be accessed [here](#).

ASSESSMENT

Secondary Care

As a result of 1000 Lives, "Improving Hospital Care of Patients Who Have a Learning Disability," significant work has been undertaken within the UHB to align our processes with the care bundle.

A multi-agency, multi-professional working group was reconvened in 2016 to finalise the 2014-15 work stream. The Cardiff and Vale LD health register has been uploaded to

Patient Management Software (PMS), Clinical Workstation (CWS) and Emergency Unit Work Station (EUWS) IT systems. This has allowed a specially designed icon to be displayed on these systems whenever an individual on the register becomes a service user. Work is in progress to upload patients on the Local Authority LD register to ensure that there is a comprehensive list of patients so that their LD diagnosis is immediately recognised when they present to the UHB for health care. This is particularly important given the known “late presentation” of patients with learning disability to emergency services, and the well documented under-reporting of symptoms and difficulties in communicating health needs to professionals.

Figure 1 UHB Actions Aligned to 1000 Lives LD Bundle

Driver	Improvement	UHB Action
Driver 1 Effective Communication with Patients, Carers, Family Members and Clinicians	Notify next of kin and /or primary carer on admission	- Automatic flagging of all patients with a Learning Disability using a dedicated Icon on CWS PMS EUWS. This information has been accessed from the Health team LD register. Permission has been gained to include individuals from the Local Authority LD register however work is ongoing to overcome the problem of many of these individuals not having hospital numbers. - Passport requested on admission, if the patient attends without it a new passport is completed in hospital. - Contact details of LD team and Risk Assessment embedded in LD icon. Staff should ask person accompanying the patient if family/Carers have been contacted. - WAST will bring patients that they have identified as having an LD directly to UHW.
	Request Hospital Passport for the person	
	Provide person centred care	
Driver 2 Provide Person Centred Care	Patient centred plan, developed with patient primary carers and/or family, reviewed and updated	- LD immediate risk assessment and reasonable adjustments form. “Show Me Where” pain risk assessment tool. - NEWS chart amended for LD use. - Traffic Light individualised care information and plan. “Easy Read” patient feedback form and plans to seek feedback from Service users with a LD as well as their carers. - At present the named nurse will be the
	Person Centred Care Plan Communicated and shared with Ward teams	
	Named nurse identified to patient/family and other staff throughout the duration	

	of stay	nurse in charge of the wards/unit.
Driver 3 Effective Review and Discharge Planning	Full multiagency/family/carer discussion held with aim of reviewing progress and or planning discharge	Current discharge planning arrangements remain.

An extensive programme of awareness raising and education has been undertaken to ensure that staff are familiar with the Care Bundle, the assessment documentation, and that they recognise the LD icon. This has included:

- UHB wide launch of the LD bundle and recent Serious Incident learning, through UHB Grand Round.
- Specific training provided to Clinical Leads and Designated Lead managers (DLM) for Protection of Vulnerable Adults (POVA) throughout UHB.
- Brief intervention training on essential care actions delivered to frontline staff, targeting Emergency Unit and Unscheduled care areas.
- Training to Pre-registration Nurses.
- Presentation to Parents groups.

In addition an All Wales Level 1 Mental Health and LD Mortality Review is being piloted with a view to piloting a stage 2 Mental Health LD Mortality Review to provide a robust system to understand the reasons why patients have died in our care.

Primary Care

Over the years the UHB has monitored uptake and undertaken a range of work to encourage and incentivise practices and registered patients to participate in annual reviews which has included:

- Amending the Directed Enhanced Service (DES) to create a Local Enhanced Service (LES) which also incentivises and includes a fee for inviting patients to attend for their annual health check.
- Liaison with the Local Medical Committee (LMC) on review of the LES.
- Arranging LD consultants to attend and present at GP protected learning time sessions on LD specific issues and the evidence base for the LES.
- Provision of information to GP practices from the Community LD Teams.
- Working with the Community LD Teams so they chase non-attendance.
- Liaising with Community LD Teams to ensure practices are supported if required when an individual's needs may be challenging or complex.
- Community LD teams are liaising with practices who do not claim or participate in the LES to understand reasons for non-participation and to encourage participation.
- Communicating with Local Authority Teams and residential and supported housing care providers to raise their awareness and to encourage individuals to participate in the annual reviews.

- Liaison with Abertawe Bro Morgannwg Health Board (ABMU) to produce literature in accessible formats to provide to individuals encouraging participation in the health checks.
- Discussions at a cluster level as to whether practices would be willing to undertake the annual checks on behalf of practices who do not participate.

Uptake of annual reviews has increased over the years but does not capture the whole eligible population. The highest uptake of annual reviews is 65% within the UHB which is in line with national uptake.

All 67 GP practices are eligible to deliver and claim against the LES but the UHB does not receive claims every year from each participating practice.

It is difficult to assess why uptake is not higher but reasons could include:

- Remuneration versus requirements of the LES.
- Complexity and challenge that many patients constitute in attendance at GP premises.
- Reluctance and non-compliance at individual patient level.

There are limitations to aligning the DES and LES to the Local Authority LD register. Individuals receiving LD services are included on the register but those who are not in receipt of services may not be included on the Local Authority LD register. Some individuals or their carers may choose not to be included on the LD register because of concerns about stigmatisation or other reasons. As a result the list of patients who are offered an annual review is not comprehensive and introduces an additional inequity into an already vulnerable group of patients with respect to the accessibility of GMS.

It is likely that as part of the current contract renegotiations that more enhanced services including the Learning Disability Health Check will be reviewed to ensure that they remain fit for purpose and deliver against the original aims and objectives. Further work on the Local Enhanced Service has therefore been delayed until that work is completed

Continuing NHS Health Care

The Primary Community and Intermediate Care (PCIC) Clinical Board is also responsible for managing the Continuing Health Care budget for adults with a learning disability who have complex needs related to their disability and there is a band 7 and band 6 nurse team that support the commissioning, management and monitoring of individuals whose care is funded wholly or jointly via Continuing NHS Health Care and are placed either in or out of County.

For individuals in independent hospital provision there is an All Wales Framework contract and contract monitoring team in place. A framework for LD residential care has also been developed and is being taken up more slowly across Wales.

Community Services

The structure of the residential LD services was determined to facilitate the closure of the hospital setting for these residents. The funding originally passed through the Vale of Glamorgan LHB but now as part of the reconfiguration into integrated Health Boards these financial flows are passed directly to ABMU as part of their allocation. There are three components to the service provided by ABMU:

- Community Teams
- Specialist Residential Services
- Assessment and Treatment Services

Community Teams

Community Health Services consist of three multidisciplinary teams who are integrated with Local Authority teams and work across the Cardiff and Vale geographical area (Cardiff East, Cardiff West and Vale of Glamorgan). Nursing, psychiatry and some therapy staff are designated to specific areas. The teams consist of health team managers, speech and language therapists, community nurses, physiotherapists and physiotherapy technicians, occupational therapists (OT) and occupational therapy technicians, clinical psychologist, consultant psychiatrists and specialist doctors. Following restructuring in ABMU community LD services are managed via the Bridgend ABMU Locality structure. A Specialist Behaviour Team (SBT) and Specialist learning disability dieticians works across all of the Health Boards.

Specialist Residential Services

There are a range of residential services which are provided in eight individual units for people with challenging behavior, two of these units are located in Cardiff; each unit supports five service users. In addition to this, there is an eight-bedded unit for people with more complex (physical) needs who would be vulnerable within the behavioural units located in Cardiff. All units provide medium to long-term care.

Assessment and Treatment Services

Healthcare Inspectorate Wales undertook a Thematic Review of Learning Disability Services across Wales, the report was published in 2017 and can be accessed [here](#). An improvement plan was developed as a result of the report and an update of these actions is included in Appendix 1. A series of unannounced inspections of the ABMU run residential and assessment and treatment units also took place over the summer months. These included:

- Laurels and Briary Residential Unit
- Lletty Newydd Residential Unit
- Ty Penfro Residential Unit
- Rowan House Assessment and Treatment

ABMU have circulated their improvement plans for these Units, and there is an expectation that updates will be provided at the bi-monthly commissioning and performance meetings.

A potential new service model is being developed, to include use of the bungalows to support individuals with a higher level of need. ABMU will design and present a business case and implementation plan before to support the decision making processes.

The commissioning arrangements with ABMU from 2009 were less formal than desirable due to the historic establishment of the service and the financial allocation being directly to ABMU, rather than to the resident Health Board. To improve this, the following actions have been taken over the last 18 months.

1. Bi-monthly Commissioning and performance meetings have been established, attended by representatives from ABMU, Cardiff and Vale UHB and Cwm Taf Health Boards to facilitate the development of a joint understanding of the current provision and setting the future strategic direction for specialist Learning Disability services. This group has overseen;
 - The development of a service specification relating to current service model, which has been signed off by all three organisations.
 - The development of Key Performance, and Quality Indicators based on the current service specification which is currently in final draft form.
 - An agreement that the service model is currently not fit for purpose, and a first workshop to discuss options, and a plan for coproduction of planning a new service model with partners and stakeholders.
 - A provisional agreement to approach the Welsh Government to propose that the Learning Disabilities allocation will flow through Cardiff and Vale and Cwm Taf Health Boards rather than being given directly to ABMU Health Board from April 2018. The details of this are currently being worked through by the finance leads for the three organisations.
 - Data collection is in progress to assess the need of those currently in receipt of Specialist health services to inform any future re-modeling of service.
 - Commissioning of a wider health needs assessment is progressing which will form part of a wider joint assessment of need with both our Local Authorities.
 - This joint needs assessment will inform a Joint Cardiff and Vale specific Adult Learning Disabilities Commissioning Plan.
2. There is a both a strategic and operational planning structure in place for Learning Disabilities services in Cardiff and the Vale of Glamorgan. The structure has recently been reviewed, and is now overseen by the Strategic Leadership. Three work streams have been identified which continue to support joint planning:

Priority 1 - Bringing together commissioning functions to more effectively deliver non hospital based services including the development of pooled budgets and development of local based supported housing options to meet the population need and to repatriate individuals who are currently based out of County

Priority 2 – Developing an integrated approach to services

Priority 3 - To influence generic and universal services to ensure adults with learning disabilities receive suitable access and support.

A further progress update of ongoing work within secondary care, primary care and community services will be provided to the committee in twelve months reviewing the effectiveness of the ongoing work and detailing further developments.

Appendix 1

Joint CSSIW/HiW Inspection: Improvement Plan**Area:** Cardiff and Vale University Health Board / Cardiff West**Date of inspection:** 4 – 5 July 2016

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
	Understanding Need				
5	C&VUHB must ensure that people with learning disabilities receive high quality care based on best practice guidelines within both primary and secondary care. C&VUHB must ensure that they plan strategically around how to promote the health of people with learning disabilities in both primary and secondary care.	To fully implement the 1000+ lives guidance for improving general hospital care for people with Learning Disabilities.	Lead Nurse Surgical Clinical Board	July 2017 April 2017	The 1000+ lives guidance was relaunched within the Health Board in 2016/17 and a number of awareness raising events were undertaken. To improve care for people with a learning disability, the Health Board developed a number of new measures in line with the guidance to ensure people with learning disabilities receive the right level of care while they are in hospital including amended NEWS guidance. The new initiative was implemented by a multi-agency, multi-professional working group to ensure patients receive dignified, person-centred care and are discharged from hospital safely. The team worked in partnership to develop systems to identify residents with a learning disability living within Cardiff and the Vale of Glamorgan. This data is now immediately available to front line staff via the

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
					Health Board's IT systems, which will display a specially designed icon whenever an individual on the list becomes a service user. This immediate flag tells front line staff providing care to this vulnerable patient group about their needs, ensuring improved care, more effective communication and a person-centred approach. It also enables effective signposting to essential partner agencies. The Health Board was shortlisted and successful in winning a National Patient Safety ward for the work. The Learning Disability Implementation Group has a dedicated work stream to address Health Inequalities led by an ABMU Service Manager. ABMU Service Manager is working with C&V nurse taking a lead for the 1000 Lives work to undertake an analysis of the project and identify next steps and the feasibility of introducing a Liaison Nurse role. Over the years the UHB has monitored uptake and undertaken a range of work to encourage and incentivise practices and registered patients to participate in the scheme which has included:

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
		To review the Enhanced service for Annual Health Checks with a view to improving and incentivising engagement of primary care and uptake for 2017/18.	Head of Primary Care, PCIC		• Amending the Designated Enhanced Services to create a Local Enhanced Service (LES) which also incentivises and includes a fee for inviting patients to attend for their health check. • Liaison with the LMC on review of the LES. • Arranging LD consultants to attend and present at GP protected learning time sessions on LD specific issues and the evidence base for the LES. • Provision of information to GP practices from the Community Learning Disability Teams. • Highlighting invites to the Community LD Teams so they chase non-attendance. • Liaising with Community Learning Disability Teams to ensure practices are supported if required when an individual's needs may be challenging or complex. • Community LD teams liaising with practices who do not claim or participate to understand reasons for declining and encourage participation. • Liaison with Local Authority Teams and residential and supported housing care providers to raise their awareness and encouragement of individuals to participate in the scheme. • Liaison with ABMU to produce literature in accessible formats to provide to individuals encouraging participation in the health checks.

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017																				
					- Discussions at a cluster level as to whether practices would be willing to undertake the annual checks on behalf of practices who do not participate. Uptake of the scheme whilst it has increased over the years does not capture the whole eligible population with 65% being the highest achieved although this is higher or equitable with uptake in other Health Board areas across Wales. All 67 GP practices are eligible to deliver and claim against the LES but the UHB does not receive claims every year from each participating practice <table><tr><td></td><td>2012/ 13</td><td>2013/ 14</td><td>2014/ 15</td><td>2015/ 16</td></tr><tr><td>Invite</td><td>200</td><td>289</td><td>390</td><td>446</td></tr><tr><td>Check</td><td>768</td><td>720</td><td>824</td><td>819</td></tr><tr><td>% of pop</td><td>57</td><td>53</td><td>65</td><td>56</td></tr></table> It is difficult to assess why uptake is not higher but they could include: - Remuneration versus requirements of the LES - Complexity and challenge that many patients constitute in attendance at GP premises - Reluctance and non-compliance at individual		2012/ 13	2013/ 14	2014/ 15	2015/ 16	Invite	200	289	390	446	Check	768	720	824	819	% of pop	57	53	65	56
	2012/ 13	2013/ 14	2014/ 15	2015/ 16																					
Invite	200	289	390	446																					
Check	768	720	824	819																					
% of pop	57	53	65	56																					

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
					patient level An issue that comes up consistently from practices and feedback from other partners is the limitation of both the original DES and the UHB LES to individuals who are on the Local Authority LD register. Whilst the majority of individuals receiving services would be on the register those who do not may not be. They and their carers may also chose not to be included on the LD register for other reasons e.g. feeling of stigmatisation. Therefore the number of individuals potentially accessing the service is reduced and it also introduces an additional inequity into an already challenging group pf patients with respect to the accessibility of GMS. It is likely that as part of the current contract renegotiations which are only just starting that more enhanced services including the Learning Disability Health check will be reviewed to ensure that they remain fit for purpose and deliver against the original aims and objectives. This action has therefore been delayed until that work is completed.
5	C&VUHB and ABMUHB should consider whether there is a need for earlier	Review of current arrangements and development of an	Director of Nursing, PCIC and	January 2017	Work is being supported and reported through ICF funding stream.

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
	involvement from health services in transition planning.	agreed transitions protocol across statutory partners: - Multiagency Task and finish group to be convened to review current arrangements and protocol. - Development/ agreement of partnership transition protocol. - Multi Agency Transition Review Interface Group (TRIG) implemented for those most vulnerable and in need of continued care and support. - Multiagency mechanisms to identify all young people at transition age including those	Service Manager for LD, ABMU Service Manager Cardiff and Vale Local Authority/ Service Manager ABMU	April 2017 April 2017 April 2017 July 2017	Progress: A Transitions Project Group was established on 7th June 2017 to agree a regional transition protocol and Cardiff structure. The project aims to create a regional transition protocol that is formally agreed by Cardiff Council (CC), the Vale of Glamorgan Council (VoG) and Cardiff and Vale University Health Board (C&V UHB). This will help ensure that individuals transitioning from Children's to Adult Services experience a well co-ordinated, timely and efficient transition, which ensures and promotes consistency and equity for citizens across the region. A TRIG group is set up within the Vale and in Cardiff the Community LD Team have refined processes with LA colleagues and there is an identified transition group which meets bi-monthly. Successful additional funding through the Integrated Care Fund, to support the development of regionalised service delivery, has allocated £104,000 to Transitions for 2017/18. This will be used to support additional transition workers within the existing Adult Learning Disabilities transition team in Cardiff and the development of transition services across the ages and the region.

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
		who do not require care and support from statutory services. implemented - Evaluation methods that capture the transition experience of young people who receive statutory support developed. - Information developed in line with new joint processes is available for those going through statutory support services.			Workshops took place with all relevant stakeholders on 3rd, 10th and 13th July and 3rd of August 2017. Feedback from these workshops will be used to develop an options appraisal for a regional protocol. The project brief was considered at the 'Disabilities Futures' Programme Board on 3rd July 2017 and the options appraisal will be considered on 4th September 2017.
5	The Health Board must ensure that future planning of service provision takes account of the challenges highlighted through this inspection, specifically:	Progress the population based needs assessment to inform strategic planning: Progress provision of commissioning	Representatives on Commissioning Board from both Cardiff and Vale and	December	A Regional Commissioning Group has been established with representation from ABMU, C&V and Cwm Taf Health Board. A Task and Finish Group has been established to focus on: Finance

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
	Services for people with challenging/complex behaviour	information from ABMU. - Analysis of need of current residents to be provided by ABMU. - Work with local Public Health Team to assess likely impact of population change. - Work with local authorities to identify need in local population. - Work with Community Child Health to improve activity around transition and identifying future need.	ABMU Health Boards	2017 March 2017 March 2017 March 2017 March 2017	- Performance and Quality Measures - Service Specification - Needs Assessment As of August 2017: - The current service model/specification has been described - Financial information is being worked through - Draft quality indicators and a performance score card have been developed and will be implemented imminently - A needs assessment and review of individuals within the long stay NHS facilities and placed out of county is underway to inform future commissioning and planning Work has not progressed at as fast a pace as would be desirable for a number of reasons and fresh impetus is being introduced into the work. Potential realignment of the Health Board footprints between Cwm Taf and ABMU may impact on this work. The principles of the Cwm Taf Statement of

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
					Strategic Intent for Children, Young People and adults with Learning disabilities (including autism and complex needs) and their families, have recently been adopted by ABMU and their local authorities. This is being presented to the September 2017, SLG so that Cardiff and Vale UHB and its local authorities also consider signing up to the principles outlined. A Learning Disabilities Governance Structure has been drafted for Cardiff and Vale UHB. This is also being presented to the September 2017 Strategic Leadership Group (SLG) for discussion and approval
Care and Support					
8	ABMUHB must ensure that people with learning disabilities have access to timely care. The Health Board should review our findings in relation to nursing, psychology and hydrotherapy and consider how to improve access and waiting times.	ABMU to review findings and to provide an update and recommendations to the LD Operational and Commissioning Groups: Review of current access times for nursing psychology and hydrotherapy.	Representatives on Commissioning Board from both Cardiff and Vale and ABMU Health Boards Service Manager,	April 2017 December 2017	Waiting times for nursing and psychology have reduced through a number of measures including: • Validation of caseloads to ensure the team are working with those most in need. • Reaffirmation of areas of core business at point of referral. • Offering a number of alternative options such as group work, advice and signposting, • Passing on of skills to providers.

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
		Agreement of regular reporting mechanism on access and waiting times and KPI's to LD Operational Group and Strategic Commissioning Group.	ABMU Representatives on Commissioning Board from both Cardiff and Vale and ABMU Health Boards	January 2017	Draft Key Performance and Quality Indicators have been developed via the Commissioning Group and a regular reporting schedule through the C&V Health Board governance structures is to be agreed.
8	C&VUHB must ensure that there is a clear process in place to allow them oversight of safeguarding referrals for learning disability services.	C&VUHB Safeguarding Lead to liaise with Safeguarding Lead for Learning Disabilities in ABMU to establish and implement a process for ensuring oversight of referrals: C&V and ABMU Safeguarding Leads to meet and agree: Flow chart for communication in	Safeguarding Lead C&V	Jan 2017	A meeting has been held between Safeguarding Leads and better communication flow is in place. Further work is required to formalise reporting arrangements in relation to Safeguarding referrals.

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
		relation to POVA referrals of Cardiff and Vale residents and escalating concerns in relation to ABMU units within the health Board boundary Quarterly reporting mechanism to the Cardiff and Vale Safeguarding Committee.			
8	Both Health Boards should ensure that staff on the frontline feel connected and engaged with the Health Boards' vision by improving communication and information flow. Specifically, Health Boards should ensure that the Cardiff locality health teams are given as much information as	The ABMU Mental Health and Learning Disability Service Delivery Unit held an engagement event on 12th February 2016. Workforce engagement is central to the Delivery Units IMTP and as the service moves through organisational change consideration will be given to how staff	Unit Director Mental Health and LD ABMU Unit Director Mental Health and LD ABMU,	Complete Complete	The ABMU MH and LD management restructuring is now complete. The Cardiff Community LD Teams are now part of the Bridgend Locality within the MH and LD Delivery Unit of ABMU Health Board. The Management Triumvirate for this locality is now in place since Nov 2016 and all members of the Cardiff community LD teams are aware of the structures in place and processes for communication within the Locality.

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
	possible about the ABMUHB restructure, vision and how it is likely to affect services.	engagement continues and is enhanced ABMU have put in place monthly team briefs to inform and update staff and discuss any concerns. Due to recent Welsh Government announcement regarding potential Health Board Boundary changes between ABMU and Cwm Taf Health Boards the MH and LD Delivery Unit are commencing additional monthly team briefs within the Bridgend Locality to update staff on potential changes. The Bridgend Locality Senior management	Locality Manager for MH and LD services within Bridgend Locality Manager for MH and LD services within Bridgend Locality Locality Manager for MH and LD services within Bridgend Locality	In place and embedded as part of routine monthly practice In place Completed Nov 2016	First Locality Team Brief is planned for 11th Sept 2017. These will be ongoing for the duration of the consultation process and then reviewed. First visit to the Cardiff LD teams took place in July 2017. This will be an ongoing rolling program.

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
		Team have commenced “walk abouts” it all of it community teams including LD Teams to improve access for frontline staff to senior managers within the service. The Locality Manager responsible for Community LD services has now been appointed through the organisational change process and will commence a programme of engagement with staff. Fortnightly meetings with Service Managers for MH and LD services within the Bridgend Locality have been put in place by Locality		Completed Jan 2017 Completed Nov 2016	The Bridgend Locality inputs into the MH and LD Delivery Unit senior management team who in turn are representatives on the Joint Commissioning Group forum between Cardiff and Vale, Cwm Taf and ABMU Health Boards where ABMU can report on their strategic intentions/vision. ABMU have been undertaking a review of the role and function of the current provision of Specialist Residential Inpatient Units and Assessment and Treatment Units. A cross health board workshop is planned for the 21st September to present the findings and vision for transforming specialist LD services/care.

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
		Manager as part of management of services and further communication with individuals from these meetings. Regular e-mail updates are circulated and cascaded to staff and there is a specific intranet page to update and inform all staff of progress in organisational change.			
	Leadership and Governance				
11	C&VUHB must ensure that they plan resources and manage performance and value for money for learning disability services. Specifically,	Health Board commissioning Group to establish: A Financial framework for LD services including Corporate overheads	Representatives on Commissioning Board from both Cardiff and	Dec 2017	See above response to action 5.

Page	Improvement Needed	Health Board Action	Responsible Officer	Timescale	Progress update August 2017
	both health boards should ensure they are gathering relevant data and information with a view to planning service provision that can clearly demonstrate how it is meeting the needs of the current learning disability population. ABMU must ensure they share commissioning data with Cardiff and Vale UHB in order to move this process further.	Directorate overheads Costs for bungalows and direct services Description of current service delivery High level service specification Outline Service Level Agreement and KPIs with ABMU ABMU to provide commissioning data to inform the above work.	Vale and ABMU Health Boards	October 2017	
11	Both Health Boards must ensure that they engage and work with the local authority on a strategic level to plan services and promote joint working.	Commissioning Group to review and develop a Framework for interaction with Local Authorities	Head of Outcomes based Commissioning, C&V	April 2017	A revised governance structure for adult learning disabilities planning and commissioning has been drafted and is awaiting sign off by the Strategic Partnership Group, before ratification by the Senior Leadership Group.

REMOVAL OF 'STATUTORY' SUPERVISION OF MIDWIVES AND A NEW MODEL FOR WALES	
Name of Meeting :	Quality, Safety and Experience Committee
Date of Meeting	6 th December 2017
Executive Lead :	Executive Nurse Director
Author :	Head of Midwifery 02920743681
Caring for People, Keeping People Well :	Avoiding waste, variation and harm and delivering outcomes that matter to people.
Financial impact :	Total capital funding for the Neonatal Unit to date is £45.563m. A business case has been submitted to WG to secure revenue for staffing in line with the South Wales Plan. Investment in the Infection, prevention and control team is recommended within the report and will also need to be considered.
Quality, Safety, Patient Experience impact :	The outbreaks had a significant impact on the quality, safety and experience of neonates and their parents. However the development of the new Neonatal Unit, improvement in staffing levels and a renewed focus on infection, prevention and control practice will mitigate many of the issues that contributed to the outbreaks in 2015.
Health and Care Standard Number	Standard 2.4
CRAF Reference Number	5.1
Equality and Health Impact Assessment Completed:	No

ASSURANCE AND RECOMMENDATION
ASSURANCE is provided by: - The development and ongoing monitoring of a robust improvement plan to address the recommendations made as result of the Independent Review The Quality, Safety and Experience Committee is asked to: NOTE the progress made in implementing the recommendations in the Improvement Plan

SITUATION

As a consequence of investigations into maternity services at Morecambe Bay NHS Foundation Trust, the Parliamentary and Health Ombudsman (PHSO 2013) recommended that midwifery supervision and regulation be separated and that the Nursing and Midwifery Council (NMC) should be in direct control of regulatory activity. Findings from the PHSO report found that the current system of statutory supervision of midwives operates in such a way that risks

failure to learn from mistakes which cannot be in the interests of the safety of mothers and babies.

Welsh Government expects the NHS in Wales to take action to deliver maternity services which place the needs of the mother and family at the centre so that pregnancy and childbirth is a safe and positive experience where women are treated with dignity and respect. In order to realise this vision, maternity services are expected to employ a highly trained workforce able to deliver high quality, safe and effective services which are constantly reviewed and improved (2011).

BACKGROUND

Following publication of the PHSO (2013) recommendations, the NMC commissioned the King's Fund to review statutory supervision in the UK which supported the recommendation that statutory supervision should end. Although the Parliamentary and Health Service Ombudsman reflected on just one NHS Foundation Trust, findings informed the Local Supervising Authority in Wales to review and radically reform the way in which supervision worked, in particular to ensure that the supervisory and regulatory roles were made distinct and separate.

A new 'Future Proofing' model for statutory supervision of midwives in Wales was developed by the Local Supervising Authority (LSA), Directors of Nursing, Heads of Midwifery, Nursing and Midwifery Council (NMC), Welsh Government, the Royal College of Midwives and involved clinicians and service user representatives. The vision within the new model was to provide a more efficient and proactive management of investigations by external supervisors to reduce bias and ensure timely remedial support for midwives.

The overarching purpose of change was to improve the quality of statutory supervision in Wales through the appointment of full time supervisors of midwives on a rotational 18 month cycle with support from two full time local supervising authority midwifery officers. Being dedicated to supervision meant that supervisors of midwives were able to increase their visibility and accessibility to midwives and service users. The future proofing model was implemented in the summer of 2014.

This previously successful change has supported the development of a new model for clinical supervision for midwives post removal from statute. CNOs from all 4 countries have signed up to ensuring that clinical supervision for midwives will remain across the UK and are working together to ensure there is 'synergie' amongst the four nations.

ASSESSMENT AND ASSURANCE

Ending statutory supervision will require legislative change which is being led by UK Government through amendments to the Section 60 Order. Following publication of the proposed changes via the Department of Health Consultation, the Order was laid before Parliament in January and debated in

both Houses at the end of February 2017. Following discussion with the Privy Council in March, Statutory supervision of midwifery ended on 31.3.17

A taskforce was convened in each UK country to explore opportunities for change and embed the agreed principles to support the availability of good professional support and development for all midwives. Whilst accepting the need to separate supervision and regulation, the UK Chief Nursing Officers are committed to support the development of a new model of clinical supervision for midwives and have agreed a set of principles on which to develop an employer led, professional model of clinical supervision for all midwives including those in roles such as education or policy.

In December 2016, Nurse Directors in Wales and the Cabinet Secretary approved a new model for clinical supervision for midwives in Wales. A role profile and job description has been developed and has been sent for Job Matching across all Health Boards in Wales. HEIs have confirmed that there are modules in place to support training and development of new clinical supervisors of midwives training and ongoing continuous professional development will be financially supported by Welsh Government.

Supervisors of Midwives from the statutory model of supervision remained in post until the new model of clinical supervision for midwives within Cardiff and Vale University Health Board was implemented. Recruitment of clinical supervisors for midwives took place in April 2017 with three midwives beginning their posts to introduce the new model of supervision in June 2017.

**Improvement Plan**

Datix ref/ WG SI reference:

Executive Directors responsible:

Date agreed:

Approved by: to be approved at Quality Safety and Experience Committee on 20-06-17

Monitoring arrangements: Quality Safety and Experience Committee

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
1	Impact and outcomes of the role will be monitored through Key Performance Indicators (KPIs).	KPIs will be reported annually in order to provide assurances through health board's quality and safety structures to the Chief Nurse / Director of Nursing that clinical supervision for midwives is being	Head of Midwifery / Lead Directorate Nurse Director of Nursing Children and Women	Interim Report November 2017	Interim report compiled by Clinical Supervisors for Midwives. First Annual Report Due 1 st June 2018.	Interim Report presented to Director of Nursing Children & Women Clinical Board and Executive Nurse Director at Professional Performance Review on 23 rd November 2017

November 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
		carried out to its full potential and that objectives are being met. Assurances will be provided to Welsh Government through existing Maternity Performance Boards on an annual basis.	Head of Midwifery / Lead Directorate Nurse Director of Nursing Children and Women Executive Nurse Director	First Annual Report due June 2018		Report shared at Welsh Government Maternity Performance Board 23.11.17
2	Governance and Reporting Arrangements	That there is a clear governance framework for reporting and sharing Clinical Supervision for Midwives activities within the Health Board	Head of Midwifery / Lead Directorate Nurse Director of Nursing Children and Women Executive Nurse Director	June 2017	The structure will report to:- - Clinical Board and Corporate Nursing and Midwifery Board - Directorate and Clinical Board Quality and Safety Forums - Annual Report via Quality and Safety Executive - Professional Performance Meetings	Completed

November 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
					with HoM/DoN/END Annual Performance Board at Welsh Government	
3	KPI 1 Resource Mapping -	Health Boards can demonstrate through the Annual Operating and Integrated Medium Term Plan that clinical supervision for midwives is being planned for the future as part of the Organisation's core business.	Head of Midwifery / Lead Directorate Nurse Director of Nursing Children and Women Executive Nurse Director	June 2018	Clinical Supervision for Midwives has been included within the Children and Women's Clinical Board's IMTP for 2018. CPD / Training has also been included to ensure that funding is secured via the Office of the Chief Nursing Officer at Welsh Government	IMTP updated and returned to Clinical Board November 2017.
4	KPI 2 Continuous Professional Development	Health Boards can demonstrate that the clinical supervisor for midwives has attended 3 of 4 CPD learning events each year and can provide evidence of learning	Head of Midwifery / Lead Directorate Nurse Clinical Supervisors for Midwives	Next Meeting Planned for 18 th January 2018	The dates have been set for the upcoming year, with various CPD activities and learning that benefit the whole team.	All three CSfM attended the inaugural event held in Cardiff on 7 th September 2017 of the All Wales Clinical Supervisors for Midwives Forum. Arrangements with Welsh Government /

November 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
						Cardiff University are in place to enable all CSfMs to complete leadership module in the New Year 2018
5	KPI 3 Clinical Supervision for Midwives	Health Boards can demonstrate annually that the mandated number of hours for both group and one to one supervision has been undertaken by all midwives that are employed in the Health Boards	Head of Midwifery / Lead Directorate Nurse Director of Nursing Children and Women Executive Nurse Director	June 2018	From January 2018, Cardiff and Vale Maternity Services will be re-structuring their mandatory study days to include a joint Governance Team session with the Risk Manager and the Concerns Manager. This combined governance team approach will make it easier for midwives to meet the mandatory four hours of supervision. Midwives will in addition be able to access one-to-one sessions with the CSfM should they wish to for support and development with clinical practice and also support with restorative work. To evidence compliance midwives must demonstrate meeting the mandatory element of four hour of clinical	88 midwives have attended group supervision, (however as we do not have access to the LSA database we no longer have a record of when midwives attended group supervision sessions prior to the new model between April and May) 21 midwives are compliant with the mandatory four hours of supervision.

November 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
					supervision to their line manager during their PADR.	
6	KPI 4 Newly qualified / Preceptorship Midwives	Health Boards can demonstrate that all newly qualified / preceptorship midwives have met with their named clinical supervisor for midwives on 3 occasions during their first year following employment / registration	Head of Midwifery / Lead Directorate Nurse Clinical Supervisors for Midwives	June 2018	The cohort of newly qualified / preceptor midwives who commenced employment in the Autumn of 2016 have all had at least 3 contacts with the CSfM team. It is clearly defined in the new midwives induction pack what their requirements are in relation to supervision for midwives, the role of the CSfM and how to contact them. CSfM have an open door policy and are very visible in the clinical area to offer support to midwives. Time has been set aside to work clinically with the new midwives as they come out of the supernumerary period.	The CSfM Team have met the 2017 cohort on 25 th October as part of their induction week and have already made plans to fulfil the KPI requirement during the rest of the first year of employment.
7	KPI 5 Identifying & Learning from Themes and Trends	Health Boards can demonstrate that any themes or trends identified through risk management / clinical governance / audit /	Head of Midwifery / Lead Directorate Nurse Clinical	June 2018	A monthly list of Themes and Trends from risk management activities and meetings are collated by the CSfM team, Risk Manager and Concerns Midwife and is then disseminated widely,	Evaluation forms collected through Group Supervision demonstrate that midwives find this very useful in keeping

November 2017

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion	Update November 2017
		clinical supervision processes are acted upon and there is evidence of learning	Supervisors for Midwives Risk / Governance Midwife		through email, newsletter, noticeboards, closed staff Facebook group, verbally at tabletop activities and during mandatory study days and group supervision sessions.	them up to date in their own and other clinical areas
8	KPI 6 Peer Review	Health Boards can demonstrate evidence that peer review of clinical supervision for midwives is undertaken across Health Boards annually and that a lay reviewer is included as part of the review team	Clinical Supervisors for Midwives Head of Midwifery / Lead Directorate Nurse MSLC Lay Person	June 2018	The All Wales implementation group are working through the logistics of how the review will take place. A key set of principles will be developed to ensure that a consistent approach is embedded across Wales.	Welsh Government to confirm dates of next implementation meeting

November 2017



**CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD
QUALITY SAFETY AND EXPERIENCE SUB-COMMITTEE**

MINUTES OF THE MEETING HELD ON 9th AUGUST 2017

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Mike Bourne	Clinical Board Director
Stuart Egan	Independent Member
Sarah Jones	Pharmacy Quality and Safety Lead
Rebecca Pettit	Medical Physics Quality and Safety Lead
Robert Bracchi	Consultant, Toxicology and Therapeutics Directorate
Christopher Tetley	On behalf of Bolette Jones, Media Resources
Suzie Cheesman	Patient Safety Facilitator
Sue Dayananda	Head of Podiatry
Sian Hewson	CT Superintendent, Radiology

Apologies:

Matthew Temby	Clinical Board Director of Operations
Lisa Griffiths	Quality Manager, Laboratory Medicine
David Lewis	Head of Finance
Rachael Daniel	Health and Safety Adviser
Maria Jones	Senior Nurse, Outpatients
Alun Morgan	Professional Lead for Quality, Safety and Experience/ Assistant Director of Therapies and Health Sciences
Ceri-Ann Hughes	Head of Workforce and OD
Rhodri John	Assistant Head of Workforce and OD
Bolette Jones	Acting Head of Media Resources
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Darrell Baker	Service Director, Pharmacy
Vicky Cummings	Haematology Quality Manager
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELIMINARIES

CDTQSE 17/275 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting and introductions were made.

CDTQSE 17/276 Apologies for Absence

Apologies for absence were **NOTED**.

CDTQSE 17/277 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 12th July 2017 were **APPROVED**.

CDTQSE 17/278 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 17/118 Terms of Reference

The terms of reference for the Clinical Board Quality and Safety Sub-Committee were presented to the Clinical Board Meeting and were **APPROVED**.

CDTQSE 17/238 Foot Assessment

The foot assessment tool was presented to the Nursing and Midwifery Board on 3rd August and the proposal for this to be included in the integrated assessment proforma was rejected. The outcome was for the foot assessment to be discussed again at the Clinical Standards Innovation Group for further review. Mike Bourne asked Sue Dayananda to write him a briefing on the reasons why the foot assessment is being rejected.

Action: Sue Dayananda

An appointment will then be requested with Ruth Walker to discuss this further.

Action: Mike Bourne/Sue Dayananda*CDTQSE 17/243 Clinical Board Identity Campaign*

Further to discussions held at the last meeting, the Clinical Board has given thought to taking forward an identity campaign to raise the profile of its staff and services. Part of this work is in development with Media Resources to create a logo for the Clinical Diagnostics and Therapeutics Clinical Board that can be used on email signatures, lanyards and screen savers etc.

CDTQSE 178/245 Compliment

Rebecca Vaughan-Roberts to seek permission from the parents of an 11 year old who wrote a compliment to Radiology, for this to be shared in the Clinical Board Newsletter.

Action: Rebecca Vaughan-Roberts

CDTQSE 17/257 Big Room

It was noted that Surgery Clinical Board presented their IP&C data at Big Room and explained how they are going to enforce Bare Below the Elbow. Medicine Clinical Board will be presenting at the next meeting. A poster has been produced by Surgery Clinical Board that could be used UHB wide. Mike Bourne will ask Media Resources to improve the graphic design, laminate the poster and print out on A1.

Action: Mike Bourne/Bolette Jones*CDT QSE 17/257 Lung Nodule Follow up*

Sue Bailey to ensure that the Lung Nodule Follow Up recommendations are distributed across the UHB

Action: Sue Bailey

Mike Bourne to present the recommendations to the LMC.

Action: Mike Bourne

Sue Bailey to ask Sue Morgan how this can be placed as an agenda item.

Action: Sue Bailey*CDTQSE 17/272 Plumbed Water Cooler at CRI*

Maria Jones has made a request for a plumbed water cooler at the CRI and is waiting for a company to undertake a visit. Charitable funds are being explored as an option for funding. Space in the waiting area in Outpatients CRI is limited and is the main reason why a water cooler has not previously been plumbed in into this area in the past.

Workplace Inspection at Medical Records UHW

Matt Temby and Stuart Egan have arranged a date to meet to discuss the issues from the inspection.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY**CDTQSE 17/279 Patient Story**

There was no patient story presented at today's meeting.

CDTQSE 17/280 Feedback from UHB QSE Committee

The minutes of the meeting held in June are not yet available.

CDTQSE 17/281 Health and Care Standards

Nothing to report.

CDTQSE 17/282 Risk Register

The Risk Register Workshop has been rearranged for 27th September.

CDTQSE 17/283 Exception Reports**Risk Assessment Central Line Attachment to Power Injectors**

Sian Hewson reported that following an incident in another Health Board, there were concerns that there was no suitable procedure in place in Radiology. In 2004 MHRA guidance was issued for pressure injectors for CVCs. This was withdrawn and no clear guidance has been reissued.

A risk assessment was undertaken in the department against the connection of high pressure injector to non compatible central lines for the introduction of contrast agents during CT scanning. There is a risk of extravasation of large volumes of contrast agents into the mediastinum with unknown consequences to health. The control measures to reduce the risk recommends that no high pressure injectors are to be attached to a central line unless it is specified as CT compatible. The risk assessment indicated that the likelihood is low but the catastrophic risk is high. It is therefore recommended that the UHB should purchase central lines which can all be connected to power injectors however this will incur a cost.

Mike Bourne agreed that patients and staff cannot be put at risk and the decision was **AGREED** that in the short term catheters should not be used that are not specifically recommended by the MHRA. It needs to be ensured that Radiology staff are not coerced into using non compliant central lines for connection to pressure injections. In the interim what is safe and not safe to go through these lines should be verified and checked. Clinical Engineering may be able to provide assistance. Sue Bailey will ask Claire Salisbury in Procurement who is responsible for purchasing central lines in the UHB.

Action: Sue Bailey

HEALTH PROMOTION PROTECTION AND IMPROVEMENT**CDTQSE 17/284 Initiatives to promote Health and Wellbeing****Hepatitis B vaccination in adults and children: temporary recommendations**

There is a global shortage of the hepatitis A and B vaccinations and the Public Health England temporary recommendations were **RECEIVED** and **NOTED**.

CDTQSE 17/285 Falls Prevention

Nothing to report.

SAFE CARE

CDTQSE 17/286 Concerns and Compliments Report

The Clinical Board received 2 formal concerns in July. Both concerns related to Radiology.

In July, there were 0 breaches in response times and the Clinical Board is reporting a total of 6 breaches since 1st April 2017.

3 AM concerns were received in July; 1 in Radiology and 2 in Podiatry. There have been 5 AM concerns since 1st April 2017.

The Clinical Board received 10 compliments in July.

Since 1st April 2017 the Clinical is reporting 20 formal concerns and 29 compliments.

The key theme for formal concerns relates to concerns with clinical diagnosis and treatment.

CDTQSE 17/287 Ombudsman Reports

Nothing to report.

CDTQSE 17/288 RCA/Improvement plans for Serious Complaints

In45450 IRMER incident occurred in the Stroke Rehabilitation Centre where the wrong patient addressograph was placed on a CT request form, resulting in a patient having a CT scan in error.

A number of actions have been completed:

- Practitioner reminded of ID Policy.
- Information shared with ward team to highlight concerns with poorly stored paper work. The team have increased the number of ward trolleys and purchased larger binder files to store current paperwork and notes securely.
- It was recommended that this incident was shared with this Clinical Board.

The report has been submitted to HIW.

CDTQSE 17/289 Patient Safety Incidents

Serious Incident Report

The Clinical Board is reporting 2 serious incidents:

In20895 Lupus incident – awaiting update from Cwm Taf in regards to whether there was any patient harm.

In51047 – a new incident involving a misidentification error in Cellular Pathology.

Ian McMullin was Datix Super User for the Clinical Board but he has now left the Health Board. The Clinical Board is seeking nominations for a replacement.

DTQSE 17/290 New SI's

In51047 – new incident relating to an identification error.

CDTQSE 17/291 RCA/Improvement Plans

The RCAs for In44505 and In45565 were **RECEIVED**. The 2 incidents relate to unexpected radiological findings and communication of the findings between Radiology department and Emergency Unit. It was noted that the Clinical Board is undertaking work in the absence of an electronic integrated results solution, to alert referrers to reports that have significant findings. Surgery Clinical Board has offered to pilot this.

CDTQSE 17/292 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 17/293 Regulation 28 Reports

Nothing to report.

CDTQSE 17/294 Patient Safety Alerts

Internal Safety Notice 001 – Consent Legibility

The Internal Safety Notice was **RECEIVED** and **NOTED**. The alert was produced following a Never Event where a patient who was undergoing a surgical procedure had a wrong site surgery undertaken as a consent form was illegible and difficult to decipher.

CDTQSE 17/295 Addressing Compliance Issues with Historical Alerts

Achieving Compliance with PSN025

A Safe Practice Reminder was **RECEIVED** in relation to the risk of inadvertently injecting skin preparation solution during medical procedures.

It was noted that the proposed actions have been implemented within Radiology.

CDTQSE 17/296 IP&C Issues

Maria Jones has agreed to take on the role of Clinical Board Flu Champion again this year.

A meeting has been arranged at the end of August to agree a strategy for this year's campaign. Volunteers are being sought across the Clinical Board to be trained as Flu Champions, particularly at UHL. It was noted that the Welsh Government target for front line staff this year is 60%.

CDTQSE 17/297 Key Patient Safety Risks**Safeguarding**

The last UHB Safeguarding Group was held on 19th July. It was reported that 2 safeguarding cases have been reported in this Clinical Board.

Female Genital Mutilation (FGM) is reportable under the Serious Crimes Act 2015. It is proposed for an AGM clinical to be provided weekly from September. A flow chart for referrals is currently being reviewed.

It is expected that there will be 100% training compliance by March 2018 for domestic abuse violence against women.

Mental Capacity Issues

Mental Capacity Act training is now mandatory and staff are to be encouraged to undertake the training.

CDTQSE 17/298 Health and Safety Issues

Nothing to report.

CDTQSE 17/299 Regulatory Compliance and Accreditation

The Human Tissue Authority is inspecting the mortuary today.

Notification has been received that HIW will be undertaking an IRMER inspection of Cardiology in October. The Clinical Board will support Specialist Services with this visit.

CDTQSE 17/300 Policies, Procedures and Guidance**WHC 2017 034 Policy on the Management of Point of Care Testing**

Sue Bailey will ask for an update from POCT on progress against the standards. To be discussed at the next meeting.

Action: Sue Bailey**WHC 2017 036 Guide to Consent for Examination or Treatment**

Notification has been received that revised guidance has been produced. The guidance will be presented to the Medical Directors' Group for approval and will be issued in due course.

WHC 2017 029 All Wales Guidelines for the Management of Devastating Brain Injury

The All Wales Guidelines were **RECEIVED**.

Management of Ovarian and Other Adnexal Cysts Imaged on Ultrasound

A protocol for reporting was **RECEIVED**. Sue Bailey will discuss further with the Radiology service outside of the meeting.

Action: Sue Bailey

EFFECTIVE CARE

CDTQSE 17/301 Clinical Audit

Nothing to report.

CDTQSE 17/302 Research and Development

The Clinical Board R&D Group was held on 25th July. The minutes of the meeting were circulated to this Group.

CDTQSE 17/303 Service Improvement Initiatives

Nothing to report.

CDTQSE 17/304 NICE Guidance

Nothing to report.

CDTQSE 17/305 Information Governance

Nothing to report.

CDTQSE 17/306 Data Quality

Nothing to report.

DIGNIFIED CARE

CDTQSE 17/307 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

The CHC visited Outpatient clinics at CRI and St Davids. The Clinical Board had raised concerns prior to the visit that the Outpatients department only manage the timetables for St Davids. The reports from the visits have not yet been received.

It was noted that an Executive Patient Safety Walkround was undertaken in Physiotherapy. The department is awaiting feedback.

CDTQSE 17/308 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

The Framework of Action for Wales 2017-2020 for care and support for people who are deaf or living with hearing loss was circulated for information. The framework refers to information around communication with patients that will have an impact on this Clinical Board.

TIMELY CARE**CDTQSE 17/309 Initiatives to Improve Access to Services**

Nothing to report.

CDTQSE 17/310 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Nothing to report.

INDIVIDUAL CARE**CDTQSE 17/311 National User Experience Framework**

The National User Experience Framework results for July 2017 have not yet been issued.

STAFF AND RESOURCES**CDTQSE 17/312 Staff Awards and Recognition**

Nothing to report.

CDTQSE 17/313 Monitoring of Mandatory Training and PADRs

Nothing to report.

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

The following minutes were **RECEIVED**:

Clinical Board R&D Group Minutes 25th July 2017

ANY OTHER BUSINESS

Nothing further to report.

DATE AND TIME OF NEXT MEETING

13th September 2017 at 2pm – venue to be confirmed.



**CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD
QUALITY SAFETY AND EXPERIENCE SUB-COMMITTEE**

MINUTES OF THE MEETING HELD ON 13TH SEPTEMBER 2017

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Lisa Griffiths	Quality Manager, Laboratory Medicine
Deborah Jones	Directorate Accountant (for David Lewis)
Sarah Jones	Pharmacy Quality and Safety Lead
Rebecca Pettit	Medical Physics Quality and Safety Lead
Robert Bracchi	Consultant, Toxicology and Therapeutics Directorate
Bolette Jones	Media Resources
Suzie Cheesman	Patient Safety Facilitator
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Maria Jones	Senior Nurse, Outpatients
Rachael Daniel	Health and Safety Adviser

Apologies:

Matthew Temby	Clinical Board Director of Operations
Mike Bourne	Clinical Board Director
Stuart Egan	Independent Member
David Lewis	Head of Finance
Alun Morgan	Professional Lead for Quality, Safety and Experience/ Assistant Director of Therapies and Health Sciences
Ceri-Ann Hughes	Head of Workforce and OD
Darrell Baker	Service Director, Pharmacy
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELIMINARIES

CDTQSE 17/314 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting and introductions were made.

CDTQSE 17/315 Apologies for Absence

Apologies for absence were **NOTED**.

CDTQSE 17/316 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 9th August 2017 were **APPROVED**.

CDTQSE 17/317 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 17/238 Foot Assessment Tool

Sue Dayananda has provided Mike Bourne with a briefing on the reasons why the foot assessment tool has been rejected by the Nursing and Midwifery Board. Mike Bourne to provide an update at the next meeting on how he wishes to take this forward.

Action: Mike Bourne**CDTQSE 17/257 Graphic Design for Surgery IP&C Poster**

Mike Bourne to meet with Bolette Jones to discuss.

Action: Mike Bourne**CDTQSE 17/261 Lung Nodule Follow Up Recommendations**

Sue Bailey has confirmed with Sue Morgan how to add this as an agenda item for the LMC. Mike Bourne has not yet presented this.

Action: Mike Bourne**CDTQSE 17/283 Purchasing Central Lines**

Sue Bailey has asked Procurement who is responsible for purchasing central lines within the UHB and is awaiting a response.

CDTQSE 17/300 WHC Point of Care Testing

Sue Bailey has discussed progress against the WHC with Annette Thomas. She has advised that a revised Point of Care Testing Policy will be submitted to the UHB QSE Committee in September. There has been a revised IM&T section and risk assessment. When ratified, the policy will be circulated across the UHB.

CDTQSE 17/300 Management of Ovarian and Other Adnexal Cysts

Sue Bailey has received background to the guidelines and a document aligned to current practice. On this basis Sue Bailey recommends that the guidelines are **APPROVED**.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY**CDTQSE 17/318 Patient Story**

There was no patient story today. Rebecca Pettit will ask Beth Jones in Medical Physics if she will present a patient story relating to radioactivity.

Action: Rebecca Pettit**CDTQSE 17/319 Feedback from UHB QSE Committee**

The minutes of the meeting held in June are not yet available.

CDTQSE 17/320 Health and Care Standards

The UHB Quality, Safety and Improvement Framework for 2017-20 was **RECEIVED**. This is the 3 year plan for Quality, Safety and Patient Experience for the UHB and is aligned to the Health and Care Standards.

It was noted that the standards map across to other standards such as record keeping, performance etc. It is anticipated that there will be performance metrics associated to the framework.

CDTQSE 17/321 Risk Register

The Risk Register Workshop has been rearranged for 27th September.

CDTQSE 17/322 Exception Reports

The HTA inspected the mortuary against a new set of standards. This was a thorough and challenging inspection and a draft report has been received which identified critical and major shortfalls. The Clinical Board have established a Gold Command Management Group which will be held weekly. The HTA were helpful in providing clear actions to be delivered within clear timeframes. An action plan has been produced and will be monitored through the Gold Command Meeting.

The UHB is in the process of responding to the inspection report.

Welsh Government has asked for shared learning with other Health Boards as this UHB was the first to be inspected against the new standards. A shared learning meeting has been arranged for 20th October and the MHRA and UKAS have also agreed to attend. Awaiting confirmation of attendance from the HTA.

Sue Bailey is keen to ensure that the positive findings of the report are not lost in the work required to address the actions.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT**CDTQSE 17/323 Initiatives to promote Health and Wellbeing**

Today is World Sepsis Day and a stand has been placed in the UHW concourse.

The UHB were assessed against the Gold Standard for Health and Wellbeing this week. It was pleasing to note that the UHB has retained its Gold Standard and the UHB is considered as the benchmark for other Health Boards.

The UHB is trialling a fruit stall at the UHW which has been well received.

Extra flu champions have been identified across the Clinical Board for this winter. There will be stricter guidance on the cold chain this year. The Flu Bug will be coming to the next meeting. The target for uptake of the vaccination by frontline staff is 65% this year. The Clinical Board will need to collate data on staff who have declined or are unable to receive the vaccination.

CDTQSE 17/323 Falls Prevention

Nothing to report.

SAFE CARE

CDTQSE 17/324 Concerns and Compliments Report

The Clinical Board received 8 formal concerns in August. There were 0 breaches against response times and the Clinical Board is reporting a total of 6 breaches since 1st April 2017.

2 AM concerns were received in August relating to Laboratory Medicine and Physiotherapy. 7 AM concerns have been received in total since 1st April 2017.

The Clinical Board received 7 compliments in August.

Since 1st April 2017 the Clinical Board is reporting 28 formal concerns and 36 compliments.

The key theme for formal concerns relates to clinical diagnosis and treatment.

CDTQSE 17/325 Ombudsman Reports

Nothing to report.

CDTQSE 17/326 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 17/327 Patient Safety Incidents

Serious Incident Report

The Clinical Board is reporting 2 Serious Incidents:

In20895 Lupus Incident – the Health Board is awaiting an update from Cwm Taf Health Board. It has informed Cwm Taf that it will be closing this incident to this Health Board at the end of September.

In51407 – misidentification incident in Cellular Pathology

CDTQSE 17/328 New SI's

There are no new SI's to report.

CDTQSE 17/329 RCA/Improvement Plans

Nothing to report.

CDTQSE 17/330 WG Closure Forms – Sign Off

In34383 – This incident was presented to a previous meeting. It involves a patient who attended Radiology UHL for an ultrasound scan on 23.9.06. An abdominal aortic aneurysm was identified. A Consultant Radiologist advised urgent surgical referral and the GP was contacted in order to activate this. It is reported that the surgical referral was made on the same day, however it did not reach the Consultant Vascular Surgeon until 12.10.06. Arrangements were made to see the patient in clinic on 17.10.16, the next available clinic however whilst processing this it became apparent that the patient had been brought into hospital on 11.10.16 and the patient did not survive. The cause of death was a ruptured abdominal aortic aneurysm.

A key recommendation from the investigation was that a joint pathway between Radiology and Vascular Surgery should be agreed for the management of such patients. In terms of Radiology, the department should have referred the patient directly to A&E and to Vascular Surgery.

CDTQSE 17/331 Regulation 28 Reports

Nothing to report.

CDTQSE 17/332 Patient Safety Alerts

ISN 2017/002 Esketamine

This alert highlights the risk of confusion between Ketamine 10mg/ml injection and Esketamine injection 5mg/ml. The alert has been circulated to directorates.

MDA 2017/022 DePuy Synthes Impactor for PFNA (Proximal Femoral Nail Anti-rotation) Blade: risk of infection

This alert has been **RECEIVED** and **NOTED**. It is not applicable to this Clinical Board.

MDA 2017/026 Overhead hoist: Freeway Easy Fit system with a swivelling trolley – risk of fixing pin moving or splaying

This alert has been **RECEIVED** and **NOTED**. It is not applicable to this Clinical Board.

MDA 2017/027 Intra-aortic balloon pump (IABP): CS100, CS100i and CS300

This alert has been **RECEIVED** and **NOTED**. It is not applicable to this Clinical Board.

CDTQSE 17/333 Addressing Compliance Issues with Historical Alerts

PSN036 Medical Air SBAR

The UHB has been undertaking work related to Patient Safety Notice 036 – Reducing the risk of oxygen tubing being connected to air flowmeters. The PSN requires barriers to be put in place to mitigate the risk. The Clinical Engineering Team have visited all areas with air flowmeters and there is one remaining barrier that medical air terminal units are covered with designated caps in areas where there is no need for medical air. This is not applicable to areas within this Clinical Board with the exception of Radiology, which needs to confirm if it has a medical air terminal unit.

Action: Rebecca Vaughan-Roberts

CDTQSE 17/334 IP&C Issues

Directorates to review the NatSSIPs flowchart which has been circulated and confirm if they have any procedures which are classed as invasive. It was noted that procedures have been identified within Outpatients and Radiology. A UHB Intranet page has been set up for NatSSIPs should directorates require further information.

The UHB IP&C Group was held today. The Clinical Board's IP&C Workplan was **RECEIVED** which will be taken forward by the Clinical Board IP&C Group.

Work around standards of dress will be taken forward following a concern received about an inappropriately dressed member of staff. A consistent tiered approach is needed based on job roles.

CDTQSE 17/335 Key Patient Safety Risks

Safeguarding

The next UHB Safeguarding Meeting will be held next week.

Mental Capacity Issues

A baseline audit was undertaken last year which highlighted inconsistency of training. Since this audit, MCA training is now mandatory.

49 incidents related to mental capacity have been captured on E-Datix. Issues have been raised around Phlebotomy in terms of compliance and consent and bespoke training has been requested for this department.

A further audit will be conducted to establish the current position. The UHB has requested regular audits and this Clinical Board has highlighted that the audit tool is inpatient based.

CDTQSE 17/336 Health and Safety Issues

Rachael Daniel reported that the Operational Health and Safety Group was held last week. 3 key issues were discussed:

There is a national shortage of Hepatitis B vaccination.

The fire service will now only attend at Health Boards across Wales if they receive a phone call to state that a fire has been confirmed. It is therefore even more imperative that staff undertake their fire training.

It has been agreed that Clinical Boards will be charged for lack of attendance of staff at training courses unless prior notice is given. A charge has been agreed at £45 to be implemented from January. Information will be circulated to Clinical Boards on how this will be applied.

Sion O'Keefe reported that risk assessments of medical records are being reviewed and action is being taken to remove records off site. The Treforest facility is now safe and secure for use.

CDTQSE 17/337 Regulatory Compliance and Accreditation

Natural Resources Wales (NRW) will be visiting Nuclear Medicine at UHL on 19th September 2017.

HIW will be visiting Cardiology/Radiology on 2nd October 2017.

CDTQSE 17/338 Policies, Procedures and Guidance

The following policies and procedures are out to consultation:

Discharge Policy and Procedure
Management of Policies, Procedures and written control documents
Safety Notices and Important Documents Management Policy and Procedure.

EFFECTIVE CARE

CDTQSE 17/339 Clinical Audit

The Clinical Audit department is looking at developing an electronic audit database to enable the Clinical Board to capture audit activity electronically and is also

looking to include service evaluation as part of this. Alex Scott has agreed to attend this meeting to discuss support required from this Clinical Board.

The Healthcare Waste Management Audit was **RECEIVED**. It was noted that Specimen reception is piloting the Clinisafe cardboard clinical waste containers.

CDTQSE 17/340 Research and Development

The Clinical Board R&D meeting will be held on Monday.

CDTQSE 17/341 Service Improvement Initiatives

Sion O'Keefe reported that a Clinical Board Transformation Group has been implemented. 4 projects have been identified based on a 60 day cycle. The group has support from the Continuous Service Improvement Team and its work aligns to the IMTP planning process and links in to the Clinical Board workshop on Cost Based Reduction which was held earlier this month.

It was noted that 2 Groups in the Clinical Board are participating in the current cohort of the LIPS Project.

The Clinical Board is considering hosting a showcase event to acknowledge and raise awareness of its service improvement projects.

CDTQSE 17/342 NICE Guidance

Nothing to report.

CDTQSE 17/343 Information Governance

It was noted that the UHB Information Governance Committee and IM&T Sub Committee will merge.

From May 2018 new regulations around data protection will come into force. These regulations will be more stringent. The regulations will allow patients to have access to their records with no charge. A key issue for this Clinical Board is around the complexity of providing patients with their full records where electronic systems do not communicate with each other. Clinical Boards are awaiting a steer from the Information Governance department how this will be operationalised.

A new retention schedule has been adopted by NHS England. The UHB People, Planning and Performance Committee in its new format will ratify this. Sion O'Keefe will provide early sight of the schedule to this Group.

Action: Sion O'Keefe

CDTQSE 17/344 Data Quality

The Health Records department will be undertaking an audit of addressographs and ensuring the correct label is being used. Linked to this, the department will also be working with Procurement on implementing a hand held device.

An initiative to improve patient demographics being updated more timely through a patient portal is also being looked at. Will need to ensure patients have the opportunity to opt out.

DIGNIFIED CARE

CDTQSE 17/345 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 17/346 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

The Dementia Champions Meeting was held last week. Jenny Pinkerton, the new Clinical Board champion will provide Sue Bailey with an update.

Sue Bailey provided an update to the Sensory Loss Group on a trial of patient pagers in Outpatients. Sion O'Keefe reported that the directorate is looking at selling space to the UHB Health Charity to help fund the pagers. The Clinical Board will also look at options around extending pagers into Pharmacy and Radiology where patients are waiting.

A trial of text reminders for ENT is underway and DNA rates have massively improved.

A lot of work is being taken forward on patient portal as highlighted earlier for patients with sensory loss.

TIMELY CARE

CDTQSE 17/347 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 17/348 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Performance in Radiology has been impacted this quarter due to the transition for MRI to mobile units. There were also capacity constraints in Physiotherapy this month.

INDIVIDUAL CARE

CDTQSE 17/349 National User Experience Framework

The National User Experience Framework results for the Clinical Board in August 2017 were **RECEIVED**. A 61% response rate was received. The overall score for patient satisfaction was 87%.

Comments were received requesting background radio music in the waiting areas in Outpatients. Sion O'Keefe reported that this request has been raised in the past and he will look into the feasibility for this.

STAFF AND RESOURCES

CDTQSE 17/350 Staff Awards and Recognition

Nothing to report.

CDTQSE 17/351 Monitoring of Mandatory Training and PADRs

The PADR rate for the Clinical Board is 69%.

Mandatory training is 75%, a decrease from 80% in December. Managers to ensure staff are completing their training.

Medical appraisals compliance is 96%.

Sickness rate is 3.76%.

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

There were no items to receive.

ANY OTHER BUSINESS

Lisa Griffiths reported that the All Wales Pathology Collaborative and National Pathology Programme Board have merged to become a Pathology National Network. This is to be submitted to Welsh Government to be ratified. A briefing paper for a Strategy for Wales has been written and will be sent out to Chief Executives at the end of September. If agreed, this will feed into a statement of intent.

There is a requirement in Laboratory Medicine to undertake a service user feedback day. Last year was not well attended. Lisa Griffiths asked if any other service would like to link in to this and set up a stall to increase interest. Any departments interested to contact her.

DATE AND TIME OF NEXT MEETING

17th October 2017 at 11am in the Council Room UHW



MENTAL HEALTH CLINICAL BOARD QUALITY & SAFETY
CLOSURE AND LESSONS LEARNED MEETING
21st September 2017
Seminar Room, Hafan y Coed, Llandough Hospital

Present:

Jayne Bell, Lead Nurse Adult Mental Health (Chair)
 Jayne Tottle, Director of Nursing Mental Health (for part of the meeting)

Will Adams, Liaison Psychiatric Nurse
 Philip Ball, Deputy Senior Nurse Manager, CMHTs
 Mark Bates, Night Manager
 Adeline Cutinha, Consultant Psychiatrist, Gabalfa
 Hannah Davis, Student Nurse
 Alison Edmunds, Concerns Co-ordinator
 Richard Evans, Social Worker, Pentwyn
 Michelle Griffiths, ANP MHSOP In-patients
 Matt Hoskins, STR
 Isabella Jurewicz, Consultant Psychiatrist, Pentwyn
 George Kirov, Professor of Psychiatry
 Mike Lewis, SIMA
 Peter Murray, Integrated Manager, Gabalfa
 Helen O'Sullivan, Senior Nurse Manager CMHTs
 Rakesh Pankajakshan, Psychiatrist, Amy Evans
 Darren Robinson, Substance Misuse Liaison Nurse
 Danielle Saunders, Staff Nurse ECT
 Darren Shore, Team Leader North CRHTT
 Nicol Smith, Trainee Forensic Psychologist
 Jayne Strong, ANP Rehab & Recovery
 Christopher Tottle, Student Nurse
 Sunni Webb, MH Act Manager
 Natalie Williams, Lead CPN Gabalfa CMHT

Monwara Ali, Assistant Psychologist
 Stephen Barrattshaw, Registrar
 Gavin Carpenter, Ward Manager Cedar
 Yvette Davies, Deputy Ward Manager, Cedar
 Mark Doherty, Lead Nurse MHSOP/Neuro
 Catherine Evans, Patient Safety Facilitator
 Ruth Evans, Lead CPN Links
 Judith Hall, Professor of Anaesthetics
 Sarah Howell, CPN Gabalfa
 Robert Kidd, Consultant Psychologist
 Sugandha Kumar, ST6 Old Age Psychiatry
 Noel Martinez-Walsh, Integrated Manager Pentwyn
 Bala Oruganti, Consultant Psychiatrist Crisis Team
 Grace O'Sundern, Student Nurse, Gabalfa
 Gemma Roberts, Principal Psychologist
 Tara Robinson, Senior Nurse Manager Rehab
 Samantha Sell, Staff Nurse ECT
 Ian Smith, Doctor, LPOP/RAID
 Victoria Sobkowski, Third Year Student MH Nurse
 Andrea Sullivan, Concerns Co-ordinator
 Rebekah Vincent-Newton, Manager, Cardiff Council
 Justin Williams, Team Leader South CRHTT

Apologies:

Owen Baglow, Clinical Lead for Quality, Safety & Governance
 Mary Morgan, Senior Nurse Manager, Adult MH
 Dr Radhika Oruganti, MHSOP liaison consultant
 Annie Procter, Director Mental Health
 Suchitra Sabari, Clinical Director Adult MH
 Kim Tallett, Lead CPN Amy Evans CMHT
 Ian Wile, Head of Operations & Delivery Mental Health

PART 1: PRELIMINARIES**1.1 Welcome and Introductions**

The Chair welcomed all to the meeting and introductions were made.
 Jayne Bell explained that Quality & Safety Lessons Learned meetings facilitated reflections on incidents that occurred in Mental Health Services. Events are discussed that have gone well and also not so well, and Managers in attendance are required to share this learning with their colleagues. The meetings are confidential and anonymous.

1.2 Apologies for Absence

Apologies for absence were noted as above.

PART 2 : ACTIONS - No Actions.

PART 3 : CLOSURES

3.1 JJ

JJ was an 82 year old male with a history of depression, anxiety and psychosis. JJ was admitted to an in-patient medical ward due to poor physical ill health as he would not eat or drink. He had severe psychotic depression. JJ described experiencing a force/power that was stopping him from drinking or eating. ECT treatment was given under Section 62 as an emergency life saving procedure. JJ suffered cardiac arrest following ECT treatment, he was resuscitated and transferred to Intensive Care Unit where very sadly a couple of days later he passed away.

This was the third treatment of the course and the previous two treatments had been administered without incident. There was a history of ischaemic heart disease.

The Consultant Anaesthetist was aware of the physical history of JJ in preparation for ECT. It was appropriate for give ECT treatment as JJ would have significant benefit especially regarding food intake. The benefit of ECT outweighed the risk.

Dr Maria Atkins, the Clinical Director of Adult Mental Health at the time, had sent the staff of ECT a message of support. Dr Atkins said that in her 16 years as Clinical Director she had not seen a cardiac arrest in ECT and commended the actions taken by staff.

Issues identified:

Frailty – ECT was the only option.

Issues regarding access to Senior Medical Support for ECT. Contact numbers for all Consultants to be made available to the ECT Suite.

Commendation:

Response to the cardiac arrest was first class. Dr Judith Hall, Professor of Anaesthetics, wished to record her praise for the ECT staff. Dr Hall said that the incident was a remote event in ECT and the staff had been absolutely magnificent in their response.

TO CLOSE.

3.2 MC

A body was found at a flat registered to MC, the person had died several months ago. The body was later confirmed as MC's. The cause of death was unascertained.

Over the three years that Mental Health Services knew MC, MC had several assessments in the community and as an in-patient; they all concluded that MC was not suffering from a serious mental illness but rather that she had very poor coping skills. MC was vulnerable in the community. Numerous Public Protection Notices (PPN) were received by Mental Health Services for MC, the themes being around bizarre behaviours in public places. The PPNs were low risk.

MC was supported by the Community Mental Health Team, Liaison Psychiatry and the Assertive Outreach team but she disengaged from services.

There was discussion about the process to be followed when a PPN is received. The PPN procedure is in the process of being reviewed by Cardiff Local Authority. Vale Local Authority is looking at standardising the process across the teams, ensuring contact with safeguarding teams.

Lesson Learned:

The Local Authority is improving the screening of PPNs. Helen O'Sullivan is representing the UHB in these discussions.

If client does not have a mental health illness then could consider referral to the safeguarding team.

Involve Cardiff & Vale UHB's Information Governance in discussions regarding processes.

TO CLOSE.

3.3 AR

A Mental Health Assessment was completed at the Community Mental Health Team (CMHT) offices after AR admitted to taking a staggered overdose of tablets. AR was detained under Section 4 of the Mental Health Act. The patient was deemed to have emergency psychiatric and emergency medical needs.

The Clinician wanted to admit AR to Cedar Ward (a Mental Health Crisis and Assessment Ward) but the Ward Manager declined the admission due to AR not being physically/medically fit. The Clinician was under the impression that A&E would not accept AR as he was on a Section 4. This resulted in AR being kept in the CMHT for some time whilst a safe outcome was being sought. There was no bed available on the Poisons ward. The Senior Nurse Manager for Crisis and Liaison intervened on the day to clarify that AR could attend A&E.

Discussion held regarding the legality of AR attending A&E whilst on a Section 4 of the MHA.

Discussion regarding the options that were available, including an emergency 999 call but the majority view was that the emergency service prioritised calls on medical need (i.e. not breathing) and in this case the priority for an ambulance would be low.

Action: Discuss conveyance with the Police and WAST. (See Lessons Learned below)

Sugandha Kumar informed the Group that in Mental Health for Older People (MHSOP), when there was a physical need they contacted the SPR On-Call to make a referral. The SPR On-Call was very helpful and the outcome in this instance would have been that AR was admitted directly to a medical ward for treatment. The medical ward could have sourced RMN support if it was deemed necessary.

AR eventually went to the Medical Assessment Unit (MAU) in a car with Community staff where he was treated for the overdose. He was subsequently transferred to Cedar Ward once medically fit.

Issues identified:

There was no paperwork on admission as the Crisis Team had been unaware of the admission assessment and the community team had not completed it. Discussion regarding Care Plan paperwork (CP1A); there was some confusion on when the CP1A could be completed. Some were under the impression that the CP1A could be completed the next day. The problem of the paperwork not being completed seemed to be mostly when the Crisis Team was not involved, the solution could be to ensure that SPRs had netbooks to enable them to complete the CP1A. (See Lessons Learned below)

Lesson Learned:

- A medic to medic referral was agreed to be the correct way forward in cases of medical emergency
- The meeting agreed that the ward was correct in not accepting an admission of a medically compromised patient

In relation to the belief of the community clinician that the patient could not attend A&E as the patient was on Section 4 of the Mental Health Act, the Mental Act Manager clarified in today's meeting that the Mental Health Act states:

“Treatment in an A&E Department en route to the hospital named in the application:

If a patient who has been made subject of an application requires emergency treatment for physical injury or disorder he could be taken to and treated in an A&E department under common law powers or, if he was mentally incapacitated, under the Mental Capacity Act 2005 before being transported to the hospital named in the application”.

- Conveyancing difficulties complicated this case. The Local Authority are holding ongoing discussions with South Wales Police and WAST about this.
- CPA assessment (1a) and risk assessment (4) must be available to Cedar ward staff either before the patient arrives, or completed by the assessing clinicians on arrival at the ward at the latest. This should be completed by any member of the assessing team. Dr Sabari will be asked to consider re-distributing netbooks that were given to Consultant Psychiatrists as the meeting acknowledged that it is often SPRs undertaking assessments out of hours. However, in this case the patient was assessed in hours, therefore the CMHT should have completed the admission paperwork in the absence of the CRHT who were not informed of the assessment.

TO CLOSE.**3.4 KL**

A high profile inquest at Coroner's Court touching the death of KL.

KL was diagnosed with schizophrenia and had been known to Mental Health Services since 2004. KL had periods of stability and also periods of relapse. KL was not always compliant with his medication as the side effects were not compatible to his life style. KL had delusions about his family and he could become aggressive towards them.

In 2015 KL became very unwell and was admitted to Whitchurch Hospital and detained under Section 2 of the Mental Health Act. There was an altercation with KL and other patients which resulted in KL being transferred to the Psychiatric Intensive Care Unit (PICU) at Whitchurch Hospital as there were no beds available on other wards.

Whilst on Section 17 escorted leave to the local shop, KL absconded and ran away. The Police were called for assistance and KL was found in a nearby Cafe. The Police escorted KL out of the Cafe but KL managed to run away into some woods and could not be found. Very sadly, KL then had an altercation with a member of the public and died.

Section 17 escorted leave had previously been successful; it was noted that KL had become less anxious and stressed following the leave.

Jayne Tottle, Director of Nursing Mental Health, recorded how proud she was of the mental health staff who gave evidence at the Coroner's Court and how much they cared about KL and his family. The Coroner's verdict was “Lawful Killing” on the basis that the member of the public felt threatened for his life. The Pathologist gave the cause of death as:

- 1a) A sudden collapse in a 42 year old man with schizophrenia and recent behavioural abnormality taking Quetiapine, after a prolonged struggle and pressure to the neck.

Regulation 28 was issued by the Coroner upon conclusion of the inquest:

The issue of Section 17 leave is covered in the Guidance issued in 2016. There is no section in this guidance covering the issue of review or revocation of Section 17 leave on transfer to another ward or to PICU. It is the concern of the Coroner that such guidance should be given across Wales in the next edition of the guidance.

Cardiff & Vale UHB are working with the Welsh Government to amend the Guidance to cover review of Section 17 leave after transfer.

Lesson Learned:

Cardiff & Vale UHB Mental Health Services now inform the RC of any transfer between wards so that Section 17 Leave can be reviewed. It was noted that the decision by nursing staff to grant Section 17 leave had been correct as KL had enjoyed such leave on at least two occasions previously.

The environment had improved since moving to Hafan y Coed from Whitchurch Hospital.

Consideration would be given to notifying a transfer of wards on the PARIS system.

TO CLOSE.

4.0 DATE OF NEXT MEETING

16th November 2017 at 9.30am in the Seminar Room, Hafan y Coed.



MENTAL HEALTH QUALITY, SAFETY AND EXPERIENCE COMMITTEE

18th October 2017

SEMINAR ROOM, LLANDOUGH HOSPITAL

- Present:** Jayne Tottle, Director of Nursing Mental Health (Chair)
 Owen Baglow, Quality, Safety & Governance Lead
 Jayne Bell, Lead Nurse Adult Mental Health
 Wendy Davies, MHCB Pharmacist
 Mark Doherty, Lead Nurse MHSOP/Neuro
 Catherine Evans, Patient Safety Facilitator
 Robert Kidd, Consultant Psychologist
 Sarah Lloyd, Directorate Manager Adult MH
- Apologies:** Carol Evans, Assistant Director of Patient Safety & Quality
 Mick McGeoch, Clinical Audit Co-ordinator
 Sabari Muthukrishnan, Clinical Director MHSOP & Neuro
 Bala Oruganti, Consultant Psychiatrist
 Annie Procter, Clinical Board Director, Mental Health
 Suchitra Sabari, Clinical Director Adult Mental Health
 Ian Wile, Head of Operations & Delivery Mental Health
 Jo Wilson, Directorate Manager MHSOP

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed all to the meeting.

1.2 Apologies for Absence

Apologies for absence were noted.

1.3 Minutes of Last Meeting

The Minutes of the Mental Health Quality and Safety meeting held on 14th June 2017 were accepted as an accurate record.

1.4 ACTION LOG/MATTERS ARISING

The Committee received the Action Log and noted the actions that had been completed, these would be removed from the Log.

Risk Register

The electronic medication transcribing and discharge system (MTed) does not contain information from PARIS.

Wendy Davies informed the Committee that this was being resolved on an All Wales basis and is on-going.

Hospital at Night Plan

This is on-going and an update will be given at the next meeting.

Action: Annie Procter

Risk Assessment/Risk Management Plan

There has been a LIPS project looking at the link between risk assessment and risk management plans, the work on this project concluded that the design of Form 4 plays a significant part in the failure to link the assessment to the management plan. Therefore, the form needs to be re-evaluated or re-designed.

Jayne Bell said that this was on-going and an update will be provided for the next meeting.

Action: Jayne Bell/Suchitra Sabari

Post Incident De-briefing meetings

Staff were supported post incident through debriefing meetings. Robert Kidd had stated that there was a risk of re-traumatising staff by having debriefing meetings as some may not want to meet and the debrief will not help them and might re-open stressful issues for others. However, it was agreed that some form of support was needed. Jayne Tottle will consider possible modifications or changes to the process together with Owen Baglow and Catherine Evans. The Suicide Prevention Supporting Guidance includes a section on "How to support staff members after a suicide". Dr Miranda Barber, one of the Authors, could be asked how best to support staff members.

Externally influenced risks

The Director of Nursing said that externally influenced risks, e.g. the UEFA Champions League Final, are considered as and when required.

Mental Health Medication whilst an in-patient on Physical Health Wards

There are issues with mental health services users receiving prescribed mental health medications whilst an in-patient on physical health wards. Issues are mental health medications not being administered, as well as duplicate administration of antipsychotic medication including long acting depots. It has been identified that physical health pharmacists have no access to mental health prescribed medications through any systems, including GP records. It was stressed GPs should be aware when patients are prescribed Clozapine in order for them to monitor their physical health.

Wendy Davies is meeting with Primary Care to look at solutions.

Action: Wendy Davies

It was noted that when PARIS and the Welsh Clinical Portal are linked in the future this problem will be eradicated.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

2.1 UHB Quality, Safety and Experience Committee

The Chair noted the Minutes of the UHB Quality, Safety and Experience Committee dated 12th September 2017:

QSE17/108 Plans for CMHT Accommodation

Some funding had been made available for Barry and further plans were being finalised.

Jayne Tottle said that this had been discussed at the Executive Performance Review meeting on 19th October. The funding was for Vale of Glamorgan and plans were being finalised with Amy Evans, Hafan Dawel and Western Vale possibly being re-located at Barry Hospital. Sarah Lloyd, Directorate Manager, is meeting with the Planning Department.

QSE17/148 Provision of a Decant ward at UHW and UHL

The UHB did not have a decant ward to enable ward refurbishment or manage infection outbreak. There was a possibility of a new ward being built on a car park at UHL and with reduced length of stay, a whole ward may be released. In terms of Gwenwyn Ward, UHL, it was noted that health and safety concerns had been raised by staff who had been told they would be merged with another ward. The Nurse Director explained that Gwenwyn was no longer a suitable environment for the client group. It was a small mixed sex area and there had been allegations of serious incidents. Any move would be subject to a full risk assessment to ensure safety features were included for staff.

Discussions are on-going regarding the feasibility to develop a ward at UHL by extending into the car park adjacent to the Boardroom.

2.2 Health and Care Standards

A meeting has been arranged with Jayne Tottle and Carol Evans. An update will be provided at the next Quality & Safety meeting.

2.3 Regulatory compliance and external accreditation - No report.**2.4 Risk Register**

The Risk Register had been circulated for information.

2.7 Directorate QSE Groups

The **Adult Directorate Quality & Safety** Minutes dated 27th July 2017 were noted:

PARIS

Michelle Lewis, Paris Co-ordinator, discussed the 'Restricted Caseload Working Model' which she is currently working on. This acts by prompting staff with a *Break Glass* notification "are you sure you want to view this record" when staff are accessing records for a patient they are not connected to. In this section on PARIS a log will be kept of all staff who have accessed the records, with a date and time of access. Michelle has yet to do testing and will feedback once complete. It will then go to the Clinical Board for review and a decision to be made as to whether to implement it.

CMHT Review

The senior steering group have met and discussed revisiting options for the team. Currently there is no clear model and task groups are struggling to move forward. The visit to London at the beginning of June had heightened reactions. There is a plan to work with an external facilitator to get an agreement for a model to pilot.

Deputy Clinical Director Adult MH Post

Andrew Vidgen, Consultant Clinical Psychologist, has been appointed to the Deputy Clinical Director Adult MH post.

The **MHSOP/Neuropsychiatry Quality & Safety** Minutes dated 3rd July 2017 were noted.

Wards

Wards East 14 and East 16 have closed. East 16 patients have moved to the Llanfair Unit and the ward is called Daffodil Ward.

Iorwerth Jones Wards are being re-located to UHL on 26 October 2017.

Clinical Director MHSOP

Currently there is no Clinical Director in MHSOP but a new one will be appointed soon.

HCSW Agency

Switch off of the use of HCSW agencies at the end of October 2017. An unqualified pool for MHSOP is being set up.

A review of the REACT team is being undertaken regarding clinical risk.

IMTP workshop on 18th October 2017.

Psychology & Counselling Quality & Safety – Minutes dated 2nd August and 4th October 2017 were noted.

2nd August 2017 Minutes:

Part 1 & Part 2 Update:

There will be two new targets: (1) for Part 1, Tier 1 target as it is and (2) a new target of 26 weeks for anything not captured by the latter for Psychology & Psychological Therapies. Jane Boyd has given Norman Young the target wording as he is undertaking the PARIS waiting list work. Jane Boyd clarified that the new targets will encompass everything that is currently not captured by the current PMHSS target i.e. Part 1, Hub, PTSD etc. and everything else (excluding Tier 2 services) will come into the 26-week target. Current target is for treatment and assessment (not tier zero).

(It was noted that Michelle Lewis, Paris Co-ordinator, has helped a lot with this work.)

Dignified Care:

Rob Kidd highlighted the recent Welsh Health Circular WHC/2017/036 "Guide to Consent for Examination or Treatment", the content of which, we need to be able to demonstrate and acknowledge in the work we do in Psychology & Psychological Therapies. It refers to the Montgomery case in the risks of treatment (following a case of a patient who was not adequately informed about the risks of her treatment), and subsequent ruling that all clients, outside of those who are detained under the Mental Health Act, are necessarily of sound mind, so have a right to be able to decide which, if any, of the available forms of treatments to undergo. The circular

emphasises that there is a legal obligation for Clinicians to provide information to patients about their treatment, and to do this the clinician has to make the patient aware of any material risks involved in any recommended treatment and of any reasonable alternative treatments.

Staff Accolades, Compliments & Complaints:

Jenny Hunt informed the meeting that one of their Administrators, Jacqui, received a staff recognition award in the Leadership Category. Rob Kidd has been awarded by the Associate Fellowship for Higher Education Institute for his Teaching quality. Neil Kitchiner (with Catrine Lewis, Jonathan Bisson, Tracey Vick and Neil Roberts) have had a self-help guide on anxiety and depression published. Julie Wilcox (with Reg Morris and Sam Fisher) have co-written a book entitled "Rebuilding your life After Stroke" which has now been published and is available from Amazon. 1,500 copies are available for Wales (1,000 of these free) and 1,000 copies for England. It has been entered onto the Prescription Scheme.

4th October 2017 Minutes:

Datix

Discussion occurred about Datix procedures following reported incidents and the notification process. It was confirmed that Datix produce a regular report but questions arose about who this was sent to. It was agreed to investigate the process further.

Effective Care

Rob Kidd had attended a UHW presentation on audits and learned that there is a delay on the purchase of a new, nationally developed audit toolkit whilst UHW decide on whether to develop a local version. A decision is expected by the end of October.

Matrics Cymru:

Matrics Cymru, published by Public Health Wales, is a Guide to Delivering Evidence Based Psychological Therapy in Wales Mental Health Services for adults, older adults and children. It was considered that this is unclear on primary care viz a viz secondary care regarding "live problem" work and that some work is inappropriate to be undertaken in Primary Care as it does not fit with Primary Care categories for treatment/admission. This is particularly affecting BPD and EUPD workstreams.

Rob Kidd said he would update the next MHCB Quality & Safety meeting.

Pharmacy

Rapid Tranquilisation

Wendy Davies had circulated the Guidelines for use of Rapid Tranquilisation in In-patient Adults (18-65 years). Noted: Both for Oral and IM Lorazepam consider prescribing up to 8 mgs per 24 hours to be used as needed. A further 4mgs can be prescribed in a given 24 hours after telephone (as per verbal prescription policy) or in person consultation with a doctor.

The Guidelines had been agreed in the MH Medicines Management Group. Wendy would now present to Corporate Medicines Management Group.

Jayne Bell remarked that as there is currently no guidance for medicating patients in Police custody waiting for a bed in in-patients, Simon Amphlett is working on a Protocol. Wendy Davies will link up with Simon.

Action: Wendy Davies

Good Prescribing Guide

Wendy Davies informed the Group that there is now a Good Prescribing Guideline App.

In-patient Satisfaction Questionnaire – Pharmacy Services

Wendy Davies had circulated the In-patient Satisfaction Questionnaire on Pharmacy Services to the Committee. The questionnaire requests feedback regarding patients' experience with the pharmacy service and use of medicines, and will be used to help improve pharmacy services. It was noted that Pharmacists will complete the questionnaire with patients on the ward.

The questionnaire is for in-patients but could be altered for use in CMHTs.

Smoking

Wendy Davies presented the Patient Group Direction (PGD) for the supply and administration of Nicotine Replacement Therapy by registered nursing staff for smoking cessation in Mental Health.

Treatment period: 72 hours under PGD after which the continuation of therapy should be undertaken by the patient's responsible clinician/ team. (12 weeks minimum treatment period thereafter for cessation, after which review of requirements needed).

Wendy commended Katie Evans and Kate Southern (Pharmacists) for their work on the PGD.

Primary Mental Health Support Service (PMHSS) – No report.

Mental Health Act Report –

Invalid Mental Health Act Detentions - There are no new detentions for this period.

Infection, Prevention & Control

No Report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

3.1 Initiatives to promote health and wellbeing

Smoking

Sarah Lloyd informed members that Gwenwyn Ward was keen to implement non smoking the same time as Hafan y Coed. Non smoking in Hafan y Coed may commence on 1st January 2018.

SAFE CARE

4.2 Patient Safety Incidents

Jayne Tottle reported on a high profile inquest at Coroner's Court touching the death of KL.

Regulation 28 was issued by the Coroner upon conclusion of the inquest to the CMO for Wales: The issue of Section 17 leave is covered in the Guidance issued in 2016. There is no section in this guidance covering the issue of review or revocation of Section 17 leave on transfer to another ward or to PICU. It is the concern of the Coroner that such guidance should be given across Wales in the next edition of the guidance.

Cardiff & Vale UHB are working with the All Wales Group and other UHBs to amend the Guidance to cover review of Section 17 leave after transfer.

Regulation 28

A regulation 28 had been received in Medicine Board regarding reviewing procedures related to FAST Ultrasound examinations. MHCB Quality & Safety Committee noted the Regulation and response.

4.3 Patient Safety Alerts

PSN036 – Reducing the risk of oxygen tubing being connected to air flowmeters

The content of the SBAR was considered and noted.

PSN ISN 2017/002 – Risks associated with confusion between Ketamine 10mg/ml injection and Esketamine injection 5mg/ml

Wendy Davies said the medication is an anaesthetic. Esketamine is used in some places as an anti-depressant but Cardiff & Vale UHB Mental Health Pharmacy does not use it. The Safety Notice was noted.

EFFECTIVE CARE

5.2 Quality Standard 154 – Violent & Aggressive behaviours in people with mental health problems

This Quality Standard covers short-term prevention and management of violent and physically threatening behaviour among adults, children and young people with a mental health problem. It applies to settings where mental health, health and social care services are provided.

Owen Baglow and Jayne Bell to look at this.

DIGNIFIED CARE

6.1 Internal Inspections

Welsh Government Quality Check – Coed y Nant, Iorwerth Jones

The Report regarding Coed y Nant, Iorwerth Jones was received. Some improvement work had been carried out.

HIW/CSSIW visit to Links CMHT

The HIW/CSSIW visit to Links CMHT was positive with some areas for improvement.

Some positive comments:

- Caring/kind interactions from staff to service users was noted
- Level of respect from staff to service users
- Staff training has led to service improvements, such as physical health monitoring

Some areas for improvement:

Good Health Promotion Boards noted but patient information could be produced in the Welsh language.

Environment in poor state of repair but plans were in place to address this immediately.

Insufficient cleaning cover. Noted that staff were cleaning areas due to lack of housekeeping provision. Noted that this needs attention.

The visit highlighted a lack of pharmacy input. Wendy Davies, MHCB Pharmacist, said there was no legal requirement to provide input.

TIMELY CARE

No report.

INDIVIDUAL CARE

8.1 Feedback from Surveys

Patient Survey

Adult Mental Health In-patient wards and Community Survey reports were received and noted

MHSOP '10 Minutes of your time' report was received and noted.

Carer's Assessment

Carer's should be offered a 'Carer's Assessment but unsure where this should be recorded. Jayne Tottle will ask Rebekah Vincent-Newson where the assessments should be recorded.

Action: Jayne Tottle

8.2 Compliments

Compliments received for:

Aron White, Professional Practice Development Nurse – Commendation for driving forward the content of the falls training.

Hafan y Coed and MHSOP – Thanks from the Chair and CEO of the NMC. The notion of professionalism and caring were key themes evident throughout their visit.

South Crisis Team, Cedar & Willow Wards - Thank you letter from the mother of a patient.

MHSOP – Plaudit Report.

Mike Harding and Team, Gabalfa CMHT – thank you letter from a patient.

Mental Health System - thank you letter from a patient

Rehab & Recovery Services & Park Road – acknowledges of care to a client from Dr Mary Lawrence.

Catherine Vrac - thank you letter from the family of a patient.

Complaints

On-going.

STAFF AND RESOURCES

9.2 Staffing Levels

Jayne Tottle said the Mental Health Nursing Conference on 4th October 2017 was a success. The Mental Health Work Stream will continue to meet and data collection will commence in November.

PART 2 : ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION

Policies and Procedures

The Group were asked to receive and ratify the following:

10.0 Welsh Government Guide to Consent for Examination or Treatment – Revised Guidance July 2017

The Welsh Government Consent Guidance issued in 2008 has been revised, with changes made to take account of important developments in case law. The Revised Guide contains a broad overview of the legal requirements in relation to seeking consent.

THE GUIDE WAS NOTED

10.1 Pine Ward Operational Policy

This Operational Policy outlines the intended role of Pine Ward within the broader framework of Cardiff & Vale UHB Addiction Services.

THE OPERATIONAL POLICY WAS APPROVED

10.2 Activity Nurse Team for Hafan y Coed Operational Guidance

This Guidance sets out the role of the Activity Nurse Team at Hafan y Coed Adult Mental Health Unit.

It was noted that demand for the Activity Nurses had increased. The Guidance should include the Crisis Team and Rehab Service. To return to the Author for amending.

THE GUIDELINE WAS NOT APPROVED

10.3 Hafan y Coed Emergency Assessment Suite (EAS) Procedure

This Procedure has been drawn up for all UHB staff to have guidance on the safe and effective use of the EAS and to ensure that service users are provided with a safe environment which will promote dignity at the point of assessment in Hafan y Coed.

THE PROCEDURE WAS APPROVED

10.4 Suicide Prevention Supporting Guidance

The Suicide Prevention Supporting Guidance document was ratified recently by the Cardiff & Vale Regional Partnership Board and had been circulated to Quality & Safety Committee members for information.

10.5 Procedural Guidance in the Event of an Unexpected Death within Adult and MHSOP In-patient Services

This Procedure provides local guidance for all health care professionals within the Mental Health Services of Cardiff & Vale UHB on the procedure to be followed in the event of an unexpected death.

THE PROCEDURE WAS APPROVED

10.6 Quality, Safety and Improvement Framework for 2017-2020

The Quality, Safety and Improvement Framework was received and noted.

10.7 Policy Group

Jayne Bell, Chair of the Mental Health Services Policy Group, asked for assistance with the review of policies and procedures. Jayne is not receiving the due updates despite many reminders to the people concerned.

It was agreed to disband the Policy Group as this was clearly not working. Jayne Tottle, with Owen Baglow's assistance, would e mail the staff concerned requesting the updates

Action: Jayne Tottle/Owen Baglow

DATE OF NEXT MEETING

13th December 2017 at 9.30am in The Seminar Room, Hafan y Coed.

(next Clinical Board Q&S Lessons Learned Meeting is on 16th November 2017 in the Seminar Room)



**MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE
HELD AT 11.30, 11 July 2017 IN ROOM 1, CRI
(SHORTENED MEETING DUE TO CEO VISIT – REPORTING BY EXCEPTION
ONLY)**

Present :	Dr Gareth Hayes (GH)	Clinical Director for Clinical Governance (Chair)
	Sue Morgan (SM)	Director of Operations
	Kay Jeynes (KJ)	Director of Nursing PCIC
	Nicola Evans (NE)	Head of Workforce and OD
	Carol Preece (CP)	Senior Nurse S&E Locality
	Helen O'Sullivan (HO)	Quality and Safety Manager
	Sarah Griffiths (SG)	Head of Primary Care Contractor Services
	Denise Shanahan (DS)	Consultant Nurse Older Vulnerable Adults
	Matt McCarthy (MMc)	Patient Safety Facilitator
	Karen May (KM)	Head of Medicines Management
	Anna Mogie (AM)	Lead Nurse, North and West Cardiff
	Ceinwen Frost (CF)	Lead Nurse, Vale Locality

Preliminaries		Action
	Welcome and Introductions	
	All present introduced themselves and were welcomed by Gareth Hayes.	
	Apologies for absence	
	Brendan Boylan, Rhian Bond, Jane Brown, Anna Kuczynska, N Hughes, H Earland	
	Declarations of Interest	
	GH asked for any declarations of interest – none noted.	
	Minutes of the previous meeting held 09 May 2017	
	Inaccuracies recorded on last minutes – CF did NOT attend the meeting. DS DID attend the meeting	
	Page 4 – KM PCIC GMS should read (2) not 92.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		Action
	Patient Story	
	To be presented at September QS&E Committee	09/2017
	<u>PCIC CB Quality and Safety Group Action Log</u>	
	The Clinical Board Quality and Safety group action log was reviewed. Members noted the content. Actions requiring further work:	

Use of Digital Cameras CF advised that some HCSW staff have received training (14 Teams in total and 28 staff have received training). This item will remain, in order that it can continue to be monitored. Risk Escalation re: TVN Waiting List The waiting list has gone up recently and is now at 10 weeks. There is a temp post that will now be made substantive which has been agreed that will assist in reducing the waiting list. Updated Concerns Report (No item ref number registered) COMPLETED Loss of the PCIC Risk Register C Darling has now completed all that is required to be done regarding the Risk Register. This will now need to be escalated formally to the Head of IT. STI Information circulated to GP's STI update to be sent to GP practices – N Hughes to follow up and clarify. Patient safety team to check if Medication error data can include the date of the incident actually taking place M MC advised that Datix can provide this information Vale of Glamorgan Network Coverage No update available due to the unexpected leave of Vale Locality Lead Nurse Influenza outbreak in N&W Locality A M advised that Immunisation rates within the Residential home were high, therefore the outbreak was not down to poor immunisation rates PCIC NICE process K Jeynes commented on the agreed process and that it has been shared with the Clinical audit team. KJ to work through some additional changes and timescales for reporting with the R&D CD and Clinical audit dept and recirculate. Cancer Action plan Made available at the July meeting. KJ said she can send electronic or paper copies. ANTT Action plan Plans are in place. Significant progress in implementing into practice, roll out will be monitored through the weekly Nursing Forum – not at this meeting. Network Access Issues in the Vale MHCS Team taking the lead. CF linking in with them for a resolution. Video conferencing – unable to progress this at the moment. Update at September meeting. Cold Chain SI Local toolkit to be agreed and signed off in September 2017. KJ to send MM	

	a copy. There will be an All Wales Toolkit – timescales are unclear at present. Quality Dashboard Update in September meeting. S&E Locality NH said no update available, due to CP being on leave. Information Governance IG audit undertaken for DN's & CRTs July 2017. We will give an update of the collated results in September 2017. Prison QS Action Plan Update Formal updated action plan required in September 2017. Ombudsman – Clifton Surgery Lessons learnt communicated out to practices. PAC Committee KJ to contact nutrition and catering committee and advise PCIC will attend, when relevant items relating to the clinical board are agenda'd. Older People's Commissioner We need an action plan in relation to the report on access for older people to GP surgeries. Update required September 2017. DOLs Guidance Update in September 2017. MSSA Template Draft template has been completed and sent to IPC for comments. POCT KJ & RB to discuss and agree a plan	
	Risk Register <u>Review Risk Log using 4 Ts</u> Risks highlighted at the meeting for further discussion were Top 5 risks and any risk escalation documents from business units : QS&E 000214 OOH'S Improved activity and compliance around statistical performance (in the week). Last week level 1 and 2 during the week and at weekend's escalation levels increase to 3/4. We need to look at sustaining this improvement across the 7 day period. Nearly 100% on all indicators in the week, but the weekend pressure is still a real issue , and we will continue to keep risk rating at 25 for the time being. GH said that his in house practice has been the quietest it has been for some time. Probably due to the weather. QS&E 110914 – Complex packages of care No update as such. We are not supporting a community package for a	

	specific patient, due to sustainability and financial risk. Still awaiting the revised contracts for FNC to be able to adapt for CHC. Patient x pre judicial review action received, Am and KJ meeting with WHL. Currently 80 complex packages of care being managed across the Localities, particular challenges in N&W. 10 fragile packages which are being closely monitored and could potentially are difficult to manage and maintain. CF alluded to another case in the Vale, which is very challenging. PICC 160614 – Primary Care Estates and PCIC 0814 – Local Development Plans Meetings are ongoing around this (May 2017) and the risk remains the same. PCIC - GMS Services/Primary Care Capacity and Sustainability. There are a number of practices that the clinical board have concerns about and are identified as fragile. There is a Procurement exercise in place and is live on Bravo at the moment for a potential GP contract for over 10,000 patients. The GP Sustainability Team are very busy trying to fill the gaps in medical cover and GPN staff across a number of practices. There is a level of concern for the activity and work that this creates for the Primary Care Team as a whole. HS asked if the risk had been adjusted, however, it is already at 25, so cannot go any higher. GH said the situation will get worse and premises issues are going to be an ever increasing issue. RB has taken a paper to the Exec Board on the position re fragile practices. We are doing everything we can as a clinical board, monitoring and supporting as much as possible. There are also a number of practices requesting changing their boundaries, but this is not being supported currently. There needs to be clarification around what funding will be available before there can be any further forward movement. AK advised that Welsh Government is aware of the local position. GH said stress testing needs to be looked at as well. Workforce This remains the same, turnover is still challenging, however a number of successful recruitment events have taken place. Further clarity is required for CHAP as a number of temporary staffing arrangements are in place to support the service.	
	SI Log <u>Current SI's</u> No current open SI's. <u>Closure Forms</u> GH noted one closure form submitted (IN44153). GP OOHs SI. <u>Medication Errors</u> 10 reported, all reviewed and appropriate actions taken but nothing of concern to note. <u>Datix Management</u> KJ reiterated the importance of timely management of Datix incidents within	

	the agreed timescales. There has not been an improvement, KJ thanked everyone and asked that we continue to try and improve response times. Interface Incident Process – This is still of concern due to the high numbers of so called incidents reported. HS & KJ to look how this can be managed more effectively going forward and is a priority for the clinical board. There is a meeting on 09/08/2017 with CDs, PMs, SG, MM, and this should try and help with revising the existing process to see how this can be improved. GPs need clarification on what is an incident and what needs to be put on Datix and what needs to be escalated to be dealt with outside of datix such as double handling of requests to take bloods or undertake follow ups. The lack of admin support is causing some significant pressure on the QS&E team. <u>Risk Escalation Reports</u> <u>GP OOH/DN contact line</u> The weekend before last the telephone lines failed affecting GP OOH and DN lines – action plan has been put in place in case there is a power cut again. DN line was down for 11 hours, however, this was not raised as an issue until the following day, which was concerning it itself. GP line was back up within hours. No complaints or incidents have been raised since the line failure. NHS Direct and EU have reported that their service contacts were up at this period of line failure. <u>Fragile Practices</u> There are a number of fragile practices considering handing back contracts or mergers which is a significant amount of work and very time consuming in managing the QS&E challenges. RB and the Team are working incredibly hard at the moment to deal with some of those issues. About 6 practices involved are either fragile or going out to tender for alternate providers. <u>Vale CRT Physiotherapy Waiting List</u> VCRS Physio delay in the waiting list by approx 140 patients which has been caused by vacancies. The Vale Locality to manage and monitor this risk as recruitment takes place. <u>Reduction of performance in the Continence Service</u> Performance has been affected, due to staff leaving and it was predicted that the waiting list will be back to normal by June 2017, but this has been delayed, due to vacancies and sickness. It is hoped to be back to normal in November. To be monitored through the Vale Locality QS&E processes. <u>Continence/ART/Wound Healing – phone line issues</u> There is a need to transfer telephone numbers from Lansdowne to St David's twice in 6 weeks due to telecoms issues within the PFI building. The highest risk to the services this affects is with continence service due to the high number of patients on the caseload. CF is looking at different processes to reduce the risks with support from the Asst Locality Manager.	
	<u>Information Governance Group</u> No update at this time	

HEALTH PROMOTION PROTECTION AND IMPROVEMENT		Action
	Quality Dashboard No further update	
SAFE CARE		Action
	HCAI An Antimicrobial action plan is required for the clinical board to manage the CDIFF/MSSA & MRSA/ECOLI HCAI's – KJ Has met with Dr Eleri Davies and the IPC team to agree a way forward. CSI support has been agreed for ECOLI target. There are implications for a number of the clinical board teams including GP's There is a need to ensure that DNs are trained and understand the implications of the antimicrobial plan for wound care and catheter and UTI management. KJ has been out in the DN teams in the last week (Vale Locality) and she was very reassured by staff understanding of the importance of topical antimicrobial use in particular. Ecoli target– new guidance around UTI management as part of the Clinical board plan – common sense approach with the GPs. Catheter management as another opportunity to reduce ECOLI. Agreed targets no more than 20 Ecoli cases a month, last month there were 28 MSSA - no more than 2 a month – last month we had 8. MRSA 0. This will all be part of a plan and we will bring back draft plans for discussion to the September QS&E committee meeting. GH said there is no point in having an unrealistic target, KJ advised this is a WG agreed target and there is no Benchmarking info available currently Locality Pressure Ulcer Reports Nothing to report, monitoring and investigations continue Concerns report There needs to be an improvement generally regarding response rates, in particular in relation to dentistry concerns. With independent contractors, the clinical board have a light touch approach, if no resolution or satisfaction is achieved when the pt approaches the independent contractor then the UHB we will step in and oversee a satisfactory response. Concerns responses are not being undertaken in a timely fashion; this is unacceptable and does not comply with the "Putting Things Right" timescales. There are both internal and external issues; KJ expects an improvement going forward.	
EFFECTIVE CARE		Action
	Nothing to report at this meeting due to time constraints	
DIGNIFIED CARE		Action
	Prison action plan Updated Action Plan is required for September 2017, a number of actions still outstanding. NH to liaise with the Locality manager for an up to date action	

	plan.	
TIMELY CARE		Action
	Nothing to report at this meeting due to time constraints	
INDIVIDUAL CARE		Action
	Nothing to report at this meeting due to time constraints	
STAFF AND RESOURCES		Action
	Workforce report from Nicola Evans Staff turnover has been particularly high (May 16 – April 17) with 49% of staff leaving for reasons relating to promotion. 42.7% of registered nurses are over the age of 51 and this is concerning. We do benefit from people retiring and returning, although only 9 staff did this in the last 12 months. This is reported at the Exec Review and updated on a regular basis. There is a workforce workshop next week where the aging workforce is being discussed in relation to District Nursing where the largest numbers of over 50's, with a view to develop robust plans for the future.	
SUB-GROUP REPORTS		Action
	Cardiff North and West Locality AM said there had been an issue this week regarding a needlestick injury for a member of staff. There was an issue related to the procedure in that the GP who was not happy to bleed the patient as per policy. KJ to raise it at the next interface meeting. AM felt it was not unreasonable for GP to support the policy when a staff member has an injury. GH asked what the purpose of the test was – BBV, risk assessment? AM stated that GP wouldn't even comment or do a risk assessment when requested to do so. Member of staff felt very let down by the attitude of the practice. Cardiff South and East Locality NH advised re nicotine replacement – a revised process in place within HMP Cardiff, E-cigs are offered at reception instead of patches and this seems to be going well and is acceptable to inmates. The prison didn't take any advice from pharmacy staff regarding this, however. There is only a 4 week window to offer E-cigs and after that, an assessment for cessation, but there are real risks around the fact most prisoners do not want to give up and the risk of smoking the patches has been an issue. There are also some risks in the prison around staffing. Electronic sign in desks have now been placed in DOSH. There is a new diabetes specialist nurse who started a few weeks ago. There is money from Welsh Government for an additional B7 Diabetes Specialist Nurse for Primary care. Hopefully, this post will be managed in the community.	

	• Vale Locality CF mentioned that the Vale mobile phone coverage (O2) is getting positive results. This is via a pager. It is all synchronising with O2 and so now going to try it with EE. This is ongoing and looking positive. There are also some concerns regarding a residential home that is not showing signs of improvement despite proactive support. This situation is being closely monitored. • Out of Hours No representation at the meeting – report noted • Medicines Management Valproate – alert cards for women of child bearing age. Unfortunately, there has been no reduction in incidents, so advice has been reissued. KM was advised by Task & Finish Group she shouldn't be handing out these cards. She challenged this in that it is only raising awareness and it was a QOF requirement. KM said the advice notice should not be distributed until there is a health board wide agreed approach, which should be coordinated.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		Action
	NICE guideline (CG146) Issued February 2017 - Osteoporosis: assessing the risk of fragility fracture https://www.nice.org.uk/guidance/CG146 NICE guideline (MIB101) - Zio service for detecting cardiac arrhythmias https://www.nice.org.uk/guidance/MIB101 NICE guideline (MIB97) - TopClosure tension relief system for wound closure http://www.nice.org.uk/guidance/MIB97 NICE guideline (MPG2) - Patient group directions http://www.nice.org.uk/guidance/MPG2 NICE guideline (NG65) - Spondyloarthritis in over 16s: diagnosis and management http://www.nice.org.uk/guidance/NG65 NICE guideline (NG60) - HIV testing: Increasing uptake among people who may have undiagnosed HIV https://www.nice.org.uk/guidance/ng60 Nice guideline (NG28) - Type 2 diabetes in adults: management https://www.nice.org.uk/guidance/NG28 Nice guideline (NG69) - Eating disorders: recognition and treatment http://www.nice.org.uk/guidance/NG69	
	ANY OTHER BUSINESS	
	KJ reported that there are a number of ongoing Safeguarding issues, which are being worked through currently with the safeguarding team and Exec team members.	
DATE OF NEXT MEETING		Action
Date and time of next meeting : 12/09/2017		



MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 20th July 2017
Venue: Critical Care Resource Room

In Attendance: Carys Fox, Director of Nursing (Chair)
 Jessica Castle (JC), Director of Operations
 Hywel Roberts (HR), Consultant Intensivist & Medical QSE Lead for Specialist Clinical Board
 Rachel Barry (RB), Lead Nurse, Neurosciences & ALAS
 Suzie Cheesman (SC), Patient Safety Facilitator, Patient Safety
 Mary Harness (MH), Senior Nurse, Haematology, TCT, Clinical Immunology & Medical Genetics
 Fiona Kear (FK), Assistant Service Manager, Haematology, TCT, Clinical Immunology & Medical Genetics
 Sarah Matthews (SM), Senior Nurse, Nephrology & Transplant
 Sian Williams (SW), Senior Nurse, Cardiothoracic Services
 Beverley Oughton (BO), Senior Nurse, Critical Care
 Gareth Jenkins, Service Manager, Haematology, TCT, Clinical Immunology & Medical Genetics
 Claire Main, Lead Nurse, N&T
 Ceri Phillips, Senior Nurse, Cardiothoracics & CC
 Maurice Wentworth, Rehabilitation Engineering Unit, ALAS
 Martyn Read, Consultant, Critical Care
 Chris Bimson, Principle Finance Manager
 Derek King, IP&C
 Vince Saunders, IP&C
 Lisa Evans, Clinical Nurse Leader, Critical Care A3/B3
 Helen Scanlan, Service Manager, Haematology
 Jennifer Proctor, Lead Nurse, Haematology, TCT, Clinical Immunology & Medical Genetics
 Vinod Ravindran, Consultant Nephrologist

Present: Angela Hughes, Acting Assistant Director of Patient Experience
 Linda Hughes-Jones, Head of Safeguarding
 Gemma Williams, PA Specialist Services Clinical Board (Note taker)

PART 1: PRELIMINARIES		ACTION
1.1	Welcome & Introductions Angela Hughes, Acting Assistant Director of Patient Experience and Linda Hughes-Jones, Head of Safeguarding were introduced to the group. Both will be presenting at today's meeting. The group introduced themselves one by one.	

1.2	<u>Apologies for absence</u> Received from: Jonathan Kell, Navroz Masani, Hywel Pullen, Colin Gibson and Maria Roberts.	
1.3	To review the Minutes of the previous meeting 30th June 2017 The minutes were agreed as an accurate record. <u>Matters Arising</u> <u>Item 1.3</u> - NatSSIPs – MR informed the group that the summary of gap had been circulated with request for the Board to return. Staff have been challenged by the size of the gap and amount of work needed. MR noted that Critical Care have produced a skeleton list to share with other Directorates listing their procedures and documents used. Critical Care are locally defining how detailed each procedure should be. Partial or full applied for each procedure. CP confirmed that she had met with Mark Bennion, Clinical Governance Facilitator for the Surgery Clinical Board regarding an overview of what they had done. Action: CP will share this information with the rest of the Directorates. - Hand Hygiene – Directorates confirmed that staff on the wards felt able to challenge any staff that were not adhering to bare below the elbow. Directorates reminded to report any deviation to NM. - C.Diff/MRSA RCA reports – VS confirmed outside of the meeting that all the RCAs had been sent out in relation to C.Difficile and the RCA Tool for E coli has been drafted and VS is awaiting comments. Action VS: Aim to send out tool by next week. - National Survey Report – GW and CF confirmed that they had met to discuss the setting up of the data base to collect monthly Directorate figures. <u>Item 2.3 - Risk Register – Review and Revision</u> Neurovascular risk still ongoing. Action: JC noted that she will send RB the latest version. <u>Item 2.4 - Exception reports and escalation of key QSE issues from Directorate QSE groups</u> Supply chain problems affecting enoxaparin (Clexane) 20mg and 40 mg pre-filled syringes. Discussed below in item 5.1. <u>Item 4.1</u> <u>Patient Safety Incidents</u> Regulation 28 response DE – patient who presented at UHW A&E with severe abdominal pain. Not directly related to our Clinical Board but lessons learnt for all Directorates, re use of USS. Particularly relates to chest drain issue in Cardiac. Action: CP will speak to Richard Wheeler in Cardiology regarding sharing this information. <u>Closure forms</u> – JC confirmed that SC had attended their Weekly Ops meeting to discuss the closure forms in detail. <u>Item 4.2 - Patient Safety Alerts</u> Directorates were requested to review the following alerts: - MDA/2017/015 Solus Flexible Wire Reinforced Laryngeal Mask Airway - MDA/2017/017 BVM (Bag-Valve-Mask) manual resuscitation systems CF confirmed that she had received information back from Cardiac and Critical Care and forwarded this on to Matthew McCarthy in Patient Safety.	CP VS JC CP

	<u>Item 4.3 - VTE</u> Directorates were reminded of the importance of ticking the box on the IP prescription chart re “have you considered prescribing thromboprophylaxis – Yes/No”. <u>Item 4.4 - Health & Safety Group TOR</u> Action: JC confirmed that she will amend the TOR ahead of the next meeting and feed back then.	JC
PART 2: GOVERNANCE LEADERSHIP AND ACCOUNTABILITY		
2.1	<u>Patient Story - Safeguarding Cases</u> LHJ introduced herself as the Head of Safeguarding for the UHB. LHJ noted that the Safeguarding team were linking in with all of the Clinical Boards in order to help understand the breadth of safeguarding and its role. LHJ listed the members of the safeguarding team with the group. The annual safeguarding report will be on their website this week. LHJ reminded the group that Domestic abuse training was a mandatory requirement bound by an act of law. Mandatory May will now include this as a face to face session. Need 100% compliance by end of March 2018. LHJ requested that Directorates directly refer to this in PADRs. A brief overview of some of the areas that safeguarding covers was given; - Modern slavery - this is coming through more and more in recent times. - Female Genital Mutilation (FGM) - mandatory reporting compulsory. Action: MH will pick this up with the CNS for Sickle Cell. - Child sex exploitation. - Child practice reviews. - Domestic homicide reviews. LHJ referred to the Multi Agency Safe Hub (MASH) – which provides an IT platform for all agencies to share information. It was noted as an excellent area where information can be shared quickly. There is also a hub in Cwm Taf and a new one is being set up in Bridgend. LHJ informed the group that BO attends the Safeguarding Steering Group for the CB and disseminates any relevant information. BO shared a family experience with the group: BO met with a son and daughter of a patient who had passed away in Critical Care. The patient was found on the floor of her bathroom before coming through to EU. The son and daughter mentioned at the end of the meeting that they had a concern regarding domestic abuse. BO informed them of the process and what the standard practice was. The son and daughter suspected that their mother didn't actually fall and it was as a result of abuse by their mother's partner. This concern from the son and daughter was documented clearly in all the notes; however an actual referral was never made to the Safeguarding team. It came to light that because police had rung the ward enquiring about this patient and how she had fallen, the Sister on the ward assumed that a referral had been made. It was agreed that whoever was initially made aware of the potential domestic abuse should make the referral. BO noted that this information has been shared as a lessons learnt in the Critical Care Sister/CN meetings and safety briefings. Action: Directorates to share this message with their teams.	MH
2.2	<u>Feedback from UHB QSE Committee</u>	ALL

31.4

	CF informed the group that a staff nurse in Critical Care was organising for staff to take part in a half marathon on the 3 rd October. There will be two groups – walking group and running group. Weekly training sessions are being held. Aiming to raise £10,000 for Critical Care; 30 people have signed up to take part which is very positive. To be featured on UHB intranet.	
PART 4: SAFE CARE		
4.1	<u>Open Serious Incidents Report</u> CF noted that any open SIs were discussed yesterday at the Weekly Ops meeting as agreed at the previous meeting. 15 open SIs in total - 5 expected to be signed off by end of July. SC referred to an IR(ME)R incident in Cardiothoracics where a gentleman had received a post PPM insertion chest X-ray unnecessarily as the PPM insertion had been cancelled. There is a potential SI where a gentleman was found on the floor in his caravan and had been lying there for some time who was admitted to ITU with pressure damage that evolved to grade 3. Clarification needed as to whether his pressure damage is hospital acquired; SC awaiting feedback from Wound Healing. SC pointed out that all grade 3 or above hospital acquired pressure damage, whether it be due to non-compliance or not, is reportable to WG. A discussion took place regarding non-compliance with pressure relief. Nephrology and Transplant have developed a form that will be used where patients, deemed to have capacity, that are non-compliant with pressure relief sign to say they are aware of the potential consequences and risk of pressure damage as a result. They are also given a patient information leaflet. A discussion took place around capacity – Action: CM to speak to Julia Barrell and then feed back at this meeting. Discussion took place on best interest decision. HR noted that you have to use the patient's last decision as of when the patient had capacity. <u>Open Inquests</u> No new inquests – those included in attachment were discussed at the last meeting.	CM
4.2	<u>Mental Health Patients and Falls</u> CF informed the group that Simon Amphlett, SNM Crisis and Liaison Services, Adult Mental Health, had recently attended the Specialist Nursing Board to discuss how they can support Directorates with any challenging mental health problems. CF informed the group that the liaison psychiatry medical team cover the wards and the nursing team cover the patients in EU but that the two teams do not necessarily link up. CF will arrange a meeting with Professor Tahir and some CB medics to take this forward. Action: RB will ask Tom Hughes to attend. CF noted that Aron White, MH Practice Educator, also attended the same Nursing Board in order to discuss falls. The last 12 months of falls in MH were thoroughly reviewed by the practice educators and it was found that one patient had fallen 15 times even though they were being specialised. Post review, one patient had their specialising reduced from 24 hours to 6 hours a day because the patient was found to always fall around the same time so specialising was put in place to cover that "at risk" time. Action: CP will arrange for this to be discussed in the next Practice Educators Forum and will feedback.	RB CP
4.3	<u>Patient Experience Framework</u> AH informed the group that the Patient Experience Framework had been	

	refreshed. The framework details the different ways in which the patient experience stream can support the Clinical Boards in getting information which can be used to make effective changes to services etc. AH noted that the 3 year plan was included at the back of the document detailing the main points. Action: AH requested that Directorates read the document and send any comments back to her. AH informed the group of the areas that the Patient Experience Team covers; chaplains/volunteering/concerns/compliments. AH referred to the machines used to get feedback on whether the patient was happy with their care or not. The machine can help to flag up any issues quickly. 5 categories and the questions are asked to different groups – staff and patients. Generally the comments are positive. The machines are being moved around clinical areas and managers receive the report every Tuesday. Patient Experience is looking to develop existing surveys i.e. “2 minutes of your time” in order to make them more useful in relation to service change. AH informed the group that she recently attended the Parent’s Federation Group and was asked to feed back that it would be useful if any Learning Disability (LD) patients could be booked in for the start or the end of clinics so that the environment was quieter for them. Action: All Directorates to look into this. CP informed the group that the Cardiology OPs Suite is now moving to a new clinic which should support some of these issues.	ALL ALL
4.4	<u>Health & Safety Group TOR</u> This was deferred to the next meeting in August.	GW
PART 5: ANY URGENT BUSINESS		
5.1	<u>Any Urgent Business</u> <u>Enoxaparin availability</u> VR referred to the supply chain problems that are affecting enoxaparin (Clexane®) 20mg and 40mg pre-filled syringes. VR asked for an update on the shortage – JC noted that an update had been circulated at the beginning of July noting that there is sufficient stock available to meet UK demand between now and October 2017 (previously only to July/August). Action: GW to email Steve Gage, Pharmacy, for another update.	GW
PART 6: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
6.1	Received and noted for information	
PART 7: DATE OF NEXT MEETING		
7.1	Friday 11th August 2017, 8am, in the Critical Care Resource room, UHW. This meeting will be LD and IP&C focused.	



MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 11th August 2017
Venue: Critical Care Resource Room
IP&C FOCUSED

In Attendance: Carys Fox (CF), Director of Nursing (Chair)
 Jessica Castle (JC), Director of Operations
 Navroz Masani (NM), Clinical Board Director
 Maria Roberts (MRR), Patient Safety Manager
 Rachel Barry (RB), Lead Nurse, Neurosciences & ALAS
 Mary Harness (MH), Senior Nurse, Haematology, TCT, Clinical Immunology & Medical Genetics
 Fiona Kear (FK), Assistant Service Manager, Haematology, TCT, Clinical Immunology & Medical Genetics
 Beverley Oughton (BO), Senior Nurse, Critical Care
 Claire Main (CM), Lead Nurse, N&T
 Ceri Phillips (CP), Senior Nurse, Cardiothoracics & Critical Care
 Maurice Wentworth (MW), Rehabilitation Engineering Unit, ALAS
 Martyn Read (MR), Consultant, Critical Care
 Vince Saunders (VS), IP&C
 Jennifer Proctor (JP), Lead Nurse, Haematology, TCT, Clinical Immunology & Medical Genetics
 Judith Burnett (JB), Sister, Critical Care
 Hywel Pullen (HP), Head of Finance
 Keith Wilson (KW), Haematology Consultant
 Mark Jones (MJ), Directorate Manager, Nephrology and Transplant
 Kevin Nicholls (KN), Service Manager, Cardiothoracics and Critical Care
 Lorraine Donovan (LD), Senior Nurse, Neurosciences

Present: Gemma Williams (GW), PA Specialist Services Clinical Board (Note taker)

PART 1: PRELIMINARIES		Lead
1.1	<u>Welcome & Introductions</u> CF congratulated KN on his now permanent role as Service Manager for Cardiothoracics and Critical Care.	
1.2	<u>Apologies for absence</u> Received from; Kathleen Morris, Suzie Cheesman, Dale-Charlotte Moore, Sarah Matthews, Colin Gibson, Hywel Roberts and Deborah Hay-Harris.	
1.3	<u>To review the Minutes of the previous meeting 20th July 2017</u>	

	The minutes were agreed as an accurate record. <u>Matters Arising</u> <u>Item 1.3</u> <u>NatSSIPs</u> – CP confirmed that she had shared the information with other Directorates after meeting with Mark Bennion. <u>C.Diff/MRSA RCA Reports</u> – CF noted that she was aware that the RCA Tool for E-coli had been drafted but that she hasn't as yet seen it. <u>Item 2.3 - Risk Register</u> – Neurovascular risk still ongoing. JC confirmed that she had sent RB the latest version that has been added to the Clinical Board Risk Register. JC updated the group noting that there is currently no Interventional Neurovascular Consultant as the substantive postholder is on leave this week and next week. Outsourcing emergencies to England, and working with WHSSC about commissioning space in the Walton for elective patients. New appointment due to start at the beginning of October. Seeking Locum into third post – start date still outstanding. <u>Item 4.1 - Patient Safety Incidents – Regulation 28 response DE</u> – relates to use of point of care ultrasound and raises some issues that we have visited previously relating to competence in such procedures, for example, chest drain insertion. CP noted that Richard Wheeler has been on leave but that she is due to meet with him today to discuss. Action: CP to feed back. <u>Item 4.4 - H&S Group TOR</u> – JC noted that this will be discussed at the next meeting on the 31st August due to the full agenda for today's meeting. <u>Item 2.1</u> <u>Safeguarding – Female Genital Mutilation (FGM) and sickle cell</u> – MH noted that they had one recent case where a patient had had this procedure carried out and that the authorities were aware. Staff awareness increased <u>Potential Domestic Abuse</u> - Directorates were reminded to take the message back to their areas that a safeguarding referral must be raised as soon as concern is raised. <u>Item 2.2 Feedback from QSE Committee</u> – GW confirmed that this information had been shared from Suzie Cheesman with the group. <u>Item 2.4</u> <u>Estate Delays</u> – MW confirmed that some of the outstanding work had now been completed but not all. Action: MW to email CF with information on the outstanding work needed and she will again escalate. <u>Promat/Air Mattresses</u> – It was noted that Linda Walker, Director of Nursing, Surgery Clinical Board, had raised concern regarding the use of Promat mattresses at the Pressure Damage Group. Work is ongoing around this issue. <u>Lost Admissions Book</u> – Action: GW confirmed that she would arrange for the incident around the missing admissions book to be discussed at the next meeting. <u>Non-invasive Ventilation Services (NIV)</u> – NM confirmed that he would now be meeting with Richard Evans initially to discuss this before meeting with a wider group. Action: NM will feed back.	CP MW/CF GW NM

	<u>Item 4.1 Open Serious Incidents Report</u> – CM confirmed that she had spoken to Julia Barrell, Mental Capacity Act Manager, around a particular case in N&T. Not able to speak to the family as yet but the case is being dealt with at the moment. Patient still on Critical Care and has deteriorated. CM explained that she had been advised that short term what the patient has requested can be complied with, but in the long term they have to use best interest decision. <u>Item 4.2 Mental Health Patients and Falls</u> – Action: RB noted that Tom Hughes, Clinical Director, Neurology, has been on leave but that she will ask him to attend the meeting that will be arranged with Prof Tahir and the Clinical Board medics. <u>Practice Educator Forum</u> – CP confirmed that this meeting will take place in September and that she will ensure that “Falls” is on the agenda to be discussed. <u>Item 4.3 Patient Experience Framework</u> – CF reiterated that the document needs to be discussed in Directorate Q&S Meetings if it hasn't already. <u>Learning Disability (LD) Patients</u> LD patients to be booked in at the start or end of clinic when it's quieter – CF noted that LD is due to be the focus of the next meeting on the 31st August. <u>Item 4.4 H&S TOR</u> – To be discussed at the next meeting on the 31st August. <u>Item 5.1 Any Other Business</u> – Action: GW to contact Steve Gage for an update on the availability of Enoxaparin once he returns from leave.	RB GW
1.4	<u>Patient Story – Mary Harness</u> CF noted that she had asked MH to present the patient story in relation to IP&C which is the focus of this meeting - “Incident of Death due to Methicillin-sensitive staphylococcus aureus bacteraemia in Haematology”. MH presented to the group a story regarding a patient with Graft Versus Host disease after a bone marrow transplant for Acute Myeloid Leukaemia. A Serious Incident Meeting took place as part 1a of the death certificate cited MSSA as the cause of death which makes the incident reportable to WG. When investigated it was felt that MSSA was the cause of death even though there were many other factors which contributed – it was felt that the MSSA was the ‘final straw’ in a complex and critically unwell patient, susceptible to infection. <u>Recommendations</u> Screening protocol issues – there is a cost implication with screening all patients for MSSA. It was agreed that in this case screening wouldn't have made a difference due to the other factors involved in the patient's death. It has been agreed that any patient with an open wound or open skin will be screened in Haematology. CF noted that the case keeps being made that we should be measuring our avoidable infections and not all cases. MMR noted that the closure form had been completed and that there are pan-Health Board considerations regarding screening protocols and compliance to explore. NM noted that there are high numbers of MSSA so they do need to be investigated. CF noted that the closure form would ideally have reflected that the death was unavoidable due to other factors such as Graph versus host disease. CF also noted that the only area screening all patients is Renal but there is an associated cost issue.	

PART 2: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	<u>Feedback from UHB QSE Committee</u> No UHB meeting since our last Clinical Board meeting.	
2.2	<u>Risk Register – review and revision</u> Not discussed.	
2.3	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> None.	
PART 3: HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	<u>Initiatives to promote health and wellbeing of:</u> <u>Winter Flu</u> CF noted that Orla Morgan, Lead Nurse in Critical Care, was normally the Flu Champion for the Clinical Board, however as she is not available, MH has kindly taken over the role in her absence. MH will email out early September to get a core group together. Aiming to surpass last year's figures. Action: Directorates to send the names of their flu champions to MH. VS noted that the target was 65% - <i>post meeting confirmed that the target is actually 60%.</i>	Dirs
PART 4: SAFE CARE		
4.1	<u>Open Serious Incidents Report</u> Report attached for information. <u>Open Inquests Report</u> Report attachment for Information. <u>Closure Forms:</u> <u>IN46794</u> This gentleman was admitted to hospital with polytrauma following a road traffic collision. On arrival he required immediate surgery, during which he was supine on a hard operating trolley and post theatre required Critical Care intervention. He sustained multiple trauma including right frontal extradural haematoma for which he underwent neurosurgical treatment and insertion of an intercranial pressure monitor. He also sustained multiple facial fractures. The patient was being treated as an unstable spinal injury and required full immobilisation and log rolling at all times and was nursed on a hard spinal mattress. He was required to wear a rigid Aspen collar at all times. The patient started to develop pressure damage associated with the collar. It developed into grade 3 pressure damage. <u>Learning/action taken:</u> This incident has been raised at Safety briefings and it's been requested that patients with a collar in place are highlighted in the Safety briefing meetings. Teaching has been provided by Julia Teconi in Critical Care. A Consultant is carrying out work as an opportunity to improve the care of such patients by implementing a protocol with multidisciplinary partners to improve the timeliness of spinal clearance. MRR noted that this action had rolled forward from a previous closure form. MR felt that there is a protocol for Critical Care Consultants to clear cervical spines quickly. It is thoracic and lumbar spines that take longer. Action: MRR to review case as well as the Consultant as he has expressed the view that procedures are in place. CF noted that the	MRR

	closure form has been sent to Welsh Government. Action: MR to confirm the situation re clearing of cervical spines in CC. <u>IN47897</u> This case is discussed above in the patient story. A patient died on a Haematology ward and staphylococcus aureus septicaemia was listed on part 1a of the patient's death certificate. Graft versus host disease after bone marrow transplant for Acute Myeloid Leukaemia was listed as 1b. The contributing factors to the events were that the patient was severely immunocompromised following a history of intensive chemotherapy for his relapsed AML and stem cell transplant. <u>Learning/action taken:</u> The case will be presented at the Haematology Directorate Quality, Safety and Experience meeting in September 2017. This case has now been presented here at the Clinical Board QSE Meeting. The closure form will also be shared with WHSSC. IP&C will now be screening all patients with skin lesions in Haematology. All actions completed. <u>IN27526</u> A patient fell whilst visiting the bathroom on B4/C4. An X-ray revealed that the patient sustained a fractured humerus. Investigation also revealed that sedative medication intended for another patient was administered to this patient due to a miscommunication between radiology and the ward relating to the MRI scan booked for a patient with the same name. Poor documentation post falls. Fact patient was at risk of falls was not communicated well between wards. <u>Learning/Actions taken:</u> <u>Ward B4</u> - Safety briefings held at the beginning of every shift with an evidence sheet highlighting which patients are at risk of falling. - A new Intentional Rounding sheet is used aimed at reducing falls, supporting nutrition and monitoring skin condition. - All handover sheets are now driven through the clinical workstation to allow all staff easy and constant access to patients at risk of falls. - A Multi disciplinary meeting is held every week day at 9.00 on B4 discussing each patient their risks and their goals. - PSAAG board now has clear identification of all patients at risk of falls on the ward. C4 actions the same as above with the following: - Arranged for meeting with all ward staff to look at falls. - All staff asked for suggestions. - Falls alert posters placed in bathrooms. - Presented at Q&S with learning outcomes. - All Departments ask for name/dob/hospital no. when requesting scans. A discussion took place around the fact that staff didn't listen to the patient when she told them that she didn't require sedation for her MRI scan. It was suggested that this should have been included in the closure form as a key lesson learnt. <u>IN42421 Renal N&T</u> This relates to a diabetic man with a medical history of Type II Diabetes and Chronic Kidney Disease (CKD). The patient died and MRSA Bacteraemia from	MR

	infected dialysis catheter is listed on part 2 of his death certificate. The patient had been due to attend Cardiff North Dialysis Unit but did not attend. Contact was made with the patient by staff at the dialysis unit. The patient stated he was too unwell to travel due to vomiting. He was advised to visit his GP. The patient on two further occasions didn't attend and advised that he was too unwell. He was advised to go to A&E or call for an ambulance. The next day the patient was brought into the EU and admitted to ward B5 where the permacath was removed due to sign of infection at the site. The patient received dialysis via a femoral line. Following dialysis the patient became unresponsive and transferred to Critical Care on the basis that the patient had line related sepsis and septic encephalopathy. The patient tested positive for MRSA bacteraemia. A repeat Head CT scan was undertaken and reported a massive left sided middle cerebral artery (MCA) stroke. Sadly the patient passed away. <u>Learning/Actions taken:</u> - Re-educating staff to ensure all patients are screened on admission as is usual practice in this Directorate. - Ensure all staff are aware that a sticker must be placed in notes once MRSA/MSSA screen has been taken and sent. - Audit in mid September and then monthly. - The Clinical Board is currently rolling out Aseptic Non Touch Technique. Introduce care pathway for insertion of central venous catheters and continue to audit. Patients will be provided with information for signs and symptoms of sepsis that they need to report as specific symptoms to their GP. - Education will be provided to dialysis units on actions to take if a patient presents with signs of sepsis. All closure forms have been sent to Welsh Government.	
4.2	Patient Safety Alerts For information and action where necessary: <u>ISN: 2017/001 Consent legibility</u> Internal Safety Notice regarding consent forms being illegible, incomplete, abbreviated and not dated correctly. CF reminded the group about the importance of clear documentation. A discussion took place on the use of stamps for names as staff are not always printing and signing their name. CF noted that Sisters/Charge Nurses should be auditing 5 sets of notes a week. RB noted that Neurology had carried out a large audit on consent and that it may be useful to present it at this meeting. Action: CF agreed that this would be useful – GW to arrange. A discussion took place on the benefits of using electronic devices such as ipads. NM noted that pre-printed consent forms were useful. KW mentioned that they use a proforma in Haematology – Action: KW to send GW the proforma they use on their ward round to circulate to the group. Action: It was agreed that it would be useful to focus on consent at the September meeting and that Junior Doctors would be invited to attend. NM encouraged the use of cross-directorate/Clinical Board quality and safety sessions to encourage sharing of information. <u>ISN: 2015 / 002 (original) updated for 2017 Risks associated with confusion between Ketamine 10mg/ml injection and ESketamine injection 5mg/ml</u> For the attention of nursing, pharmacy and medical staff. Long term supply problem with Ketamine injection 10mg/ml led to the decision to purchase ESketamine injection from Germany – which is an unlicensed product in the	GW/RB KW/GW GW/CF

	UK. ESketamine is twice as potent as Ketamine. MH informed the group of an incident in Haematology where a patient was given ESketamine by mistake. It was noted that the patient was not harmed by the incident but there could have been serious consequences. MRR noted that this incident highlighted that the previous safety notice was not known to the staff and it was worth considering in this example whether Pharmacy could attach it if they dispense ESketamine instead of Ketamine. <u>PSN036 / November 2016 - Reducing the risk of oxygen tubing being connected to air flowmeters and Medical Air SBAR – August 2017</u> Air and oxygen flowmeters can be difficult to tell apart and as they both have universal outlets, oxygen can be attached to both. It has been recommended that medical air terminal units (wall outlets) are covered with designated caps in areas where there is no need for medical air. Medical air flowmeters are removed from terminal units (wall outlets) and stored in an allocated place when not in use. Air flow meters are fitted with a labelled, mobile flap. Action: CF asked Directorates to look at where they have air outlets on the wards and produce a plan around capping them off where suitable. CF suggested that a standardised HB approach would be useful as there is some concern from the Directorates about doing this without the support of the relevant departments who have been working on this safety notice to date. Action: MRR will feed this back. <u>Welsh Health Circular - All Wales Guidelines for the Management of Devastating Brain Injury</u> The guidelines are intended to reduce the variation in clinical practice across Wales in the management of Devastating brain injury. <u>Briefing paper – Achieving compliance with Patient Safety Notice 025 – Risk of death or severe harm due to inadvertent injection of skin preparation solution.</u> It was noted that this issue has been solved in Critical Care as they do not use any liquid skin prep. Action: Directorates to check whether they use pourable liquid in their areas. CF noted that the safest solution would be to use sponges or sprays. MMR added that the idea had been that once Critical Care achieves compliance, their practice can be shared which will aid those Directorates still using pourable skin preparation solutions. Discussion arose around the strength of suitable solutions for different procedures. Action: RB to look at practice re lumbar punctures. <u>Staff reminder for all staff involved with invasive procedures – linked to 025 safety notice</u> Safe Practice Reminder. If “pourable” skin disinfectant is clinically required, your Directorate must have written procedure in place to ensure the risk of accidental injection is minimised.	Dirs MRR Dirs RB
4.3	<u>New proposed management of radiology results</u> A number of recent cases within the HB have highlighted the need to develop a robust safety-net for the communication of critical and significant findings to prevent future harm of patients. Proposal for Radiology Notification Procedure for information.	
4.4	<u>Health Care Associated Infections - April 2017- July 2017</u> VS updated the group. July figures – 4 cases of C.Difficile. 14 to date so far. MRSA - 2 cases to date. Should be aiming for 0. MSSA - 12 cases so far – 2 cases in July.	

	E-Coli - 11 cases from April - 2 cases in July. E-Coli RCA Tool is now out. CF, VS and ED met with Renal and Haematology – going to look closer at Renal association guidelines as Renal figures have been a concern however it was noted that the context is important. VS noted that there had been a significant reduction in HCAs in Renal particularly in C.Difficile. CM noted that Renal perform well when benchmarked. MH noted an increase in line infections with Corynebacterium Jeikeium. Each individual case is being reviewed. Carrying out an audit to identify possible causes. KW noted that he wasn't sure there was an actual increase as lab reporting has changed. VS noted an outbreak in Medicine of C.Difficile. <u>HCAI Minutes 31.07.17</u> For information. <u>Clinical Board HCAI Review to end of June 2017</u> For information.	
4.5	<u>Lessons from Infection Outbreaks 2016/17</u> Slides for information/sharing in Directorates.	ALL/Dirs
4.6	<u>Sepsis Update</u> It was noted that Gemma Ellis, Consultant Nurse in Critical Care was not available to attend this meeting. Action: Defer to a future meeting.	GW
PART 5: ANY URGENT BUSINESS		
5.1	<u>Any Urgent Business</u> <u>Patient Fall in Bathroom</u> CM informed the group of another patient fall in the bathroom due to the floor being wet on T5. Patients don't feel safe as bathroom always wet. Action: CF will arrange a visit to T5. Also looking to move the waste disposal bin areas to somewhere more suitable. Exploring options. <u>Internal Audit – Serious Incidents (SIs)</u> For information - MRR informed the group that Internal Audit are carrying out an audit on SIs reported to Welsh Government from January-July this year. Directorates may be contacted regarding their management of their Serious Incidents.	CF
PART 6: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
6.1	Received and noted for information	
PART 7: DATE OF NEXT MEETING		
7.1	Thursday 31 st August 2017, 8am, in the Critical Care Resource room, UHW.	



MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 31st August 2017
Venue: Critical Care Resource Room
LD FOCUSED

In Attendance: Carys Fox (CF), Director of Nursing (Chair)
 Jessica Castle (JC), Director of Operations
 Hywel Roberts (HR), Consultant Intensivist & Medical QSE Lead for Specialist Clinical Board
 Suzie Cheesman (SC), Patient Safety Team
 Mary Harness (MH), Senior Nurse, Haematology, TCT, Clinical Immunology & Medical Genetics
 Fiona Kear (FK), Assistant Service Manager, Haematology, TCT, Clinical Immunology & Medical Genetics
 Beverley Oughton (BO), Senior Nurse, Critical Care
 Ceri Phillips (CP), Senior Nurse, Cardiothoracics & Critical Care
 Martyn Read (MR), Consultant, Critical Care
 Colin Gibson (CG), Clinical Engineer, Rehab Engineering, ALAS
 Vince Saunders (VS), IP&C
 Keith Wilson (KW), Haematology Consultant
 Kevin Nicholls (KN), Service Manager, Cardiothoracics and Critical Care
 Lorraine Donovan (LD), Senior Nurse, Neurosciences
 Martyn Read (MR), Consultant, Critical Care
 Dale Charlotte-Moore (DCM), Directorate Manager, Cardiothoracics & Critical Care
 Lisa Evans (LE), Sister, Critical Care
 Sarah Matthews (SM), Senior Nurse, N&T
 Sian Williams (SW), Senior Nurse, Cardiothoracics
 Richard Wheeler (RW), Consultant, Cardiology
 John Martin (JM), Clinical Director, Neurosurgery
 Mathew Price (MP), Service Manager, Neurosciences
 Helen Scalan (HS), Assistant Service Manager, Haematology, TCT, Clinical Immunology & Medical Genetics

Present: Gemma Williams (GW), PA Specialist Services Clinical Board (Note taker)
 Bethan Shiers (BS), ACHD Nurse and Lead for LD for the Clinical Board
 Kath Prosser (KP), Quality and Governance Lead, Medicine Clinical Board
 Andy Jones (AJ), Lead Nurse, General Surgery, Urology, ENT & Ophthalmology
 Professor Alan Fraser (AF), Consultant Cardiologist

PART 1: PRELIMINARIES		Lead
1.1	<u>Welcome & Introductions</u> CF welcomed everyone to the meeting. All attendees had their ID badges on display which CF noted was very good practice.	
1.2	<u>Apologies for absence</u> Received from; Maria Roberts, Navroz Masani, Beverley Oughton, Mark Jones and Jennifer Proctor.	
1.3	<u>To review the Minutes and action log of the previous meeting 11th August 2017</u> The minutes were agreed as an accurate record. <u>Matters Arising</u> <u>Item 1.3/4.1</u> CP noted that Navroz Masani, Peter O'Callaghan and Richard Wheeler have met regarding the regulation 28 response (initials DE) in relation to point of care ultrasound and competence in such procedures. There may be funding implications as a consequence and this is being worked through by the Directorate. <u>Item 1.3/2.4</u> CF confirmed that she had escalated the outstanding estates delay (pump for cleaning) on behalf of ALAS. GW confirmed that she had emailed Martyn Read regarding presenting the lost admission book incident in Critical Care and will confirm a date. No further update from Nav Masani regarding Non-invasive Ventilation Services (NIV). Action: CF will pick this up at the next meeting. <u>Item 1.3/4.2</u> CF confirmed that Tom Hughes is happy to be the medical rep at the meeting with Mental Health and Psychiatry. <u>Item 1.3/5.1</u> CF confirmed that an update had been circulated from Steve Gage, Pharmacy, on the availability of Enoxaparin. <u>Item 3.1</u> MH confirmed that all Directorates had sent the names of their Flu Champions to her. <u>Item 4.1</u> <u>Closure form IN46794 – Grade 3 pressure damage from Aspen collar:</u> MR confirmed that they did have a protocol for clearing cervical spines quickly but CF raised concern that the patient had the collar on for 3 weeks. Action: MR to discuss at Critical Care Q&S Meeting and review the process from a clearing point of view. <u>Item 4.2</u> GW confirmed that the Neurology consent audit will be discussed at a future meeting and will link in with a consent focused meeting – Action: Junior Drs to be invited to attend. Action: GW will circulate the consent proforma from KW to the group. CF confirmed that she had received the Directorate responses regarding the	CF MR GW GW

	capping off of flowmeters on the ward. Information on ordering caps has been circulated and Estates have agreed to fit where needed. Directorates to look at using sprays or sponges in relation to the inadvertent injection of skin preparation (if not already using). Action: LD to feedback to RB that spray needs to be used for lumbar punctures and skin prep. <u>Item 4.5</u> Reminder that “Lessons from Infection outbreaks” presentation to be shared in Directorates. <u>Item 4.6</u> GW confirmed that she had emailed Gemma Ellis, Nurse Consultant in Critical Care, regarding providing a sepsis update at a future meeting. <u>Item 5.1</u> CF will continue to look into the patient falls on T5 due to the wet bathroom. Action: Update at next meeting.	LD CF
1.4	<u>Patient Stories 1:</u> Professor Alan Fraser presented the first patient story to the group “Provision of transcatheter aortic valve implantation – lessons from case review”. This related to a case where a gentleman contracted acute lobar pneumonia whilst awaiting TAVI surgery and sadly died. The death certificate cited: Ia Bronchopneumonia II Severe aortic stenosis Chronic myelomonocytic leukaemia The patient’s widow wrote a letter of concern that her husband had been neglected by the doctors and by the hospital. Raising concern that her husband was left too long waiting for the operation. The report noted that earlier treatment might have altered the clinical course. The patient’s risk of acquiring pneumonia in hospital would have been reduced. There were avoidable delays in the time taken for consultations, in the time taken for some investigations, and in the time required to arrange his procedure. <u>Recommendations:</u> Mechanism to facilitate prompt treatment by TAVI in clinical circumstances where delay is inappropriate. Target for treatment within one week reasonable for urgent cases, within even shorter time when clinical emergency. Reasonable to draw analogy with urgent management by cardiac surgery of patients with critical aortic stenosis and heart failure. Guidelines on the management of valvular heart disease were also discussed: - Decision making should ideally be made by a “heart team” with a particular expertise in VHD. - TAVI should only be performed in hospitals with cardiac surgery on site. Multidisciplinary team meetings: In similar circumstances in future, patients should be placed directly onto the waiting list and arrangements made for their prompt treatment, without further delay while waiting for the next MDT. This would not prevent a decision from being reviewed and endorsed at a meeting, but it should not be deferred until that	

	has happened. RW noted that the TAVI list needs to be much more flexible. It was noted that the service was set up for surgical substitution for elective cases and not for acutely unwell patients. RW noted that they lose days adhering to the MDT principle waiting for decisions to be signed off. KW noted that in Haematology they don't use MDT to initiate treatment but for ratifying diagnosis. Action: CG will contact Professor Fraser regarding speaking at the Medical Equipment group which he attends for the Clinical Board. <u>Patient story 2:</u> Kath Prosser, Clinical Governance Lead for the Medicine Clinical Board, presented the 2nd patient story to the group in relation to the focus of the meeting; Learning Disability patients. The case related to a patient with severe learning difficulties, deafness, epilepsy and Graves disease. The patient was referred by her GP to MEAU UHL with a background history of vomiting noting her to have a tachycardia with thread radial and brachial pulses and a low BP with right basal creps. Within 17 hours of admission the patient's condition acutely deteriorated which required admission to Critical Care and whilst being intubated suffered an unsuccessful cardiac arrest. The cause of death was noted as Bronchial Pneumonia. Causes: - Patient couldn't communicate. - Nurses NEWS score showed that obs were not repeated for 12 hours. - The SpR that was called to see the patient was very focused on getting the patient well but didn't call the Consultant in for support/advice. - If 2222 call made there could have been a more focused approach/plan. Learning: A LIPS project was carried out which focused on patients with a Learning Disability. They looked at key risk assessments including communication, mental capacity, pain score, and levels of specialising. All of which aimed to improve the care of patients with a learning disability. HR raised concern that he was never asked for statement regarding this case and he was with the patient at the very end of her life. Action: KP said she will check that this is the same case and feed this back to the Investigating Officer. RW asked why the patient was being treated at UHL. Concern was raised regarding the level of care available at UHL for very sick patients compared to UHW, no Critical Care Outreach Team etc. HR noted that they are unable to provide the same level of Critical Care support at UHL compared to UHW. Action: CF will escalate these concerns to Graham Shortland, Medical Director and ask for an update on the situation.	CG KP CF
PART 2: SAFE CARE		
2.1	<u>Andy Jones, Learning Disability patients</u> Andy Jones presented to the group "Improving general hospital care for Learning Disability patients". Key Steps: • Early recognition • Effective communication • Patient centred care • Effective review and discharge planning.	

	Steps to be taken within 4 hours/steps to be taken daily/and steps to be taken within 7 days were discussed. The importance of immediate automatic flagging of Learning Disability patients was also noted. Andy showed the group where they could access the LD documents/support. “Show me where” app – was free now costs £5. Action: Directorates to engage with BS and AJ regarding the documents. CF noted that this work was nominated for the Nursing Times award and also the Patient Safety Award. Action: LE to include this information in the Critical Care Newsletter and speak to Nicola Robinson, Assistant Head Of Workforce And OD, regarding including this information in the next Specialist Services Newsletter. Action: GW to circulate the presentation to the group.	ALL LE GW
2.2	<u>Open Serious Incidents</u> CF and SC updated the group. New SI reported - Pressure damage in Critical Care sustained from a urinary catheter. Closed 2 SI's this month. Both Renal patients In11972 Suite 19 discharged – WAST not happy to take the patient. Called paramedic co-coordinator. Patient had a cardiac arrest in A&E and died on B5 the next day. In48866 C.Difficile case cited as cause of death on certificate. Ongoing further concerns as the patient had a Tenkoff catheter which was thought to be infected and have contributed to the patient's death. Action: Both closure forms to be presented at the next QSE. Currently down to 8 open SI's.	GW/CF/SC
2.3	<u>Patient Safety Alerts</u> Action: To be circulated after the meeting. <u>Medical Device Alerts:</u> MDA/2017/027 Intra-aortic balloon pump (IABP): CS100, CS100i, and CS300 – risk of haemodynamic instability to patients with critical conditions due to a delay in or sudden interruption of therapy. Looking at this in Cardiac there is one machine at risk in Cath Labs. Taken out of commission. Waiting for company to come and resolve. Device needs to be isolated and not just note on machine. Medical device Alert MDA/2017/019 Unomedical high concentration oxygen masks (specific lots) – risk of hypoxia as the tubing can disconnect from the oxygen mask. Awaiting information on whether we stock in procurement. <u>Safety Newsflash retained Guidewires</u> 8 of the 16 Never events reported over the past 2 years in the ED are retained guidewires following chest drain and central line insertion.	GW

	HR noted that it was £18.50 for the Wiresafe kit which would not be 100% guarantee of avoidance, it is also a rare complication so not cost effective. If price comes down then may reassess.	
2.4	<u>Health & Safety TOR</u> Action: Deferred to next meeting.	GW
2.5	<u>Healthcare Associated Infections</u> VS updated the group. • C.Difficile – 4 in August. 16 cases in the HB. Should be no more than 10. Same for all HBs across Wales. • 1 MRSA bacteraemia in Critical Care – line related. 3 cases to date. 5 in 2016/17. • MSSA bacteraemia – 1 case in August. • E-coli – 5 cases to date. CF noted that NM has finalised the PVC Intentional Rounding Tool. Test in Cardiac and feedback. Junior Drs are seeing every patient on ward every day retain or remove decision.	
PART 3: GOVERNANCE LEADERSHIP AND ACCOUNTABILITY		
3.1	<u>Feedback from UHB QSE Committee</u> Not discussed.	
3.2	<u>Risk Register – review and revision</u> JM updated the group on the risks around the Interventional Neuroradiology (INR) Service. There is currently no INR Service in this hospital at the moment. Patients are being sent to England. Looking at the beginning of October before the service will hopefully be up and running again. 10 elective cases are being sent to Liverpool. JM noted that Emma Jones, Neurovascular Nurse Specialist, has been doing an excellent job fielding a significant amount of telephone calls from patients wanting to know when they will be treated. CF noted that this risk was number 25 on the Clinical Board Risk Register. Working with CD&T, WHSSC and Executives trying to find a solution.	
3.3	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> None identified.	
PART 4: ANY URGENT BUSINESS		
4.1	<u>Any Urgent Business</u> <u>Contrast CT Scans</u> SC raised concern that patients going for scans won't be able to receive contrast CTs. HR noted that they were aware of this issue and that there was a solution. Action: SC and HR will discuss further outside of the meeting and to be discussed in CC Q&S.	SC/HR
PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	Received and noted for information	
PART 6: DATE OF NEXT MEETING		
6.1	Friday 22 nd September 2017, 8am, in the Critical Care Resource room, UHW.	



**Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 22nd September 2017
Venue: Critical Care Resource Room
MINUTES**

In Attendance: Hywel Roberts (HR), Consultant Intensivist & Medical QSE Lead for the Board
 Jessica Castle (JC), Director of Operations
 Navroz Masani (NM), Clinical Board Director
 Suzie Cheesman (SC), Patient Safety Team
 Fiona Kear (FK), Assistant Service Manager, Haematology, TCT, Clinical Immunology & Medical Genetics
 Colin Gibson (CG), Clinical Engineer, Rehab Engineering, ALAS
 Vince Saunders (VS), IP&C
 Keith Wilson (KW), Haematology Consultant
 Kevin Nicholls (KN), Service Manager, Cardiothoracics and Critical Care
 Lorraine Donovan (LD), Senior Nurse, Neurosciences
 Sarah Matthews (SM), Senior Nurse, N&T
 Sian Williams (SW), Senior Nurse, Cardiothoracics
 Mathew Price (MP), Service Manager, Neurosciences
 Lisa Morgan (LM), Senior Nurse, N&T
 Gareth Jenkins (GJ), Service Manager, Haematology, Immunology and Medical Genetics
 Jennifer Proctor (JP), Lead Nurse, Haematology, TCT, Immunology and Medical Genetics
 Rafael Chavez (RC), Consultant, N&T
 Steve Gage (SG), Lead Pharmacist for the Board
 Maria Roberts (MRR), Patient Safety Manager
 Gemma Ellis (GE), Consultant Nurse, Critical Care and Sepsis Lead Nurse

PART 1: PRELIMINARIES		Lead
1.1	<u>Welcome & Introductions</u>	
1.2	<u>Apologies for absence</u> Received from; Carys Fox, Mark Jones, Mary Harness, Andrea Edwards, Carol Evans, Hywel Pullen and Ceri Phillips.	
1.3	<u>To review the Minutes and action log of the previous meeting 31st August 2017</u> The minutes were agreed as an accurate record. HR requested that the action log is circulated shortly after the meeting so that attendees have more notice to carry out their actions. <u>Matters Arising</u> 1.3/2.4 – NM noted that there had been an NCEPOD report on Non-Invasive Ventilation Services (NIV) which mainly related to the Medicine Clinical Board but that there were some issues to be picked up within Specialist. This work is	

	ongoing. There was a business case but that it was high cost so now looking at what can be done within the financial framework. GE noted that she was one of the authors of the report and would be happy to be involved. Action: NM will contact GE outside of the meeting. 1.3/4.1 – MR to discuss the protocol for clearing cervical spines at the Critical Care Q&S meeting and review the process. Action: MR to update. 1.3/4.2 – GW confirmed that the consent focused meeting would be taking place in October. GW also confirmed that she had circulated the consent audit from Keith Wilson. 1.3/4.2 – LD confirmed that she had liaised with Haematology and found a 0.2% spray that they could use instead of Chloroprep for lumbar punctures and skin prep in Neuro. 1.3/5/1 Carys Fox, Director of Nursing for the Clinical Board, was not available to give an update on the wet bathrooms on T5 but SM confirmed that Carys had visited T5 expecting to meet Estates but that they didn't arrive. SM noted that they were currently trying to get the bathrooms changed to wet rooms but that they were a long way down the list on the bathroom priority programme. It was agreed that the H&S risk to patients must mean that these bathrooms should be a priority. Action: SM to liaise with Carys outside of the meeting. Review at next meeting. 1.4 – CG confirmed that Professor Fraser would be attending the Medical Equipment Group re the patient story that he gave at the last meeting. KP was going to check that it was the same case that HR had been involved with and let the investigating officer know if so. NM will speak to Carys when she returns regarding whether she had managed to escalate the issues of treating very unwell patients at UHL which is not as equipped for these patients as UHW. 2.1 – Directorates were reminded that they needed to engage with Bethan Shires and Andy Jones re the Learning Disability documents available. Lisa Evans not available – Action: GW will check that she has included the Learning Disability (LD) information in the Critical Care newsletter and contacted Nicola Robinson about including it in the Clinical Board newsletter. GW confirmed that she had circulated the LD presentation that Andy Jones gave at the last meeting. 2.2 – GW confirmed that the two closure forms (In48866 and In11972) were included on the agenda to be discussed. 2.3 – GW confirmed that the following patient safety alerts had been circulated to the group; MDA/2017/027 and MDA/2017/019. 2.4 – GW confirmed that the H&S Terms of Reference (TOR) were included on the agenda to be discussed. 4.1 – HR confirmed that the issue with contrast CT scans was an ongoing issue that they have been aware of for some time and that there was a solution.	NM MR SM GW
1.4	<u>Patient Story</u> HR confirmed that there was no patient story today.	

PART 2: SAFE CARE

2.1	<u>Sepsis Update</u> GE presented an update on Sepsis to the group. A large amount of activity in all countries – 44,000 people a year die from Sepsis (estimate) in the UK. From 2010 to present, rates of sepsis have come down. Rates are now at 18% which is good. Introduction of NEWS and the Critical Care Outreach Team (CCOT) helped to reduce the rate of sepsis. Sepsis Medical Lead is Paul Morgan and the Sepsis Nursing Lead is Gemma Ellis. Sepsis Six Trolleys have been introduced which mean that it is easier for staff to deliver the “Sepsis Six” in a timely manner and is a checklist of what needs to be done when treating someone for sepsis. The NICE compliance Sepsis pathway has been rolled out UHB wide. Plan still needed for UHL. World Sepsis Day 2017 – Aled Evans, HCSW/student nurse, won first prize for his story board. HR noted that the whole team should be congratulated. JC noted that it would be beneficial to promote this work to other Clinical Boards. Action: JC will email the other Clinical Boards to arrange for GE to present at their Q&S meetings. GE noted that she would be happy to support any areas where needed. Action: GW will circulate GE’s presentation to the group.	JC GW
2.2	<u>Open Serious Incidents</u> SC confirmed that there were currently 10 open SIs – including 1 old. 8 of them were out of date and not submitted to Welsh Government in time. 2 are still in time. SC referred to the new SI reported at the last meeting where a patient had sustained pressure damage from a urinary catheter and noted that the patient had now sustained further pressure damage to their ankle. <u>Closure Form IN11972</u> A patient known to the dialysis staff attended Suite 19 for dialysis. The patient had chronic lung disease and required home oxygen, along with a number of other health conditions. She was also a wheelchair user due to Spina Bifida. She had been discharged from hospital a week prior to the incident. The patient complained of feeling unwell shortly before coming off dialysis, observations were taken and she was reviewed by a junior doctor who discharged her. On transfer to Welsh Ambulance (WAST) staff were concerned about her condition and informed the staff at the hospital. This was discussed with the junior doctor but no further review took place. WAST staff requested assistance from their control and a paramedic attended. The patient was transferred to the emergency unit suffered a cardiac arrest where she was resuscitated. The patient sadly died the following day. The findings were discussed in detail, full list available on the closure form. Confirmation of actions: - Ensure ambulance crew collect the patient from the clinical area and are satisfied that patient is stable for transfer prior to taking to ambulance. - Implement review of patients by medical team to ensure prescriptions are up to date including reassessment of dry weight. - Implement standardised assessment tool for monitoring observations and patient changes – NEWS. - Implement SBAR tool for handover of patient and agreed protocol for escalation of patients.	

	This form has been sent to Welsh Government. <u>Closure form In48866</u> The patient was admitted to hospital from clinic with a distended abdomen and discharged 2 days later with no sign of infection. A short while after the patient was readmitted to Critical Care and then sadly died a couple of weeks later in hospital. Part 2 of the cause of death is recorded as; Renal Transplant 1999, Infected Tenckhoff line, Clostridium Difficile infection. Family concerned it was a line related infection which should have been taken out sooner. The findings were discussed in detail with the group. Confirmation of actions: - Review any incidents of C.Difficile on the transplant unit to ensure an RCA is completed in a timely manner and reviewed by the Directorate's senior clinical staff in conjunction with IP&C and Clinical Board management team. - Antimicrobial stewardship to continue with a programme of monitoring hand hygiene audits, bare below the elbows audits, equipment and commodes. - Review the patient's case with microbiology colleagues and IP&C. - The Clinical Board will continue to focus regular Q&S meetings on the infection prevention and control agenda. Welsh Government has now closed this case.	
2.3	<u>Patient Safety Alerts</u> Ref: EFA/2011/007 – Estates and Facilities alert: Risk of ammonia gas leakage from Electrolux (Domestic) absorption pharmacy / drug refrigerators. All Directorates confirmed that the necessary actions had been taken.	
2.4	<u>VAD Guidelines to be ratified</u> JP noted that the documents had been sent out prior to the meeting to check that Directorates were happy to use this guidance in their areas. Action: Directorates to review and respond back to JP ahead of the October meeting. Action: JP to provide update at the next meeting.	Dirs JP
2.5	<u>Health & Safety TOR</u> JC noted that the TOR were at the final draft stage and were ready for review. They mirror the UHB H&S Committee TOR. One of the Directorate Managers will chair the meeting which will take place quarterly. The minutes will be brought to this group for information. The group agreed that this seemed an appropriate way forward. The TOR were approved.	
2.6	<u>Healthcare Associated Infections</u> NM referred to the issue of antibiotic prescribing and high levels of C.Difficile noting that this had recently been discussed in IP&C, HSMB and the Clinical Board Executive Performance Review. NM noted that an email would be coming out to Directorates looking for a leadership team to work with Federica Faggian, Consultant Microbiologist, who is leading on this, to take this work forward. Rigorous reviews are needed on what antibiotics we are using. VS referred to the report he that he had circulated ahead of the meeting. MSSA Bacteraemia – 2 new cases on CCD. 15 cases to date. C.Difficile – 2 new cases B4N and CTU UHW. 20 cases to date. MRSA Bacteraemia – no new cases. 4 to date, only 5 last year. E.coli bacteraemia – 4 new cases to date UHW B1, UHW B5, UHW B4H, UHW	

31.4

31.4



Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
Date and time: 17th August 17 14:00 – 16:30
Venue: Classroom 2

Present: Jason Roberts Kath Prosser Gemma Murray
 Barbara Davies Lisa Harwood Vince Saunders
 Alice Richards Delyth Jones Lisa Waters
 Sian Brookes Lisa Graham Derek King
 Debbie Hendrickson Gill Spinola
 Katrina Pearce

In attendance: Sue Bailey Simon Barry

Apologies: Dave Pitchforth Tara Cardew Mudassir Pasha
 Sharon O'Brien James Coulson

Preliminaries		Action
A1	Welcome & Introductions JR Welcomed all present.	
A2	Apologies for absence Apologies noted as above.	
A3	To receive the Minutes of the previous meeting The minutes of the previous meeting, held on 20 th July, were accepted as an accurate record of the meeting. Actions: It had been agreed that the outcome of RCAs could be shared with the patient's family before it had been closed by the WG. It was also agreed that all members of staff being included in email discussions about the RCA should be informed when it had been closed. RA had spoken to Sandra Coles regarding comments shared on Facebook regarding the recent changes to arrangements regarding specialising.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.1	Patient Story – Internal Medicine BD had been contacted by the Daily Mail to inform her that an article involving a patient who had died on a Medicine ward and been left on the ward from 7am to 3.30pm was due to be published the following weekend. Although BD was not aware of the full content of the article, she gave an account of the incident as reported by the ward staff:	

	- The patient had died at 8.10am and the family had been informed - A porter was requested at around 11am, after the family had been to the ward, and ward staff were told at around 12pm that the concealment trolley could not be found as contractors working in the mortuary had moved the trolley - Due to the work being carried out in the mortuary, it could not be accessed until 2.30pm and it was accepted that the patient could not be moved until this time, even though the deceased patient was in a public area and visitors would be on the ward during this time - An anatomical mortuary technician was not called as nobody on the ward knew they should - On the ward in question, the deceased patient could have been moved to a treatment room but not all wards would have had this option. The patient was not moved to a cubicle as they were occupied by patients with IPC issues, thus taking priority over end of life - BD and the staff on the ward at the time had not believed this to be a reportable incident due to the circumstances This had been reported to the Daily Mail by another patient or their family, not by the family of the deceased, who were unaware of the Daily Mail's intention to publish the article. JR was due to contact the family to give them advanced warning.	
1.2	Feedback from UHB QSE Committee http://www.cardiffandvaleuhb.wales.nhs.uk/quality-safety-and-experience-committee- All present were alerted to the above link for information.	
1.3	Directorate QSE minutes – exception reporting KP had received papers attached in the following link: ..\..\Directorate Q&S mtgs\2017 JR asked that a record of the meetings held and minutes submitted be made and circulated with future agenda for this meeting.	AH
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	Flu Plan 2017 KP had received nominations to receive Flu Champion training but there was still one ward outstanding yet to nominate a Flu Champion. KP reminded all present of the role and duties of the Flu Champions in maintaining greater control over the number of vaccinations given and maintaining records on numbers of staff refusing to be vaccinated. The target for 2017/18 was 60%. It was not yet known when the vaccinations would be provided but this was believed to be mid to late September.	
2.2	Older Persons Day This UK wide event was due to be held on 1 st October but Ian Dovaston, who was leading on this on behalf of the Clinical Board, had planned a number of activities and awareness to be held on 2 nd October. The Fire Service was due to be invited to attend to provide safety information.	
2.3	Inspiring Change Simon Barry had recently carried out a review of the quality of care provided to patient receiving acute non-invasive ventilation on the Medicine wards. There was a requirement that NEWS charts were to be completed and vital signs to be recorded hourly until the patient's acidosis was	

	corrected. This raised governance issues around the medical nursing arrangements in place. Self-supporting NIV patients could be supported in UHL noting the difficulties with the appropriate medical and nursing cover. SB had written a business case for 3 male and 3 female NIV beds on ward B7 for acute NIV patients. Richard Evans had requested an options paper from the directorate; JM agreed to speak to Cari Randall and Aled Roberts about the progress of the paper.	JM
SAFE CARE		
3.1	New SIs KP congratulated all present on the number of SIs, the lowest in a long time. There were none currently open in Internal Medicine. Five new SIs had been reported in July. The following incidents, that had been closed by the WG, were shared for discussion and learning: <u>Emergency Medicine</u> Two incidents relating to patients not being recalled following X rays: In44505 A patient with renal colic had refused to wait to see a surgeon and discharged herself. Her X rays showed an abnormality with a potential for lung cancer; this was not followed up and she later died of lung cancer. In45565 A facial X ray suggested myeloma; this was not followed up and the patient was later found to have breast cancer. Findings: It was unclear whether one of the X rays had been seen; the other had been reviewed as a paper copy. The existing SOP is implemented well but had since been reiterated and consultants were now being asked to sign the X ray form to confirm they had reviewed the X ray. SB advised that Radiology operated two IT systems, RADIS and PACS; these had limited capability to communicate with each other and were mainly used to store images. More integrated systems were available and PACS was due for replacement but Cardiff and Vale was required to accept the All Wales solution that was not currently integrated. <u>Clinical Gerontology</u> In47910 A sling hoist had been used rather than a Hoverjack. The Ward Sister had fed back to ward staff on the importance of selecting the correct hoist and the potential for causing further harm when using the wrong hoist. NB: KP noted that the quality of the report provided by the Ward Sister was of a high standard and could be used as an exemplar. <u>Dermatology</u> In45847 A patient with a basal cell carcinoma (BSC) was put on a waiting list. The patient reported changes in his condition to his GP who referred him back to Dermatology for an ultrasound and onward referral to a vascular surgeon. The patient was subsequently diagnosed with an extremely rare carcinoma and brain and lung metastases were also detected. This was a rare and unusual case and it had been found that the initial diagnosis was correct and the ultimate outcome for the patient would have been the same even if they had been treated differently. The BSC waiting list had been the subject of a transformation programme to reduce waiting times. There were also discussions on-going around whether referrals for further scanning should come from Dermatology or the	

	vascular surgeon.	
3.2	Patient Safety Alerts The following alerts were noted for information: PSN 025 Safe practice reminder – Inadvertent injection of skin preparation solutions ISN 2017 001 Consent legibility Public Health England: Hepatitis B Vaccination in adults and children: temporary recommendations PSN036 Air flow meters	
3.3	Health Care Associated Infections HCAI rates C.Diff/MRSA RCA reports 3 days had passed since the last reported case of C.Diff, 2 days since MSSA and 3 days e.coli. With regard to reduction targets, the Medicine Clinical Board had exceeded the C.Diff target by 2 and the e coli target by 4 but was within the MSSA target by 1 reported case. KP emphasised the urgency in improving this situation and asked that RCAs be completed in a timely manner. RCAs for the C.Diff cases had been received; early indications were that antibiotics had been given in accordance to accepted guidance but discussions were being held regarding bare below the elbow requirements. JR had received emails from a number of clinicians asking if an increase in cases of C.Diff was seen following the increase in antibiotics given for the prevention/treatment of sepsis. JR was giving this matter further consideration. It was not known whether other Clinical Boards had seen an increase in HCAI. There was no common theme between the C.Diff cases reported on A7, C7, SRC, CFU and East 8. 3 patients on A7 had been ribotyped and a further 2 were expected on SRC. GS advised that HPV cleaning had not been available for the past two weeks. It was noted that the results of handwashing audits differed greatly when completed by the wards, with results at 100%, and IPC auditors, at 77%. JR agreed to undertake a review of the housekeeping schedules and asked all present to inform him of any individuals who refused to comply with bare below the elbow requirements.	JR
3.4	SBAR Traceability Patient safety notice SB reported on a recent inspection visit to the Blood Transfusion Lab by the MHRA: - It was expected that every unit of blood should be fully traceable from donation to receipt with records to be kept for 30 years	

	- Incidents of records not being found were to be recorded on Datix and the MHRA expected that an RCA was also completed - Reports on data non-compliance had been circulated - It was expected that one tool would be used to summarise all incidents and subsequent actions - It was suggested by the Senior Nurses that one box be used on each ward to collate all labels or to send the labels directly back to the labs via a pod. The use of a box had previously been discouraged due to the requirement that labels were returned within 24 hours	
3.5	NPSA 16 Radiology/results reporting process A patient safety notice had been issued to ensure radiology reports were reviewed and acted upon and to ensure that the Radiology department delivered reports to clinicians. The Radiology department had developed a notification procedure to flag certain reports; a red flag to highlight anything untoward, patient to be recalled and a suspected new cancer. It was intended that a list of flagged X rays would be emailed to a reliable email list with an expectation that a nominated person in the directorate would action any flagged reports. This programme was to be piloted in the near future; JR agreed to feed back to Richard Evans with the suggestion that the Medicine Clinical Board take part.	JR
3.6	NaTSSIPs update National Safety for Invasive Procedures Designated leads had been appointed in all but one of the Medicine directorates. KP had suggested that Internal Medicine and Clinical Gerontology use the same designated lead due to the similarities across the directorates. KP asked for all responses to be submitted in time for her to provide feedback on 11th September.	
EFFECTIVE CARE		
4.1	Director of Nursing Quality & Safety Reports JR noted that the Clinical Board was performing well in a number of areas and thanked all present for their hard work in driving down SIs and the timely return of RCAs; both of which had been noted at a recent Exec Review. JR intended to discuss the gradual increase in PSIs at the forthcoming Lead Nurse meeting. Performance around IP&C had been positive but following a recent drop it was intended that the Clinical Board put together a recovery and improvement plan. At 39%, Concerns responses were well below the target of 60% - the Board was planning how assurances that this would improve could be given at the Exec Review due to be held in September. There had been no increase in the number of patient falls; the Clinical Board was following an average number despite recent changes to specialising arrangements. JM reported that the enhanced care level 4 had increased over the past week.	
4.2	Model Ward Report	

	A report had been circulated; wards A4 and East 2 were piloting a model ward scheme for nutrition and hydration, initially for a period of 6 weeks but this had been extended to 2 months. As part of this pilot, changes had been made to ordering processes for patient meals, presentation of meals had been improved and increased milkshake and juice rounds had been provided. The existing Health and Care Standards had been used as a baseline measure and great improvements in patient nutrition and hydration had been seen. During the pilot there were no measurable changes in LoS but this was attributed to external factors. Data on falls improvements were similarly inconclusive. Both wards had reported the pilot to be a hugely positive experience and had hosted excellent CHC visits during the pilot. Ward A4 had also hosted a visit from the Health Minister, who had been impressed by the scheme.	
4.3	Audits for sharing: Delirium Audit – JR congratulated the staff of UHL following a successful audit during which 60% patients did not move wards Following Fall Audit – KP agreed to share resources used on individual wards Management of Young Peoples Mental Health in Emergency Medicine – noted OTTAWA Knee Rules – noted	
DIGNIFIED CARE		
5.0	HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans – verbal update on action plan JR asked that this be carried forward to the meeting due to be held in October.	AH
TIMELY CARE		
6.1	Waits within Emergency/Acute Medicine JR queried the possibility of including information on patients waiting 40, 50 and 60 hours following a weekend. JM agreed to give a briefing on actions arising from a discussion on this. The Chief Exec, Len Richards, was interested on work around the number of discharges before 9am. It was noted that in UHL five patients are transferred to the discharge lounge each day before 9am.	JM
INDIVIDUAL CARE		
7.1	National User Experience Framework Feedback from 2 minutes of your time survey – relevant improvement plans Wordle noted.	
7.2	Shared Claim KP recounted a claim around a husband and wife who had died while inpatients noting that both concerns were based around poor of communication: Mrs A had been placed on a commode and fallen off, she subsequently died from a large haematoma a few days later. Her death certificate recorded aspiration, pneumonia, dementia and haematoma.	

	Mr A had been admitted following a heartache, at which time his family informed staff that he used Movacol but this was not prescribed for him while he was on the ward. He subsequently became severely constipated, vomiting faecal matter, and matter.	
7.3	Complaints and trends It was agreed that the reported figure of only 39% of concerns closed within the target timescale was correct as a high number of concerns had been closed over recent weeks. A new figure was to be provided. One informal concern had been received from a lady who had visited her sister on a ward and become aware that a deceased patient had been left on the ward for five hours. JM had spoken to the lady raising the concern who had suggested that a room on the ward be made available for such events. A patient known to Mental Health had recently lost a brace in A&E and had been in contact to ask if it had been found. LW agreed to check if this had been followed up. Compliments Compliments had been received for wards East 4 and A7 and Emergency Medicine.	
Staff and Resources		
8.1	Staffing levels This item was not discussed, JR agreed to add a written summary to future agenda.	JR/AH

PART 2: Items to be recorded as Received and Noted for Information by the Committee

Date and time of next meeting: 19th October venue to be confirmed



Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
Date and time: 19th October 17 14:00 – 16:30
Venue: Classroom 1

Present: J Roberts G Murray B Durham J Murphy
 R Alyward I Dovaston G Ellis K Pearce
 K Prosser S Parkhouse S Curtis
 T Cardew D King L Harwood
 G Spinola D Pitchforth S Cheesman

Apologies: S O'Brien A Jones
 S Jones W Parsons
 D Hendrickson L Graham
 D Shannahan

Preliminaries	
A1	Welcome & Introductions JR welcomed all present.
A2	Apologies for absence Apologies as noted above.
A3	To receive the Minutes of the previous meeting The minutes of the previous meeting held on 17 th August 2017 were accepted with two amendments: 3.1 change of Incident number In47210 to In47910. 7.2 shared claim Novacol changed to Movacol.
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY	
1.1	Patient Story – Emergency/Acute Medicine BD presented a patient story in relation to a patient who attended the Emergency Department with a potential stroke. From the time of admission to the unit and transfer to the ward the patients journey was a total of 3 hours. This was found to be a result of working in partnership with the Acute Stroke Unit and joint working in terms of providing a seamless and timely admission to the UHB. Praise was given noting that the UHB is now recognised as a Centre B for Acute Stroke Care Pathway. Older Persons Day. ID gave a brief summary of the excellent Older Persons sessions that were carried out across the UHB including afternoon teas, advice on physiotherapy/occupational therapy MOT's and strength and balance advice. Newsletter to be widely shared across the UHB.
1.2	Feedback from UHB QSE Committee http://www.cardiffandvaleuhb.wales.nhs.uk/quality-safety-and-experience-committee- All present were alerted to the above link for information.
1.3	Directorate QSE minutes – exception reporting

	KP advised that in terms of Directorate QSE meeting and minutes: Emergency Medicine received from Directorate QSE 13th September. JR highlighted E Datix reporting within Emergency Medicine and a concern raised that staff are unable to enter information regarding patients being in the wrong area of the department. KP reassured the group that staff are able to identify individual areas within Datix for patients being potentially nursed in inappropriate areas. BD to feedback to JM. Adult Massive Haemorrhage protocol has been agreed. Internal Medicine QSE meeting was held in September – await minutes Gastroenterology QSE meeting was held in September – await minutes Clinical Gerontology QSE next meeting being held in November Acute Medicine QSE next meeting being held 26th October
HEALTH PROMOTION PROTECTION AND IMPROVEMENT	
2.1	Flu Plan 2017 up date KP advised we are in week three of the flu vaccination programme. Scores for week 2 is that we have vaccinated 20% of staff. Compared to last year Public Health have advised that we have already vaccinated more staff at this point than the whole of October 2016. KP thanked all of those Champions who have already started vaccinating and for supporting those areas that do not have Champions. JR discussed the prize money for the most improved Clinical Board and best Clinical Board for flu vaccination. Each Clinical Board is able to decide how they want to spend the money if they are successful. The message is still that it is important to vaccinate our staff to protect patients and that we should be promoting the uptake of this.
2.2	UHB Sepsis up date GE Consultant Nurse in Critical Care and Sepsis Lead Nurse for the UHB provided an update on Sepsis within the UHB. Significant focus on Sepsis at the moment both locally and globally. Sepsis accounts for 44,000 deaths a year, in Wales 2,200. The Sepsis 6 which is advocated is compliant with NCPOD, NICE guidance and standards. It is essentially give three take three, give oxygen, IV anti-biotics and IV fluid challenge, take blood cultures, lactate and FBC and measure urinary output. Since August 2016 all UHBs have had to report to WG compliance with Sepsis 6. Currently only reliable data available is mortality data. Since 2010 UHW mortality from sepsis has reduced from 33% to 18%. In UHL there has been no movement in sepsis and the mortality rate remains 33%. Both hospitals have the introduction of NEWS and outreach service at UHW which has had an impact on identifying sepsis. AKI e alerts are also be studied as AKI patients will develop sepsis. Within UHB a medical and nursing lead has been appointed and a multi-disciplinary Sepsis Interest Group and a UHB Sepsis page and sepsis awareness days. Ongoing randomised trial with WAST to review if patients could have blood cultures taken and be given anti-biotics at scene. New NICE sepsis 6 guidelines shared. Red flag sepsis action planning tool includes a purple sticker that can be peeled off to go into notes and an anti-microbial sticker to place in notes to confirm a review has been undertaken within 24 – 48 hours. Sepsis open day planned in November for UHL. Compliance with Sepsis 6 is hoped to be by April 2018 but recognise there is a significant amount of work required in order to achieve this. JR asked if there could be a 'nurse led' review of anti-biotics which would need to be agreed by the clinicians caring for the patient. Swallow Care Training Stroke Patients SC shared that they are looking at the swallow screen tool that is currently being utilised within the UHB. The UHB currently using the HEAD Tool since 2009 and

	validated against acute strokes and nurses being able to safely assess a patients swallowing ability. Concerns raised around evidence behind this tool. Stroke physicians are keen on the Yale Swallow Protocol which has multiple validation studies. The HEAD tool is noted to be vague and not enough prompts to note the patients swallow data. No all Wales Swallowing Screen is currently available. The Yale Swallow Protocol has a clear exclusion criteria, includes a cognitive examination and has an 85ml water challenge that patients are required to undertake. Simulation training is provided within the Emergency and Acute medicine departments and that the Practice Educators can provide cascade training which would be a more robust form of training when screening patients who attend with a potential acute stroke. LH raised concerns around the cascade training for swallow screening. Cascade training may raise governance concerns to ensure that all staff are trained to the standard expected. SC confirmed that the two to three hour stimulation training is provided and will continue with SALT but supportive training and supervision would continue to ensure that competencies are maintained. JR advised that the Medicine Clinical Board is happy to ratify this new procedure but it would need to go through the Corporate Governance Committee and Nursing and Midwifery Board for final ratification before being utilised. Action JR to discuss with Ruth Walker
2.3	Tissue Viability Task and Finish Group update – pressure damage GS shared the up-date from the last Tissue Viability Task and Finish Group meeting in October. One of the key discussions was around the total bed management contract. The decision is to roll out Promat mattresses and to reassure staff that these mattresses can be used for any patient who is at risk of developing pressure damage or has Grade 1 – 3 pressure damage. A blower (air pump) can also be used with these mattresses. Concerns have been raised and are being monitored by the Patient Safety Team and the Group around patients acquiring pressure damage as a result of these mattresses. It has been noted that the risk of using fitted sheets on these increases the risk of the patient acquiring pressure damage so the advice is to ensure that flat sheets are used. This is causing a stock issue with the linen department and is being picked up by L Walker who chairs the Task and Finish Group. Aerospace mattresses are not going to be used. Any patient with a Grade 3 and above pressure damage should be nursed on a Duo 2 air mattress. A revamp of the training for Promat mattresses are going to be recommenced to support staff. Patient passports are also being trialled within two areas for patients coming into the organisation with known pressure damage and this follows the patient through the inpatient journey. GS shared the Datix stickers which are being used which captures all patient incidents as a means of identifying to staff that a Datix has been completed in order to avoid duplication and to support staff in identifying for example a patient admitted with pressure damage with the site and grade noted. TC raised a concern that Primary Care colleagues were advised to report moisture lesions as hospital acquired Grade 2 pressure damage following an inpatient stay and as a result the number of Vulnerable Adult referrals had significantly increase. SC clarified that this is incorrect and that moisture lesions should not be reported as pressure damage. Action: SC to clarify with MR Head of Patient Safety Team
SAFE CARE	
3.1	Serious Injuries KP advised the group that there were 3 serious incidents reported to Welsh Government in August and September. One injurious injury, one infection control

concern, and one hospital acquired pressure damage. To date in October there have been 5 serious incidents, one of which has been reported to Welsh Government as a Never Event. This relates to a patient receiving the wrong blood transfusion. All staff were reminded to ensure that all staff within their areas are aware of the Blood Transfusion guidelines and that all staff have had their competencies signed off before being allowed to perform this task. All agency staff are not permitted to set up blood transfusions within the UHB. JR provided a brief detail of the error and the triangulation of the patient check was not completed correctly and the patient received approximately 15mls of the incorrect blood.

Action: GM and ID to identify competencies across the Clinical Board to ensure that all staff have received training and that competencies have been signed off. Number of nurses trained and competencies signed off to be shared at the next QSE in November.

WG closure forms for discussion and shared learning:

In50218: Unwitnessed fall which resulted in a Sub Arachnoid Haemorrhage. Injurious Assessment identified that neurological observations were not completed in line with NICE 2015 guidelines and UHB best practice. The patient was sling hoisted back onto the bed rather than the preferred Hover jack. It was unclear if the patients sensor mat was functioning correctly. This would have alerted staff immediately to the patient attempting to leave the bed. It is believed that this contributed towards the patient leaving the bed and attempting to mobilize unaided without any supervision. The low rise bed the patient was being nursed on was not kept at its lowest and the patients post falls risk assessment was not updated in a timely manner following the patients fall in line with UHB best practice. Actions completed include all sensor mats being checked immediately after this incident to ensure that they were in working order. All staff were reminded of their professional responsibility to ensure that all falls prevention equipment such as sensor mats are plugged in and functioning when providing care for a patient. Additions to the Intentional Rounding Tool has been implemented for patients who are cared for with additional falls prevention measures such as a sensor mat. This also includes any patient who is nursed on a low rise bed that the bed is kept at its lowest. All staff are in the process of receiving educational updates in relation to post falls procedures and should be completed by December 2017. Documentation audits continue as part of the ward audit cycle with the required actions evidenced and shared with the Senior Nurse. Spot check documentation audits continue with feedback given to the staff immediately to ensure that documentation is maintained as per UHB best practice.

Action: ID to share the amended Intentional Rounding Tool throughout the Clinical Board. ID and GM to jointly review an overall amended Intentional Rounding Tool that could be used.

In51510: Unwitnessed fall which resulted in a fractured neck of femur. Injurious Assessment identified that the patient had requested that the bed rails be left down which resulted in the patient rolling out of bed and sustaining a fracture. This was against what the bed rail risk assessment had recommended in that half length bed rails were required. It was deemed that the patient had capacity to make this decision. Neurological observations were completed by not strictly in line with NICE 2015 guidelines post falls procedure. The preferred Hover jack was not available as it was broken at the time of this fall and injurious assessment. Documentation did not accurately reflect if the patient was screened for a head injury particularly as the patient was on anti-coagulation therapy. This treatment was withheld following the fall as advised by the medical team. All staff were advised immediately of the requirement to completed neurological observations in line with NICE 2015 guidelines with an ongoing education programme in place. Documentation audits continue, and all staff have been reminded of their professional responsibility and accountability to ensure that documentation is completed in line with UHB best practice and NMC guidelines.

In49302: Patient with a BCC experienced a delay in relation to the diagnosis (Mohs surgery) and commencement of treatment. The investigation highlighted there was a

	significant delay from the initial GP referral to the patient having Mohs surgery and biopsies to confirm the diagnosis. This resulted in the patient requiring further surgery in the form of a Pinnectomy. Biopsies confirmed a complex BCC which may have resulted in the patient actually requiring a Pinnectomy and that the time delay may not have contributed to this. Scoping work is currently being undertaken for patients who are referred for Mohs procedures. Technician support for histopathology was identified as an issue when waiting for histopathology results, this is being reviewed as part of the Directorate and Clinical Board IMTP plan. The risk associated with these delays has been reflected in both Directorate and Clinical Board Risk Registers. Ongoing outpatient transformation project to improve overall efficiency and productivity of service continues.
3.2	Patient Safety Alert PSN 035 Risk of death and severe harm from ingestion of superabsorbent polymer gel granules – shared amongst the group for noting
3.3	Health Care Associated Infections DK shared the Clinical Boards recent HCAI rates CDifficile 39 days since last case MRSA 215 days since last case MSSA 37 days since last case E Coli 5 days since last case It is recognised that the Clinical Board has a significant challenge ahead to get back on target in order to achieve expected reduction figures. RCA reports continue to reflect anti-microbial stewardship for C Difficile remains a concern. DK advised that the timeframe for the completion of HCAI's has changed from 4 weeks to 3 weeks. KP raised that the ward sisters are completing the RCA's within time but there are concerns regarding the clinicians completing. Action: Any delays with the completion of RCA's by the respective teams to be escalated directly to JR. DK raised some concerns around fit testing for the new masks. 'Train the trainer will continue', IP&C do not have any kits to share for training but each area identified enough to ensure that training can commence. DK confirmed that ideally we would require 3 – 5 fit test trainers in each area. The Health Board is changing to the FSM duckbill mask as the first line choice rather than 3M masks which can be used as a second line. This will require all staff to be fit tested for the new masks but existing 3M masks can continue to be used to ensure that all stock is used. Action: JR to discuss with Procurement Nurse regarding the potential change to order these in bulk.
3.4	SBAR Clinical Board evaluation Enhanced Supervision Framework RA shared the evaluation paper for the Enhanced Supervision Framework. The work was prompted following an internal audit committee highlighting an improvement required in our supervision documentation and assessment. Measures since June have seen a dramatic fall in the amount of hours used for specialising and the financial cost associated with this. 3,000 hours reduction noted over the last four months. Additional measures included monitoring patient harm to ensure that no harm has come to patients as a result of this change including falls and challenging behaviour. To date no major harm has been identified. Patient and carer feedback, and experience has been positive. Staff have also provided feedback which has been positively received. Recommendations need to be taken forward including updating Clinical Workstation so that it matches our assessments and documentation, developing a leaflet to patients and carers which explains what supervision is being undertaken, reviewing current documentation and to ensure that resources are available on the ward to undertake purposeful activities with patients. DP asked for clarification/guidance within the Framework for those patients who are detained under Section 2 of the Mental Health Act.

	The Enhanced Supervision Framework is also being tried within two other Clinical Boards and other Health Boards have shown interest.
3.5	Information Governance Pro forma KP shared the Information Governance pro forma which each Directorate will be required to complete to ensure that we have clear Information Governance procedures. KP advised that this has been sent by RE to all Directorate Managers to complete and the expectation is that this should be completed by them.
EFFECTIVE CARE	
4.1	Director of Nursing Quality & Safety reports JR up dated the committee on the recent Quality and Safety report. Significant improvement in the number of Serious Incidents reported and the timeliness of closure. JR reminded the committee to ensure that all staff are reminded that all Datix submitted awaiting review, or in progress are up dated and completed in a timely manner. Any delays will need to be escalated as deemed appropriate. Significant improvement is required for the next month end. PADR's remain a concern, ESR is now embedded within the Clinical Board so this tool needs to be used when completing staff PADR's. Workshops are ongoing to support the 'hierarchy' approach that is linked with ESR. 11% improvement noted for concerns, tracker meeting continues to ensure that this remains on target.
4.2	Audits for sharing • RCEM Consultant Sign Off • RCEM Moderate and Acute Severe Asthma • Accuracy of prescribing for Parkinson Disease • Are we giving adequate analgesia to adults with abdominal pain • Radiology and Major Trauma • RCEM Severe Sepsis and Septic shock
4.3	Bedside Checklist Acute NIV patients To be carried forward
DIGNIFIED CARE	
5.0	HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans Secondary to S OB being on annual leave a further up date will be required at the November meeting.
TIMELY CARE	
6.1	Waits within Emergency/Acute Medicine Analysis shared
INDIVIDUAL CARE	
7.1	National User Experience Framework Feedback from 2 minutes of your time survey – relevant improvement plans Chair KP shared some positive feedback including how caring nursing staff are. Negative feedback highlighted patients feeling cold, and interestingly one comment was noted around the lack of visibility to identify welsh speaking staff.
7.2	Shared Learning from Claims Ombudsman case 201600131- A Surgical patient who required a speciality review by Gastroenterology. Concerns were raised around poor communication with the surgeons who were caring for the patient and a delay in discussing a resuscitation status with the next of kin which resulted in this being undertaken over the telephone. The Ombudsman recommended that all clinicians involved including the Gastroenterology team are reminded of the importance of communication with family members, in particular of the need to discuss DNAR decisions at an appropriate time and in an appropriate manner. This has been shared at Gastroenterology QSE meeting in October 2017.

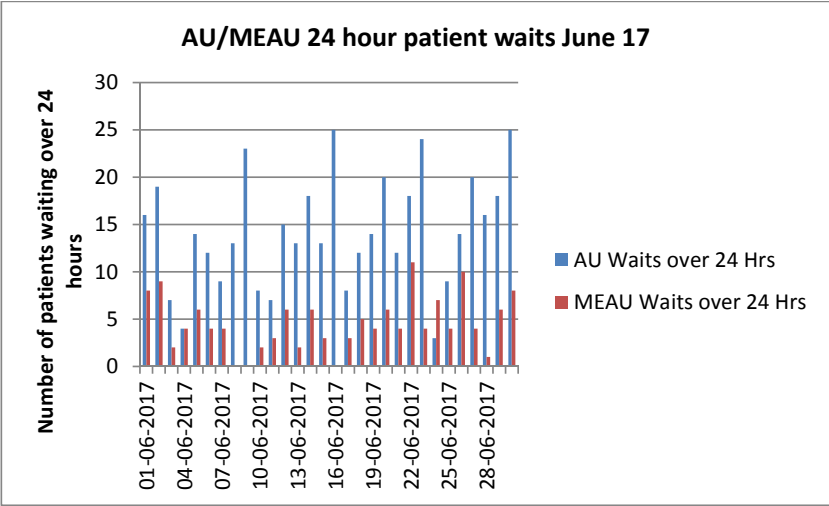
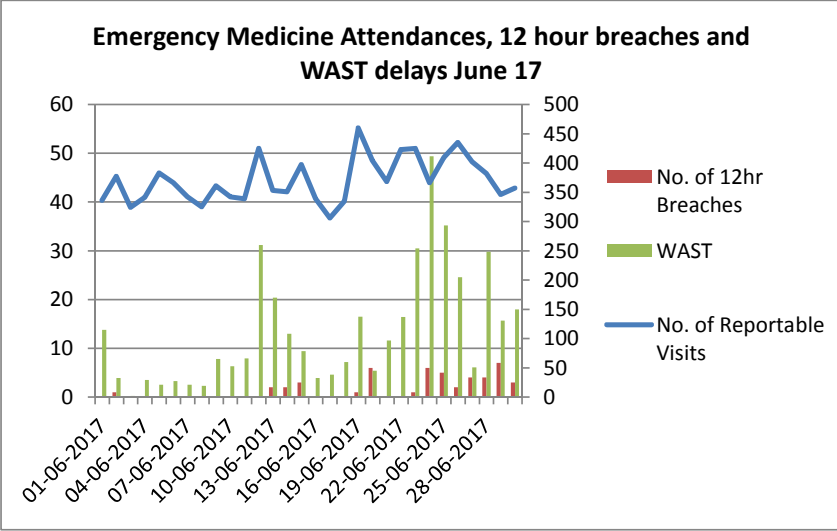
	Appendix S ref: CN/UHW/2601 – The standard of care given to the deceased in August 2011 fell below the expected level and the failure to refer the patient for cardiology investigations ultimately caused his death.
7.3	Complaints and trends KP 19 concerns outstanding which remain in target, slow improvement noted. Currently for October 62% in target. KP shared some lovely compliments from patients and relatives for Dermatology, Gastroenterology and Medical Admissions Unit at UHL. Congratulation and well done to Ward Sister E Mitchell from East 4 at UHL who was runner up for the placement of the year award for all health and social care students.
Staff and Resources	
8.1	Staffing levels Nil to note
PART 2: Items to be recorded as Received and Noted for Information by the Committee	
9	• AOB Winter Pressures to be added as a standing agenda item

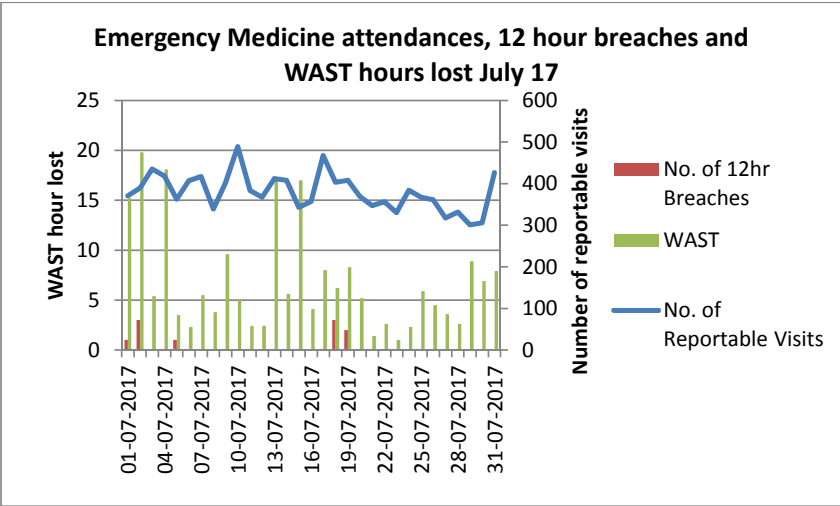
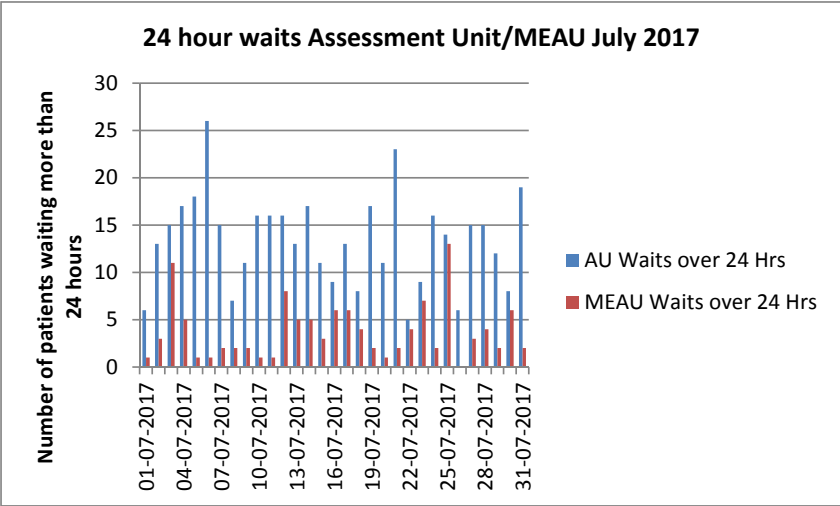
Date and time of next meeting: 16th November 2017 Classroom 1



Medicine Clinical Board QSE August 2017

UHW/UHL Acute and Emergency waits June – July 2017

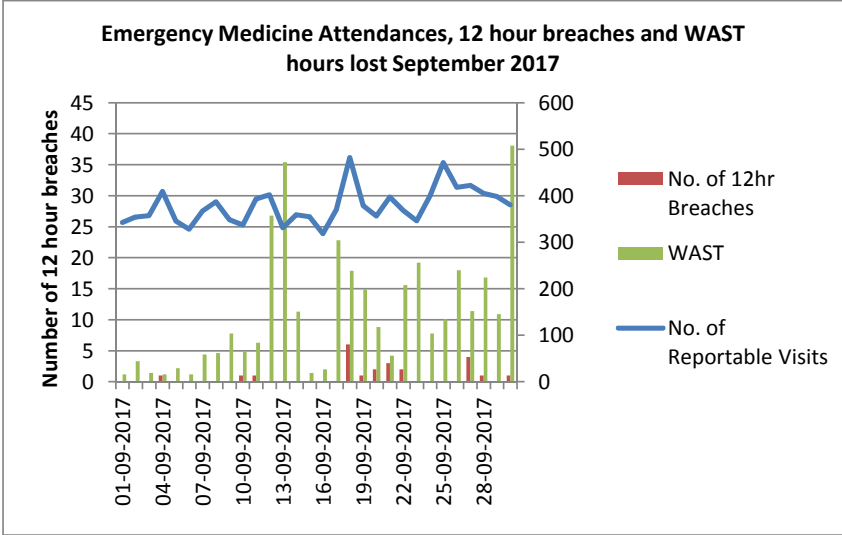
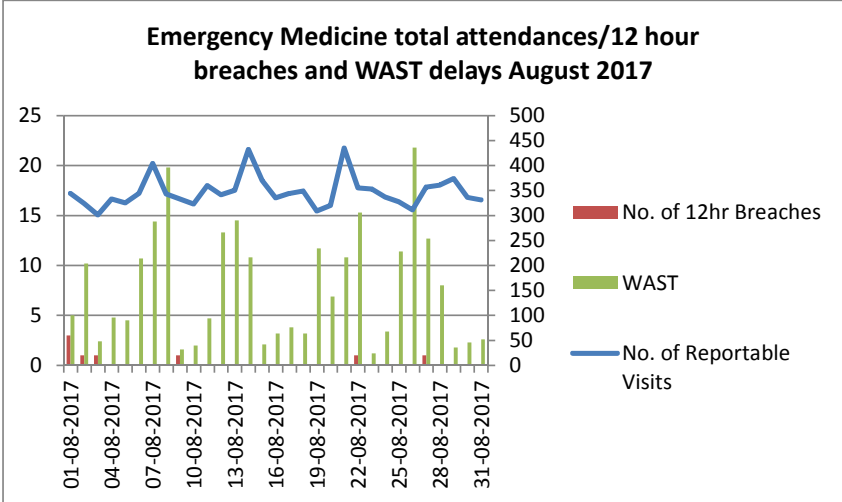




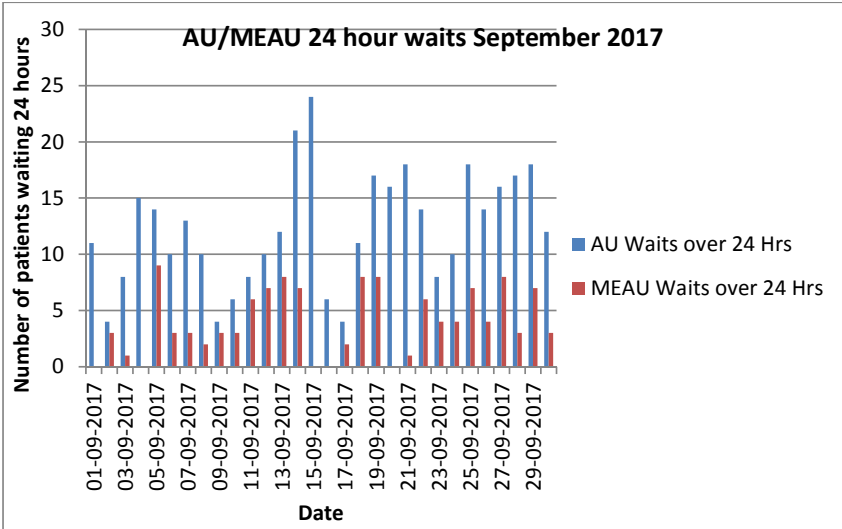
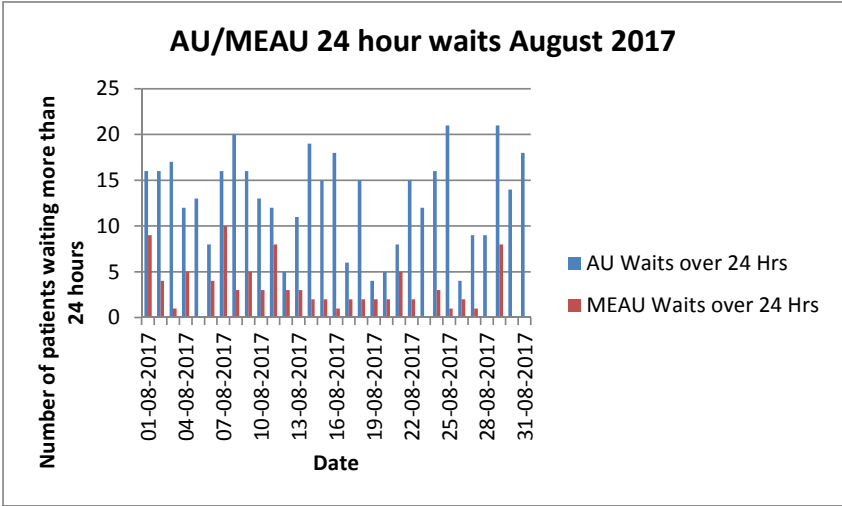


Medicine Clinical Board QSE October 2017

UHW/UHL Acute and Emergency waits August – September 2017



31.5





**SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP**
Tuesday 18th July 2017, 08:00-10:30 hours
Council Room, UHW

CONFIRMED MINUTES

Present:

Richard Hughes	Chair, Consultant Anaesthetist	RH
Clare Wade	Lead Nurse, Surgery Clinical Board	CW
Andy Jones	Lead Nurse, General Surgery, Urology, ENT, Ophthalmology	AJ
Susan Mogford	Senior Nurse, SSSU/Pain Services	SM
Angela Jones	Senior Nurse, Resuscitation Service	AngJ
Mark Bennion	Clinical Governance Facilitator, Perioperative Services	MB
Gillian Edwards	Lead Nurse, Trauma & Orthopaedics	GE
Helen Luton	Senior Nurse, Trauma & Orthopaedics	HL
Dan Jones	Deputy DM, Trauma & Orthopaedics	DJ
Catherine Evans	Patient Safety Facilitator	CE
Adrian Turk	Pharmacy	AT
Yvonne Hyde	Clinical Nurse Specialist, IP&C	CM
Clare Wade	Lead Nurse, Surgery Clinical Board	CIW
Oleg Tatarov	Consultant Urologist	OT
Barbara Jones	Perioperative Care	BJ
David Owens	Clinical Director, ENT	
In attendance:		
Julia Barrell	Mental Capacity Act Manager – for Item 17/034	
Edwina Shackell	PA, Surgery Clinical Board	ES

17/029 Patient Story: General Surgery Directorate: Breast Surgery

The patient pathway was described by DJ and the key sequence of events summarised. At the pre-operative MDT the pathology representative was believed to have said that the lymph nodes were positive. The decision was taken by the MDT for lymph node clearance. The cellular pathology report was not referred to at the patient appointment when treatment was decided. Post operatively, the lymph nodes were reported free of cancer. The patient had therefore had more intrusive surgery than required, and delayed chemotherapy of 1 week whilst awaiting confirmed pathology results.

Lessons learned:

More robust system now in place for MDT
Pathology policy is that all reports should be to hand prior to decision to treat in discussion with patient.

Notable practice:

The surgeon informed the patient and GP once the error was realised.
The patient has been kept updated.
Pathology reports must be checked prior to surgery – implemented immediately.

All recommendations completed, and the SI closed with WG.		
PART 1: PRELIMINARIES (<i>Chair</i>)		
17/030	Welcome and Introductions Colleagues were welcomed to the meeting and introductions made around the table.	
17/031	Apologies for Absence Received from Linda Walker, Rafael Baraz, Mark Wise, Carol Evans, Clare Mahoney, Graham Roblin, Sally Finlay, Mike Bond, Rhian Davies, Ceri Chinn and Chris Williams.	
17/032	Declarations of Interest None declared.	
17/033	Out of Hours Interventional Radiology cover at UHL Mr Tatarov summarised the significant problems experienced by Urology due to a lack of a rota for Out of Hours Interventional Radiology cover at UHL and UHW. The 2 patient categories affected were: • Nephrostomies • Embolisation of kidney for either post-operative bleeding or trauma. Numerous incidents had been reported and discussed at Urology Quality and Safety meetings over several years, and had been communicated to Radiology on numerous occasions, in particular with the Clinical Director for Radiology who had unfortunately been unable to attend today's meeting. This appeared to be unresolved at present. Weekends were of particular concern. At present it appeared that the radiology service was reliant upon the good will and availability of specialists. To date no patient had come to harm. Of particular concern was the anticipated referral to the UHB of trauma patients in its status as a single trauma centre. The majority of renal injuries with ongoing bleeding would potentially present for embolisation, the alternative to which was the removal of kidney, a high risk procedure. It was recognised that there was a plan to recruit sufficient radiologists to establish an interventional radiology rota, but the timescale was not clear. It was confirmed that this issue had been placed on the risk registers for both Urology and General Surgery. It was confirmed that Datix forms were completed when procedures were unable to be done due to lack of service. CE advised that this should include 'near misses'. Awareness of this issue to be raised at Weekend Planning meetings. Action: CW	CW
17/034	Mental Capacity Act update JB described the role of the UHB Mental Health Capacity Legislation Committee (MHLC), which monitored whether the UHB was compliant with the law when treating patients, and raised awareness throughout the UHB. Each Clinical Board had been invited in turn to the previous 4 meetings to explain what was being done to embed the Mental Capacity Act within their areas. Following the May 2017 meeting, JB as the point of contact, had circulated the key changes to the Act, and would be asking for updates on how teams were embedding this into practice. The Mental Health Advocacy Service (MHAS) had reported to the MHLC that it had found patients with DNACPR recorded when the patient did not have capacity, and next of kin had not been consulted. In instances of there being no next of kin, the MHAS must be involved. The MHAS continued to feedback that UHB staff did not understand the Mental Capacity Act, did not understand the difference between compliance and consent, nor the best interest of the patient. There a leaflet available which defines 'next of kin'.	

	JB had included links to useful information in the update referred to above, e.g. MHAS, and the Code of Practice, and suggested this would be useful to circulate to teams. Mental Capacity Act mandatory training was available via e-learning, or a monthly session. In addition, ad hoc sessions could be arranged for teams. The Learning Education Department would be asked to provide training figures for each Clinical board. RH noted the limited time available to clinicians to attend a 2.5 hour training session, however JB emphasised that clinicians did need to know the Act. JB would circulate the 8 questions on the mini quiz for staff to complete. If staff could not answer correctly, they must do the training. It was suggested that this also be placed on the Surgery CB Facebook page. Action: BJ	BJ
17/035	Approval of the minutes of meeting held 9th May The Minutes were accepted as an accurate record.	
17/036	Matters Arising To receive Action Log from the above meeting <u>Minute 2.1.3 17/5/2011. Pregnancy before surgery</u> – ongoing. No update. <u>16/182 Consent Audit Perioperative</u> Assurance to be provided that: <i>All Directorates had distributed the Consent Policy to teams</i> <i>Patient Safety Alert notice – progress and update</i> RH had asked all colleagues to ensure that no abbreviations were used on operating lists. In addition prescriptions should be in black ink AND generic drug names printed. The question was raised as to whether a UHB working group had been convened to look at the new consent process, particularly in view of recent Serious Incidents where apparently serious complications had not been listed. There was no knowledge of such a group. It was confirmed that specific procedures, e.g. Robotic surgery, used specific consent forms in addition to the standard form. Outside of the above, the EIDDO leaflets were given to patients; it was noted that there were conditions for which no EIDDO leaflet was available, and where potential complications were not listed. It was acknowledged that a challenge existed with regard to the consent procedure for Short Stay Surgery due to the volume of patients and restricted time available to consultant Anaesthetists/surgeons to review all the issues. The Pre-Operative Assessment Clinic process was robust. Directorates were responsible for ensuring that the consent process is embedded. It was acknowledged that an All Wales Agreement was required. A Patient Safety Notice had been drafted and would be circulated by PST. <u>17/011 Directorate Assurance Report: Perioperative.</u> 6-monthly validation of Theatres had been requested. To be followed up. Action: Clare Mahoney Estates representative for the Clinical Board IP&C Sub Group had identified. CLOSED. <u>17/014 Alerts and Safety Notices:</u> <u>CG80 (March 2017) Early and locally advanced breast cancer: diagnosis and treatment.</u> For General Surgery. Action: AJ to follow up with Helen Sweetland	CE CM AJ

	<u>DG27(Feb 2017) Molecular testing strategies for Lynch syndrome in people with colorectal cancer</u> Action: AJ to follow up with Colorectal Surgeons. <u>MTG30 (Dec2016) – XprESS multisinus dilation system for treating chronic sinusitis.</u> Graham Roblin to be asked for response. Mr Owens advised that there is a need for further evidence with regard to this procedure. Action: Mr Roblin to complete the response form and send to Clinical Audit <u>17/015 Key Messages from Board/Committees/Groups: Safeguarding Steering Group 22 March 2017</u> <i>Safeguarding Steering Group 22nd March 2017. Lack of domestic abuse training for perpetrators to be raised at next meeting.</i> AJ had met with the new Domestic Violence Adviser. DV training is part of the mandatory e-Learning package. It was suggested that the Adviser be invited to a future meeting. Action: ES to discuss with Linda Walker and issue invitation accordingly. <u>17/022 SBAR Blood Glucose Monitoring Training and Assessment 7/2/17.</u> <i>Lead Nurses to inspect wards and provide assurance of competency.</i> RH reiterated the message. Assurance from Lead Nurses outstanding. Action: Assurance to be provided. <u>17/026 UEFA Championships, Bank office arrangements.</u> CLOSED. <u>17/027 AOB: Health & Safety presentation.</u> Feedback had been provided to the presenter. Closed.	AJ GR ES LNs
PART 2: PATIENT SAFETY AND QUALITY		
17/037	Standing Item: NatSIPPS Progress report The success of the event on 12th May was noted. All teams were reminded of the September implementation deadline and the need to plan for this Directorate leads are to be nominated to lead on this piece of work and to complete gap analysis. Babs Jones and Mark Bennion, Perioperative Care, had offered support to other Clinical Board Directorates, and wider across the Health Board. Action: AJ to provide CW with lead for General Surgery, Urology, ENT, Ophthalmology. A definition of an 'invasive procedure' is awaited.	AJ
17/038	Director of Nursing Q&S Report Minutes of May and June 2017 meetings RECEIVED. Welsh Government SI closure forms submitted: 3 in April: 1 x line positioning; 1 x pressure damage; 1 x Acinetobacter on B6. 3 in May: 2 x pressure damage; 1 x line insertion. New SI: failure of equipment in Neuro theatres. Closed SIs: 3 in April: 1 x unwitnessed fall. T&O to review transfer documentation. Additional training in place on neurological observations for night shift. 1 x C Diff – all correct actions had been taken, deemed unavoidable. 4 in May: 1 x longstanding ENT (to present at next meeting) – failure to follow up; 1 x white matter in cardiac theatres: 1 x pressure damage, very complex long stay patient, slight delay in reporting; 1 x #pubic ramus. Falls risk assessment not updated frequently enough, delay in X ray post fall, no evidence that Next of Kin informed, had not recognise need for low rise/crash mattress. WG no longer requires #pubic ramus to be reported unless it significantly impacts on treatment.	ALL

	Datix: 200 open to the end of May, which need to be reviewed and closed. CW is available to support/help if needed from managers that are building up queues. CB are challenged at performance review on number of open Datix incidents. Medication errors in May: 12, 6 attributed to the Clinical Board. All to review and share with staff. Action: ALL Concerns: 65 in May, 72% managed via the informal route. 38% responded to in 30 days, an improvement. Hand Hygiene. All colleagues to ensure that ALL staff and visitors to the wards are Bare Below Elbow. CE advised that multiple pressure damage reports were being opened for the same patient when they transferred between wards. CE asked that staff be reminded of the importance of reviewing the patient's grading, and updating this, and not open a new report. It was not possible to see on Datix that the same patient has duplicate forms. Action: Lead Nurses.	ALL LNs
17/039	Directorate Assurance Reports: 1. <u>General Surgery, Urology, Ophthalmology</u> Report to be provided. Key issues: NatSIIPS – assurance received that this had been discussed, nurse sensitive indicators shared. Exception report: - Adverse effect on General Surgery of last minute theatre cancellations, an inability to reutilise medical staff. - B2 renovation reducing bed base. - Coroner's case pending re massive haemorrhage. Learning to be brought to this meeting. RCA in process. - Delays in AER decontamination of nasoendoscopes, therefore non-compliant. Awaiting relocation of machine to Suite 18. Work with estates, timescale unknown. Room temperature issues to be addressed. - Urology. Incident 46919, with Perioperative, investigation underway. Components missing during operative intervention. - Urology lists delayed due to lack of staff. SM reassured Mr Tatarov that the daily Scrum meetings worked hard to prioritise across all theatres which lists could go ahead and to ensure the right skill mix. It was explained that the successful recruitment of numbers of Anaesthetic Assistants would improve the situation in the next 6 months. It was raised by DO that it would be beneficial if cancelled lists could be communicated a week in advance, to avoid cancelling staff at short notice who were then unable to be reallocated to other work (e.g. outpatient clinics). SM explained that the staffing for the following week was reviewed each Wednesday. Consultant colleagues were understanding of the position, albeit a significant number of cases had been lost due to lack of theatre staff. It was explained that every Directorate should be represented at the weekly Scrum. It was therefore for Directorates to communicate with their teams following feedback from SCRUM meeting and it was not the role of theatres to do this. 2. <u>ENT</u> Report to be provided. 3. Perioperative Services Report received. Key issues: - Medication Never Event (In41431) Investigation completed and submitted to WG; comment received back. - Patient awareness under anaesthetic (In34500), reported to WG, and Report shared with patient. Ready for closure. - Ventilation in Orthopaedic theatres 5 & 6 at UHL now repaired. - Ventilation Cardiac Theatre 11, repair underway. - Stroke following artery cannulation (In44500) – closure form submitted to WG w/c 10/7/17. - Failure of reamer during neurosurgery (In46388) investigation underway.	AJ AJ

	- Central line insertion (In45102), X-ray not viewed correctly. Investigation underway. - Wrong route medication (In47972) investigation underway. - Laser safety testing. Medical physics no longer undertake electrical safety testing. The advice received has been to contact equipment suppliers. CW advised that this issue had been escalated to CD&T CB. - Radioactive material found in waste contractor's wheelie bin on landfill site. (In49744) Investigation underway. - T&O patient woken without procedure, lack of sterile wrist plates (In 49744). RCA underway. - Patient woken, equipment not available (In49619). Patient has been rescheduled. - Information Governance Breach, UHL (In49605). Cause identified, remedial action taken to avoid repetition. Information Governance had been informed. SBAR Blood Glucose Monitoring Training and Assessment 7/2/17- actioned by BJ and Ceri Chinn. 4. <u>Anaesthetics</u> Report received and noted. 5. <u>Trauma & Orthopaedics</u> Report received. Key issues: - Wrong site surgery RCA shared in audit 17/6/17 - HH and BBE – results at audit, training provided via PDN Exception report: - Acinetobacter baumannii B6 outbreak stood down. B6S due to open 19/7/17 pending results of patients screened on North. A patient had been admitted from abroad with Acinetobacter. Yvonne Hyde confirmed that the results for other patients on the North end were clear. - Consent Policy shared with directorate - Theatre 5 & 6 ventilation issues and impact on lists as above. - Frequent Trauma list cancellations and impact on patients - In42888 – injurious fall, RCA and findings discussed in nursing forums. - In41655 – facet joint injection RCA underway. - Clexane shortages and switch to Fragmin in T&O from 17/7/17, supported by pharmacy.	
17/040	Exception reports from Directorates/Working Groups 1. General Surgery, Vascular, Wound Healing – described at 17/039 above 2. Head & Neck, Maxillo Facial and Ophthalmology – described at 17/039 above. 3. Urology – described at 17/039 above 4. Theatres & Anaesthetics, SSSU, Day Surgery & Sterile Services: - Cleaning of X-ray machine. Advice from the supplier has stipulated that this is unsuitable for HPV cleaning. A high risk patient was treated in theatre, when staff had insisted that the X-ray arm be left in situ. The machine had now had to go to engineering. The same patient again returned to theatre, resulting in two machines being out of use. YH confirmed that IPC contacted the company, as it did not state that their equipment could not be HPV cleaned. In future, validation may be needed with companies to provide assurance that equipment can be HPV cleaned. 5. Trauma and Orthopaedics – described at 17/039 above.	
17/041	Policies and Procedures <u>Chaperone Policy</u> All to raise awareness with directorate teams. If a member of clinical staff felt at risk, they should find a chaperone and keep themselves safe.	
17/042	Alerts and other Safety Notices The following were received and noted, for dissemination to Directorate teams, and actioning by the named clinical leads. <u>NICE guidelines:</u> 1. Surgery CB summary spreadsheet 2. <u>IPG 578 (April 2017) – Minimally invasive sacroiliac joint fusion surgery for chronic</u>	

<u>sacroiliac pain</u>. Actioned and returned to Clinical Audit by CD for T&O. 3. <u>IPG579 (May 2017) – Irreversible electroporation for treating pancreatic cancer –with Guy Blackshaw for action.</u> 4. <u>IPG580 (May 2017) – Endoscopic full thickness removal of non-lifting colonic polyps. With Guy Blackshaw for action.</u> 5. <u>CG124 (May 2017) – Hip fracture: management. Circulated by the CD for T&O, response sent to Clinical Audit.</u> 6. <u>CG174(May 2017) – Intravenous fluid therapy in adults in hospital – updated version. It was requested by RH that this be highlighted to trainees.</u> <u>Medical Device Notification</u> Recall Notice on Sling Bar 5/7/2017. Assurance RECEIVED that this had been circulated to all areas. <u>MDA</u> MDA/2017/015, Issued 09 June 2017: Solus Flexible Wire Reinforced Laryngeal Mask Airway – risk of hypoxia due to partial or total occlusion of the airway tube after inflating the cuff. This MDA had been shared widely with teams. Assurance RECEIVED that there are none of these devices in the Surgery Clinical Board. MDA/2017/017, issued 21 June 2017: BVM (Bag-Valve-Mask) manual resuscitation systems – risk of delay to emergency treatment. This MDA had been shared widely with teams. Assurance RECEIVED that there are none of these devices in the Surgery Clinical Board. <u>Welsh Health Circulars:</u> 1. <u>WHC(2017) 026 Prescribing of co-proxamol</u> . AdT provided assurance that this is not stocked in pharmacy and that there is none within the Clinical Board. 2. <u>WHC(2017)025 Guidance on Cyber Security and Information Governance requirements relating to suppliers and the supply chain</u> Examples: ▪ Coloplast hosts a database of patients. An email had been sent to seek assurance of their cybersecurity. A response is awaited. (AJ) ▪ Velindre holds patient and staff details ▪ RH stressed the need to identify any equipment connected to the intranet, and to seek assurance from the supplier that they have a cyber-security patch in place. Action: ALL 3. <u>WHC(2017)032 Implementation of Pre-Exposure Prophylaxis in Wales</u> Relates to HIV. <u>Clexane Shortages</u> <u>SBAR Enoxaparin availability</u> The UHB supplies of Enoxaparin (Clexane) 40mg syringes ran out on the 23/6/17. The sole UK manufacturer has sufficient stock to meet UK demand until October 2017. Nationally, this of major consequence. Forward planning: - Companies who make alternatives are being approached. - T&O plan to change to dalteparin (Fragmin). A policy had been agreed by the T&O team, with a proposed start date of 17/7/17. The UHB is working with this manufacturer, being one of the Trusts/Health Boards which they are willing to supply. - It is likely that there will be insufficient national availability of alternatives. Two generic biosimilar products of enoxaparin manufactured in China are not licensed in the UK yet but are under review with the MHRA.	ALL

	4. <u>Risk Assessment Tool – Thromboprophylaxis for acute orthopaedic admissions June 2017</u> RECEIVED and NOTED	
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
17/043	Key Messages from Board/ Committees/ Groups 1. <u>UHB Medicines Management Group Minutes 18th May 2017 & 15th June 2017</u> ▪ Supply of eye drops post cataract surgery – resolved. ▪ Proposal to establish Non-medical prescribing forum – had yet to meet. ▪ Perioperative antiplatelet prescribing to remain the responsibility of the anaesthetist recommending the change ▪ UHB medicines code. Final sign off at NMB due 22/6/17. AdT noted that the £80M treatment fund for medicines over 5 years was not filtered to directorates, but was corporately held. This would support, e.g. NICE Technology Appraisals when drugs were reaching their deadline, and would be put on the Formulary to avoid breaching 60 days. The goal was to avoid a postcode lottery. 2. Decontamination Committee Minutes – last meeting cancelled 3. Research Governance Group update - deferred 4. Clinical Board H&S Group Minutes 19 April 2017 - nil of note. An Estates representative had been identified who will attend meeting going forward. 5. Clinical Board IP&C Group Minutes – next meeting 24/7/17 – Estates rep as above. 6. UHB Water Safety Group update. Ceri Chinn attended. IPC heater/cooler issue in Theatre 11 was in hand. 7. Blood Transfusion Group Minutes 28th April 2017. CW provided and update: - A reminder to all relevant staff that they must be trained and assessed. Assessment is valid for 3 years and will be discussed at PADRs. RH confirmed that this had been raised with clinicians. - Reissue of Massive Haemorrhage Protocol. Portertrac to be used to call a porter.	
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
17/044	1. <u>IP&C RCA database</u> CW. This was renewed each April. Reduction expectations had been shared: C Diff 26/100000; E Coli 67/100000; bacteraemias 20/100000 MSSAs to date = 8. 2. <u>2017/18 IPC Action Plan</u> All colleagues were asked to look at this Plan, which had been set in discussion with directorates and would be monitored at every IP&C Sub Group meeting. Action: To be shared in local IPC meetings, feedback to CB IPC Sub Group. ▪ 1.8 – Ensure Fit testing for Anaesthetists in Theatres. It was noted that the Perioperative Practice Educators did not have responsibility for fit testing Anaesthetists. It had been agreed that sessions would be provided on audit days. A list of fit testers was located outside of the Directorate office. ▪ ANTT roll out – September. YH advised that of 8000 staff require e-learning, 2000 had completed. ALL staff who undertake relevant procedures MUST complete the e-learning and be competency assessed. BJ was liaising with Anaesthetists. 3. 2017/18 HCAI reduction expectations for C&V UHB – RECEIVED and NOTED.	LNs/CDs /DMs
17/045	LIPS Progress Report – ENT & Ophthalmology Nil specific to report. To collate update for next meeting.	AJ
PART 5: GOVERNANCE		
17/046	Concerns (Clinical Incidents, Complaints, and Claims) 1. <u>Open Sis, No Surprises.</u>	

	CE commended the efforts of the team. 10 remained open. Of these, 5 dated from 2016, and 5 from 2017/18. Most were complex. It was anticipated that 2/3 could be closed this month. 2. <u>Regulation 28 report & Open Inquests</u> In40103 – AAA and ultrasound issues: shared learning arising from a Medicine Clinical Board incident. CE reviewed the case. Coroner's concerns: the Dr who conducted the ultrasound had not completed the necessary triangulation and should have been supervised. Scans were not routinely stored. Lessons learned: Where a patient had AAA and was symptomatic, they should be treated accordingly. Actions completed: ▪ Training – records and competencies recorded and held in EU. ▪ Recording fast ultrasound outcome. All clinicians had been formally written to, reminding them that the date and time of the scan must be recorded in the patient's notes, and a copy scan printed and placed in the notes. ▪ Patients as above should be referred to radiology for CT scan and to medics for further review regardless of the size of the aneurysm. RH noted the reluctance of staff to challenge clinical practice if they were unsure whether another member of staff was trained to use equipment; this was however the users professional responsibility to ensure that they were competent to use the equipment. The lack of connection to the Intranet for portable scanners was highlighted. CE reminded colleagues of their professional accountability. 3. <u>Serious Incidents:</u> Closure forms sent to WG since 9/5/17 Compliance with trajectory for improvement by Clinical Board. Target: 5 closures per month. CW explained that investigations needed to be robust and appropriate. It was a challenge to complete a good investigation within the 60 day target. Colleagues were thanked for their focus and commitment. 1. In38815 - Wrong site Surgery, T&O Improvement Plan. Some corrections had been made. Action: bring back to next meeting. MB 2. In41431 – Medication Error, Perioperative Care Improvement Plan 3. In44500 – Inadvertent arterial cannulation, Perioperative Care Improvement Plan. Closure form submitted to WG. 4. In39309 – Closure Summary- particles, Theatres. Closure form submitted to WG. 4. <u>Injurious Falls Report:</u> Nil since April 2017 5. <u>Complaints, Claims and other Concerns</u> (i) All New Clinical Negligence claims opened 10/5/17 – 17/7/17 (ii) All Clinical Negligence Claims Settled 10/5/17 – 17/7/17 (iii) Personal Injuries Negligence Claims settled 10/5/17 p 17/7/17 (iv) New Personal Injuries Negligence Claims opened 10/5/17 – 17/7/17 Action: Karen Lewis to be asked to attend a future meeting to give an overview. ES 6. <u>Ombudsman's Reports received:</u> nil	MB ES
17/047	Clinical Governance/Audit Programme – Agree Annual Programme No audit plan for this year. Waiting on Audit Dept. to come back with Themes, and each directorate to choose their themes. Action: CW to follow up.	CW
17/048	Review HIW Ophthalmology Thematic Report Improvement Plan Deferred to next meeting. Action: DW to present	DW
17/049	Patient Surveys:	

	- National Survey Report for Surgery (June 2017) "2 minutes of your Time" (June 2017) - Wales Cancer Patient Experience Survey 2016 – generic feedback. To be shared with teams, both lessons learned and compliments.	
17/050	Research & Development Nil reported.	
PART 6: DATES OF NEXT MEETING Tuesday, 12th September, 08.00 – 10.30, Council Room, UHW		

PART 7: URGENT BUSINESS		
17/051	Regulation 28, Cwm Taf. AngJ referred to this event where there was found to be a failure to undertake NEWS scoring appropriately, failure to escalate, and failure to undertake neurological observations. AngJ had liaised with Tony Turley, CD for Perioperative Care Services, to discuss the mechanism used for ensuring that staff were reminded of the policy. A Deteriorating Patient Policy was being written, which would contain details of who to contact in the case of a deteriorating patient. AngJ questioned who was leading on the issue of neurological observations, and was assured that this was in progress.	
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
17/052	Alerts and Other Safety Notices Nil	
17/053	Recent Reports & Communications - TARN Report – Core measures for all patients thoracic and abdominal injuries, Patients in Shock, March 2017 - Direct Healthcare Professional Communication, Clexane: updates to strength expression, dose regimens in CVT/PE, use in patients with severe renal impairment. - Male Honour Abuse Briefing - HIW Governance Framework - HIW Annual Report 2016-2017 - WG Information and guidance on domestic abuse: Safeguarding older people in Wales & Casework Seminar Events	
17/054	Directorate Q&S Minutes - Ophthalmology 6th Dec 2016 - Ophthalmology 15th February 2017 - Anaesthetic Minutes February 2017 - Anaesthetic Minutes 6th April 2017 - Anaesthetic Minutes 19th May 2017 - Anaesthetic Minutes June 2017	



MINUTES

**CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE**

Tuesday 22 August 2017

8.30am, Council Room, UHW

Preliminaries		Action
1.1	Welcome & Introductions Cath Heath (CH), Director of Nursing (Chair) Jenny Thomas (JT), Clinical Board Director Sarah Evans (SME), Head of Workforce & OD Matthew McCarthy (MM), Patient Safety Mary Glover (MG), Lead Nurse, Acute Child Health Diane Rogers (DR), Interim Directorate HOD, Acute Child Health Heather Gater (HG), Interim Head of Therapies, Acute Child Health Rachael Daniel (RD), Health & Safety Advisor (on behalf of Rachael Sykes) Angela Jones (AJ), Senior Nurse Resuscitation Alicia Williams (AW), Interim Deputy Directorate HOD, Acute Child Health Lois Mortimer (LM), Senior Midwife Sarah Spencer (SS), Senior Midwife Paula Davies (PD), Lead Nurse, Community Child Health Suzanne Hardacre (SH), Head of Midwifery Laura Bassett (LB), Risk Manager, Obstetrics & Gynaecology Jane Maddison (JM), Interim Head of Therapies, Community Child Health Rim Alsamsam (RAS), Acting Clinical Director, Acute Child Health Bev Thomas (BT), Deputy Directorate HOD, Community Child Health In Attendance Kirsty Hook (KH), Board Secretary Alex Scott (AS), Patient Safety (item 1.3 only)	
1.2	Apologies for absence Rachael Sykes, Catherine Salter, Rachel Burton	
1.3	Annual Audit Plans Alex Scott was welcomed to the meeting and provided an update on the process for the Annual Audit Plans. Discussions ensued where it was noted there is a requirements for all clinical governance audits to be reported. There was acknowledgement that there are lots of audits being undertaken, however noted that these are not being recorded robustly across the Health Board. An IT tool is being reviewed as an option for implementation allowing a visible and transparent process going forward. It was noted that for the Clinical Board, 12 audits were recorded as being completed however only 2 were registered. It was agreed that this information would be sent to the Clinical Board Director for information as it was noted that a number have been signed off, however there was an assumption that some of these may not have been registered separately due to being part of national audits or service improvement. Each Directorate	

	were asked to identify 1 audit and follow through the process straight through to the Clinical Governance process. It was agreed that the information provided by AS would be shared following the meeting in order to agree all were happy with the audits identified. This will then be added to the Clinical Audit Plan for the year.	KH/AS
PART 1: HEALTH & SAFETY		
2.1	To note any Matters Arising from the last CB H&S Meeting dated 23 May 2017 The minutes for information were noted and had previously been ratified. The matters arising from the minutes were noted as follows: Matters Arising Opening of Fire Doors Guidance being developed outlining the requirements for all departments in order to assist with any issues. Once completed this will be circulated widely across the Health Board in order for all staff to be aware of responsibilities and processes to follow. Fees for Non Attendance at Manual Handling & Fire Training Discussions are ongoing at present. No further update to add.	
2.2	To note H&S Performance Benchmarking The performance benchmarking was noted for information and RD advised that the information had been based on 2016/17 data. This has been developed to provide assurances against the benchmarking data. Discussion ensued and it was noted that this information is based on Clinical Board positions against the previous year. There have been significant improvements in a number of areas, and queries were raised as to how frequently this information will be received. A request was made that the information be split by Directorate and RD agreed to feedback this request. Representation at the UHB Health & Safety Meeting was discussed as it was noted that there had been regular Clinical Board representation at the meetings. RD agreed that this would be reviewed in order to ensure this had been accurately recorded.	RD RD
2.3	Feedback from UHB Health & Safety Operational Group Meeting HG provided feedback following the last Health & Safety Operational Group held on 05th June 2017 • X5 policies have been approved and were now available on the intranet: - Management of Violence & Aggression Policy - Lone Worker Policy - Minimal Handling Policy - Waste Management Policy - Water Safety Policy • HSE Report has been closed in relation to the incident involving a member of staff being struck by a vehicle on the emergency admissions road at UHW. A number of actions will be implemented following the outcome of this report including a barrier being erected to stop vehicles mounting the kerb. Strategic site safety plans have been requested and HSE meeting with staff side representatives. SH raised concerns regarding the temporary entrance being implemented for out of hours for maternity which will be behind the tertiary tower as currently this is not fit for purpose. Work is ongoing however it was noted that some of the actions outlined within the HSE report will contradict this action plan being taken forward. It was noted that this continues to be monitored and regular walkabouts are being undertaken to assess the situation.	

	- Legionella Improvement notice has been closed off however there is an ongoing mandate in place for audit and assurance. - Fire Report was presented, where it was highlighted that from 1st April 2017 only 1 appliance (as opposed to 3) will be sent to investigate any automatic activation from fire alarms unless a fire is confirmed. If a fire is discovered then staff must ring 3333 as well as activating the alarm. All were asked to be vigilant and cascade the information accordingly - Medical Evacuation Chairs – it was noted that this is ongoing due to issues with the current contract. Further feedback will be provided as soon as this is received. - Contractor fall – concern was raised that this incident is currently being reported as part of the O&G figures. RD agreed to review if this can be moved to H&S. - Lone worker devices - 613 devices in use – average utilisation of 73.25% for the 8 month period from 01/08/16 – 31/03/17. The H&S Committee has asked for confirmation that staff at risk either have a device or suitable alternative arrangements in place. Monthly utilisation is monitored and reports sent to each area.	
2.4	To note the latest Health & Safety Report The Health & Safety report was noted for information. It was noted that incidents figures remain high; however work is underway in order to resolve the number of open incidents. One RIDDOR has been investigated and actions completed.	
2.5	COSSH Report for Noting The COSSH report was noted for information, the group were asked to ensure that this is updated and all COSSH assessments to be completed where required.	ALL
2.6	Workplace Inspections Update New WPI Form for implementation The new WPI was circulated for information and implementation across all areas. The Directorates were asked to disseminate widely within all areas. This is a UHB standardised approach which is now live.	ALL
2.7	Feedback from H&S Staff Side - Progress was requested on the sun reflection on the Children's Outpatient Reception Desk. MG agreed to follow up on progress with Alison Oliver and feedback. - Manual Handling – are the risks separated for classroom and e learning? It was noted that the COWS have made a significant difference however it was noted that the manual handling is an operational issue which is being progressed. Work is continuing in relation to super user and proxy users. SME will forward the information to DR following the meeting. - Workplace inspection schedule and working group. The group were asked to ensure that workplace inspection schedules are available in all areas and ensure that the inspections are carried out in a timely manner.	MG SME DMT's
2.8	Exception Reports and Escalation of key H&S issues from Directorates Acute Child Health Mandatory Training – information on the inaccuracies is now available and SME requested that the information be sent in order to ensure that LED can update accordingly. It was agreed that these concerns would be raised at HSMB as this is proving to be very time consuming. COSSH Reporting – this has now been updated and forwarded for information Fire Risk Assessment – these are being actioned as the reports are receive	

PART 3: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	To receive the Minutes of the previous meeting dated 26 June 2017 for approval The minutes of the meeting were agreed to be an accurate record.	
3.2	QSE bring forward action log / Matters Arising See updated action log Matters Arising Paeds Resus Practitioner Work is ongoing following a request for further information. Feedback will be provided as this work progresses.	AJ
3.3	Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)	
3.3a	Acute Child Health - One case from Carmarthen received and it was noted that this was a Chemo burn and this has been reported back to the referring health board. - Hand hygiene audits have been reinforcing BBE and Hand Hygiene. A poster competition was undertaken with the play specialists and one of the posters won. - Child Friendly Patient information boards are being progressed and hoped to be up and running imminently - RTT predicted position for Quarter 2 was noted as 47 patients waiting over 36 weeks and 0 52 week waits. Challenges continue however monitoring and daily management continues. - Development of a Children's Charter and Children's Rights information is in progress and information will be shared as this progresses. It was agreed that this would be reviewed to have a Clinical Board Children's Charter. Invitation will be sent to Children's Commissioner and Chair. - First cohort of new nurses commenced 20th August and an advert is out for PICU nurses where it was acknowledged that there have been a number of very strong applications received. Vacancy requests for Therapies are being submitted imminently for consideration.	
3.3b	Obstetrics & Gynaecology - LIPS project – Health Pregnancy Clinic has been completed and it was agreed that this would be shared at the next Q&S Meeting for information - Security tagging system is out to tender and is being funded through Capital monies. - Gap and Grow is being implemented, with an action plan being developed where NICE and GAP guidance will be reviewed. This will also be presented at the Obstetric audit in September. - X2 baby falls have been reported and investigations are in the process of being completed. Neonatal SOP is awaited from Acute Child Health. - CSSI infection rate was 5.1%, which is a significant improvement following the work that has been undertaken. Work is ongoing with Public Health Wales however it was acknowledged that the target has already been met. - BFI assessment is due in September and work is ongoing on the improvements. - Pathway for FGM has been implemented, further training is being undertaken and there is an FGM intranet page. A flowchart has been drafted and is awaiting approval. Further updates will be provided as the work progresses. - Post mortem consent training available on an 'as require' basis, awaiting details on update training for cascade trainers.	

	• DVT recording – clarification is being sought as to where this needs to be recorded. It was noted that the drug chart is what the target is being measured against and it was noted that audits are now being undertaken to ensure this is being accurately recorded. It was noted that improvements are required as soon as possible on the drug chart and it was agreed that a further audit would be undertaken in 3 months to review progress. • Preceptorship badges being ordered for all new midwives • A LGBT awareness lunch time session was organised by RCM which was well received. • Pen Y Fan Walk is planned for September to raise funds for the maternity unit • Caring for you Meeting scheduled for 15th September • Proposal to decrease bed availability at the weekend is being reviewed for C1. This proposal will be shared with the Executive Team for consideration. • Hospital at Night Specialty Management – this is being reviewed and once further information is received, this will be shared • Increase of labour ward cover is required and further discussions are ongoing with the Deanery as to how this can be undertaken. This will require investment and a business case is being developed. • Birthrate plus business case has been presented and further information has been requested. This will need to be submitted by 01 September 2017.	
3.3c	Community Child Health • LIPS Project – Pre School Booster has been completed and will be presented at future Directorate and Clinical Board Q&S Meeting • Archiving issues are being worked through and it was noted that this will be transferred to Trefforest. • Looked after Children placed out of area. There are issues as there is an inability for the out of area Health Board to see them due to capacity issues. Discussions have taken place and it was noted that there is a breach of duty of care within ABMU. CH also agreed to follow up with the Nurse Director as information needs to be provided to Welsh Government if this continues. It was agreed that further detailed discussions would take place outside of the meeting to look at a robust plan for these children. • Data Protection breach has been reported as a serious incident. This is being progressed and there was assurance that all staff are completing information governance training. • Maintenance of standing frame has been highlighted as a concern. This frame has been taken out of area and needs to be brought back for maintenance. JM agreed to forward the detail to JT for follow up outside of the meeting. • Regular monthly meeting to monitor E Datix and Concerns has been implemented. • Safeguarding concern raised with regards to CHC and it was noted that there are no children placed. PD will be part of the meetings to monitor this. • Pathway developed with Safeguarding Team for Ysgol y Deri and joint safeguarding is being undertaken to ensure all agree the new process. • Tender for CCNS Service is being produced and meetings are taking place with Local Authority to look at residential options available. • Ombudsman Investigation is being undertaken in relation to referral to Ophthalmology and a written protocol has been produced to outline requirements for referrals following parental concerns. • Legal Advice is being sought and a contract of care for children on ventilation is being progressed in order to ensure appropriate management of patients • LIPS Programme on Transition being taken forward. Work being undertaken with Primary Care on the transition pathway. • Patient Feedback in the Children's Centres are low and requests have been made for the information to be split. Discussions ensued in relation to the possibility of volunteers providing support for patients/carers to provide feedback.	

	Discussion regarding whether a standard multi agency response required for concerns when it is clear that processes have been followed. CH agreed that this should be taken to the Safeguarding Committee for consideration.	
3.4	Exception Reporting / New Risks to be considered for the Clinical Board Risk Register No specific exception reporting or new items for the risk register to note from this meeting.	
3.5	Paediatric Surgery Update Paediatric Surgery Action Plan The action plan was noted for information. It was noted that the Royal College of Surgeons completed a Clinical Notes Review. The action plan outlines all actions, including the feedback received from the RCS. The formal report is awaited; however initial feedback was that the service is safe. Some of the areas of concern were in relation to:- - Handover and recognition of deteriorating patient – work is underway in relation to implementing a new rota which it is hoped will improve this going forward. Recruitment for the service is continuing and the appointment of x3 further substantive consultants is underway. Improved processes have been put into place in order to monitor handover and to ensure a proper process for patient management is in place, allowing nursing feedback and concerns to be discussed and acknowledged. It was noted that this process has improved and work continues - Mortality and Morbidity Process – where it was felt that the process was not as robust as it should be. Work is ongoing in order to ensure that the process is robust and actions and processes recorded appropriately. - Duty of Candour A detailed report on the 19 cases is awaited and following receipt of this, information will be shared with the staff that have highlighted the concerns. Work continues in order to ensure that the service is robust and the service model is appropriate going forward. It was agreed that information would be forwarded in order for this to be shared with Clinical Leads. It was acknowledged that a Health & Safety Review will be undertaken by WHSSC however a date is awaited for this. Discussion ensued and it was noted that the issues in relation to handover are also being experienced in other areas. It was agreed that this needs to be embedded within job plans as part of routine practice.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
4.1	Initiatives to promote health and wellbeing of: - Patients - Staff This was discussed as part of the QS&PE Directorate reports under item 2.3.	
SAFE CARE		
5.1	Update on Serious Incidents X2 new incidents have been reported – x1 Information Governance Breach (previously discussed under item 2.3c) and x1 following harm received as part of a forceps delivery. These are being progressed and further update will be provided once investigations are complete in order to share lessons learnt.	
5.2	RCA - FP for Noting This case involved a 3yr old patient who was admitted to PICU with a diagnosis of Haemolytic anemic syndrome (HUS). The patient commenced parenteral (PE) nutrition however during	

	the session became bradycardic and had a cardio respiratory arrest where unfortunately the patient was unable to be resuscitated. A full investigation was undertaken, including a review of the patients' initial admission to the Royal Gwent Hospital. The RCA did not identify any preventable causes to the patient's death. The feedback received from the family however was noted that they felt there was a delay in contact being made following their child's passing. This has been acknowledged by the team and the need to ensure contact is made within the agreed timescale has been reiterated to all. The incidental learning found that there were some minor issues with the prescription chart during the PE process, as it was the first this procedure had been practiced in PICU and this has now been reviewed within the team and one version is available for each session. It was noted that this case has been shared for learning and debriefing sessions have also taken place.	
	RCA SE Incident number 240055 Incident involving a fractured clavicle following a spontaneous vaginal delivery was reported, however on investigation of the notes and a timeline produced it was felt that the shoulder dystocia was well managed and the fractured clavicle was likely to have occurred during the physiological birth process and not due to manoeuvres by the midwife, therefore the incident did not require a full RCA investigation. The SBAR and timeline has been shared for information and lessons learnt.	
	RCA EG Incident number 24054 LB gave an overview of an RCA that had joint Midwifery, Obstetric and neonatal IO's which has been reported to Welsh Government as an SI. This case is also due in Coroners court in October. LB shared an overview of this patient's journey. LB explained that there are many lessons to be learnt from this RCA and an action plan has been developed to address all the recommendations. Following coroners court the RCA will be anonymised and shared for learning within the clinical board.	
5.3	Infection Prevention Control Update Report was noted for information. X1 MRSA which was identified in mortuary of which the RCA is awaited. E Coli data is now being captured for 2017/18. ANTT is being progressed throughout all areas. Winning Patient Poster for Hand Hygiene Shared for information. Noted as part of Item 2.3	
5.4	Safeguarding SBAR – Health Visitor Forms Noted for information. Concerns were highlighted that the process is unsustainable. Discussion ensued and it was agreed that this would be shared with the Nurse Director and Deputy Nurse Director for information in order to highlight the issues. Further discussions will take place outside of the meeting to review options for a manageable way forward within the Clinical Board.	CH CH/MG

31.7

EFFECTIVE CARE		
6.1	Amended VA referral to include category for Grade 3 and 4 Pressure areas Noted for information. This is specifically for vulnerable adults and it was agreed that clarification would be sought on the requirements for children. CH agreed to follow up.	CH
7.1	Latest Cleaning Scores Report – for information The report was noted for information. No specific areas of concern to note.	
TIMELY CARE		
8.1	Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes – for information It was noted that there was no scheduled Executive Performance Review for August however as soon as the latest information is available; this would be circulated to the group for information.	
INDIVIDUAL CARE		
9.1	Update on latest 2 minutes of your Time feedback Discussed as part of exception reporting.	
STAFF AND RESOURCES		
10.1	Feedback on current position for :- - PADR – medical staff increase to 89% however the improvement for other staff is not being seen, it is anticipated that there will be an improvement following submission of information to LED as a result of hierarchy. - Sickness has decreased from 4.5% to 4.4% Thanks were expressed to all for the continued effort in managing these areas and for the ongoing improvements being made.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
11.1	Medication Errors Report – July 2017 Noted for information. There have been administration errors reported this month and it was noted that the drug investigations are being carried out in line with policy.	
11.2	Newborn Bloodspot Poor Quality Sample Feedback - June 2017 Noted for information. Samples continue to be well managed.	
11.3	Enforcement Agencies Report Noted for information.	
ANY OTHER BUSINESS		
DATE AND TIME OF NEXT MEETING		
The next meeting is scheduled for Tuesday 26th September, 8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW (Quality & Safety Focus)		



Dental Clinical Board

Minutes of Quality, Safety & Experience Committee Group Meeting 7th September 2017 at 8:00 AM Annexe Meeting Room

Present:		
Mr Andrew Cronin (Chair)(AC)	Dinah Jones (DJ)	Barbara Chadwick (BC)
Rowena Griffiths (RG)	Catherine Evans (CE)	Julia Charles (JC)
	N Drage (ND)	Gurcharn Bhamra (GB)
In attendance:		
Jonathan Peck (JP)		
Apologies Received from:		
Sarah Merrett	Eira Yassien	
Ivor Chestnutt	James Gillespie	

		ACTION
PRELIMINERIES		
1.1	Welcome & Introductions AC welcomed everyone to the meeting of the Quality, Safety and Experience Group.	
1.2	Apologies for absence Received as above.	
1.3	To receive the Minutes of the previous meeting The minutes of the Quality & Safety meeting held on the 15 th June 2017 were accepted as an accurate record. Matters Arising RG noted under Matters Arising of the last meeting that the current agenda format was to be discussed and altered to make it more specific to Dental. After discussions with Fiona Jenkins it has been agreed that the grey headings are to remain but the sub headings can be altered to suit the various audit meetings or locality groups. AC commented that Dental Clinical Board was happy to comply and the sub headings were to be looked at by the different audit leads. AC requested only relevant information for audit be passed to JP for inclusion.	
MONITORING & REPORTING – DENTAL CLINICAL BOARD SUB GROUPS		
2.1	Oral Surgery, Medicine and Pathology - Mr N Drage Minutes from the OSMF Audit Group meeting on the 13th June 2017 were received and noted. AC chaired the 12 th July Audit Group meeting and informed the group there were 2 presentations:	

	- A service review of Oral Medicine provision at the University Dental Hospital - Nikesh Farmah. Evidence collected by Sheril Mathew, Professor M Lewis and Dr P Atkin AC commented that this presentation was well received. - Oral & Maxillofacial Surgery use of Emergency Theatre – Aoife Swain. Aoife gave an interesting overview of the different types of trauma cases that used the Emergency theatres in the UHW. AC noted the presentation raised the question as to whether patients should be re-categorised. ND informed the group that the ongoing agenda item with relation to Medicine Related Osteonecrosis of the jaw, MRONJ, had now been closed. It has been decided to follow Scottish Guidance.	
2.2	Restorative Dentistry - Mr G Bhamra Minutes from the Restorative Dentistry Audit Group meeting on the 20th June 2017 were received and noted. GB noted the presentations given: - Emma Stone – Inoculation Injuries ES explained the procedures that are to be followed when an inoculation injury is sustained. - Helen Poole - Smoking Cessation Update The group were informed of an update to the Patient Management System with regard to smoking cessation referrals. GB commented that although there was a field on the SALUD system to note smoking cessation referrals this would not then automatically forward the referral to be registered and acted upon.	
2.3	Joint Orthodontic and Paediatric Dentistry - Ms S Merrett & Mrs S Bhatia Minutes from the Joint Orthodontic and Paediatric Dentistry Audit Group meeting on the 13th June 2017 were received and noted.	
2.4	Community Dental Service - Mr J Gillespie	
2.5	DSG HSC: Minutes of the Dental Division and School H & S Advisory Group - Prof I Chestnutt	
	AC informed the group at this point that Patient Stories, both good and bad, were required to be presented at Clinical Board. It was also the wish of Clinical Board to invite the patient themselves to the presentations to contribute. AC suggested a story 'bank' be created whereby patient story presentations that are given are then forwarded to JP to be kept separately. BC commented that in some cases it would not be appropriate for the patient to be present at presentations. AC will email all audit leads requesting patient story presentations are forwarded to JP.	AC
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Health and Care Standards Monitoring data Healthcare Standards action plan 2015-2016 The document was received and noted. RG summarised the document and noted that it would have to be agreed who would lead on each standard and take forward. AC requested expressions of interest from group members with regard taking lead on standards by the next Quality & Safety group meeting.	All Group Members
3.2	Consent ISN 2017 001 Consent legibility The document was received and noted. AC summarised the document and informed the group of a recent incident in Llandough Hospital. AC noted that	

	clinicians were honour bound to improve legibility. BC suggested setting up a legibility audit with further re-audits at 3 to 6 month intervals. RG commented that the Community Dental Service had already agreed to complete an audit with regard consent.	
3.3	Patient Identification Policy - Patient ID Policy February 2012-Q&S version The document was received and noted. RG noted in particular page 6 of the document. When identifying a patient always ask the patient (or a relative / carer if the patient is unable) to state: 1. Their name 2. Address 3. Date of birth This information must then be checked against relevant documentation and the armband, and must include a check of the hospital / NHS number. BC commented that there was nothing in the document about dealing with difficult patients who will not wear the band and only have the band put on when they are asleep.	
3.4	Audit Plan 2017 / 2018 for discussion	
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 Report - Incident Report 130617 – 290817 The document was received and noted. AC noted in particular: - Incident In48288 – ‘I opened an LA Tray-10 1001338 from LA and found a needle with safety plus handle still attached. The needle was partially sheathed.’ AC commented that it would be worthwhile knowing if the modified WHO checklist will be able to identify the operator and whether the two signatures required are present. AC also inquired if the operator responsible was aware. RG replied that it had been previously agreed that first time instances would not be brought to their attention. Operators would be notified if it happened a second time. RG will find out if the WHO checklist identifies the operator. - Incident In48433 – Theft of money. AC confirmed the incident had been reported to the Police. - Incident In48408 – AC queried the learning point from this incident as it was unclear. RG will look at who reported the incident. Top 3 learning areas arising from review of incidents and clinical audits New Serious Incident IRMER Breach - Never Event 2 & 3 Improvement plan FINAL The document was received and noted. RG summarised the incident which was investigated externally. AC outlined the circumstances surrounding the incident and what has been highlighted as a result of the investigation. A patient identification issue was apparent as the patient in question had queried the	RG RG

	procedure that was to be carried out and pointed to the teeth that they thought were to be worked on. There was also disparity between the statements provided for the investigation. AC informed the group that the performance of the clinician had been evaluated and there was to be no further action. The incident has been concluded and the patient is to be redressed. The patient is also to be given an implant. RG informed the group that the acceptance plan has been accepted by Welsh Government and this needs to be shared with audit groups. • Never Event 3 POWERPOINT The document was received and noted. Document is to be shared at audit. • Saying Sorry – Leaflet The document was received and noted. Document is to be shared at audit.	
5.3	Medicines Management Audit Report – Rowena Griffiths • Medicine Management audit final The document was received and noted. RG informed the group that there was no further progress at the moment. New UHB policies are going to be issued in the near future. Medicine incident – Andrew Cronin	
5.4	New Medical alerts • Internal Safety Notice Esketamine 2017 002 v Final The document was received and noted. JC noted that Esketamine was no longer used in GA. • Briefing paper PSN025 v1.0 The document was received and noted. AC summarised.	
5.5	Medical devices/equipment issues • Medical device action plan COMPLETE The document was received and noted. RG commented that recommendation 2 was a potential patient safety issue. The issue has been added to the Risk Register and was soon to be raised at the Medical Management Group meeting with a request for funding.	
5.6	Decontamination CDS WHTM01-05 • CDS DECONTAMINATION ACTION PLAN The document was received and noted. AC acknowledged the huge amount of work that had been undertaken. This was still ongoing but most of the assurances had been given. DJ commented that the same plan was going to be put in place for the prison.	
5.7	HIW Inspections and report • C&V UHB Annual Report 2016-2017 The document was received and noted. • Acceptance letter and agreed plans The document was received and noted.	
5.8	Infection, Prevention & Control • IPC Action Plan Dental Clinical Board 17/18 The document was received and noted. AC commented that the monthly hand hygiene audits were still ongoing and their results were improving. Clinic inspection reports and improvement plans	
5.9	NatSSIPs – Julia Charles • PSN025 Staff reminder v0.2 PDF The document was received and noted. JC gave the group an update on the National Safety Standards for Invasive Procedures (NatSSIPs), the meeting that she and AC had recently attended and how procedures and policies need to be standardised across the UHB. AC requests ideas from the group on how to take	

	this forward but did note that the Dental Clinical Board were ahead of timescales that have been put in place. JC commented that the GAP Analysis had been completed and an intranet web page was in the process of being developed.	
EFFECTIVE CARE		
6.1	Monitoring of CB Clinical Audit plan Ongoing Audits The document was received and noted. AC reminded audit leads that ongoing audits needed to be monitored and closed when appropriate.	
6.2	Research and development - BC - HRA Study Set Up Changes The document was received and noted. BC summarised the document. - BC - Joint Research and Development Service - R+D Leads July 17 The document was received and noted.	
DIGNIFIED CARE		
7.1	Initiatives to improve services for people with: - Dementia – Dinah Jones - Sensory loss – Eira Yassien - Mental Capacity Act RG informed the group that the UHB has requested Clinical Boards to run audits around the Mental Capacity Act. RG is going to meet with Grace Kelly to discuss this further.	
TIMELY CARE		
8.1	RTT – Eira Yassein Waiting list issues – Eira Yassein	
8.2	LIPS Bariatric Pathway - Complexities to developing a care pathway The document was received and noted. - LIPS1v3 (2) The document was received and noted. 2017 Bariatric Care Pathway (Weekday) The document was received and noted. RG commented that this was going to be taken to Dental Clinical Board this week to discuss how to take further.	
INDIVIDUAL CARE		
9.1	Complaints Reg 28 and response AAA case 06 17 The document was received and noted.	
9.2	Compliments The document was received and noted.	
9.3	Safeguarding VA1 - Adult Protection Referral Form The document was received and noted.	
STAFF AND RESOURCES		
10.1	Employee of the Month - July – Pathology Lab, UDH - August – Jean Yeoman, CDS	

	AC acknowledged and congratulated.	
10.2	Staffing levels – Eira Yassien	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
	ENC30 - Clinical Inspection Report The document was received and noted.	
	ENC31 - Clinical Inspections Action Plan 2017 The document was received and noted.	
	ENC32 - NHS Wales Health & Care Monitoring System - Reports Jan-August The document was received and noted.	
	ENC33 - NHS Wales Health & Care Monitoring System - Reports Report Manager The document was received and noted.	
Any Other Business		
	JC informed the group that GA nurses were having a number of calls from clinics requesting them to attend as there were problems with mental health / psychiatric patients who were becoming aggressive. JC noted that there was no reason for this as GA nurses are not specifically trained to deal with these patients.	
	ND summarised a recent IRMER Breach where a patient had submitted an old X-ray request form and the request had been carried out. This was currently being investigated.	
	CE commented that the Never Event action plan still had actions required and needed to further discussion at the next meeting for an update.	
	DJ informed the group of an upcoming CHC inspection in Barry Hospital.	

Date and time of next meeting

Thursday 2 nd November 2017	8.00 AM	Dental Boardroom

PRIVATE QUALITY SAFETY AND EXPERIENCE COMMITTEE

6th December 2017
Corporate Meeting Room, HQ, University Hospital of Wales

AGENDA

1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	Oral
4	Minutes of the Private Committee held on • 12th September and • 17th October 2017	<i>Chair</i>
5	Action Log	<i>Chair</i>
6	Chair's Action Taken since the last meeting	Oral <i>Chair</i>
7	Safeguarding Update	<i>Executive Nurse Director</i>
8	Interventional Neuroradiology	<i>Chief Operating Officer</i>
9	Paediatric Surgery	<i>Executive Nurse & Medical Directors</i>
10	Paediatric Surgery Junior Doctor Staffing Difficulties (Workforce and OD Compliance)	<i>Medical Director</i>
11	Items to bring to the attention of the Board/other Committee	Oral – <i>Chair</i>
12	Review of the Meeting	Oral – <i>Chair</i>
13	Date of next meeting Tuesday 13 th February 2018	