Portsmouth Hospitals NHS
NHS Trust

**TRUST BOARD PART I – MARCH 2012**

**Agenda Item Number: 44/12**
**Enclosure Number: (10)**

| | |
|---|---|
| **Subject:** | **Patient Safety Walkabout (January and February 2012 position)** |
| **Prepared by:**<br><br>**Sponsored by:**<br><br>**Presented by:** | Fiona McNeight, Head of Governance and Patient Safety<br><br>Steve Erskine, Non-Executive Director<br><br>Peter Mellor, Company Secretary |
| **Purpose of paper**<br>*Why is this paper going to the Trust Board?* | Regular Reporting<br>For Information / Awareness |
| **Key points for Trust Board members**<br>*Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals* | Board patient safety walkabouts commenced on 18th November 2010 and occur fortnightly. These are led by the Non-Executive Directors (NED). These walkabouts clearly reflect the Boards commitment to patient safety and provide the opportunity for direct engagement with staff at all levels to discuss patient safety issues/concerns/challenges. They also afford an opportunity for direct contact with patients.<br><br>This is the first formal briefing to the Board on the key findings from the Patient Safety Walkabouts in January and February 2012. This is a high level summary of findings. There are detailed action logs produced for each walkabout and actions are managed and monitored within the appropriate Clinical Service Centre (CSC).<br><br>The Board are asked to note the key findings.<br><br>The Board will receive briefings at each Board meeting, for the preceding month's walkabouts. |
| **Options and decisions required**<br>*Clearly identify options that are to be considered and any decisions required* | Nil decisions required. |
| **Next steps / future actions**:<br>*Clearly identify what will follow the Trust Board's discussion* | Ongoing reporting of safety walkabouts |
| **Consideration of legal issues** (including Equality Impact Assessment)? | Considered – None. |
| **Consideration of Public and Patient Involvement and Communications Implications?** | Considered – None. |

| PATIENT SAFETY WALKABOUTS: JANUARY – FEBRUARY 2012 | | |
|---|---|---|
| **CSC** | **Speciality** | **Findings** |
| **January 2012** | | |
| **Medicine** | **Respiratory High Care** | Compliments to the team on the rotation scheme of staff between the respiratory wards and High Care. Not only does this build a winter reserve but also spreads good practice in high care to the respiratory wards. |
| | | Compliments to the CSC Senior Management Team (SMT) for expanding nurse recruitment before the winter season. This has facilitated the smooth running of the department during a very busy Chronic Obstructive Pulmonary Disease (COPD) season. |
| | **General Wards** | VitalPAC was acknowledged to be a big step forward by the doctors and nurses but there are still technical problems relating to system down-time caused by the age of the infrastructure and hand held devices. |
| | | NED's recognised the initiative of prescribing facilities at ward level for general medications to ease delays on discharge. |
| | **Endoscopy** | The impressive service expansion on the back of the bowel screening initiative was well received. |
| | | The cleaning facility is small and noisy, giving rise to concerns about staff comfort and safety. Simple steps have been taken to enhance air exchange rate and to expand the working space with an office for the technician. The potential for upgrade of cleaning facilities was discussed during the walkabout. A question was also raised about why equipment cleaning activities are carried out in a number of different locations in the hospital. |
| **February 2012** | | |
| **Cancer** | **Oncology Day Unit** | The Day Unit waiting room is designed to be a place of comfort where patients wait 5-10 minutes before moving on to treatment. However, occasional delays occur increasing the patient waiting time due to the following:<br>- Late prescriptions<br>- Incorrect prescriptions resulting in pharmacy delay<br>- Lost prescriptions<br>E-prescribing should help resolve these issues. |
| | | There is a plan to rotate staff from the Day Unit to increase and maintain nursing skills and hence improve retention. |
| | | Patients reported that the Day Unit chairs were not comfortable when having prolonged treatment. The department need to ensure that the comfort of the patients is maintained. |
| | **General Wards** | Good practice was noted on the wards of name boards outside of the bays having a red/green tray indicator so patients requiring assistance are clearly identified.. |
| | | Ward intentional rounding has been introduced to support patient safety and reducing harm. |

| | | |
|---|---|---|
| **MOPRS** | **General observations** | The NEDs had observed a significant improvement over the last 18 months. |
| | | There was a proactive feel to the service centre and the senior management's team approach to the challenges in this vital area of medicine. They reflected a board of strong support for the adoption and quest for excellence in care for the patients with so many complex and challenging illnesses. |
| | | |
| | | Staff shared evidence of the external pressures of a limited 24hr on-call GP service and potential deficiencies in community beds for convalescence in our commissioning areas. The Non-Executive Directors acknowledge all the good work relating to the Older Persons Partnership Project, and commended the consultant triage in ED which had led to saving 2 admissions per day. |
| | | To support the MOPRS Head of Nursing's need to build a high profile for nursing of the elderly the NEDs encourage the Company Secretary to invite a CSC presentation at a future board. |
| | **G3** | Pressure sores and falls - the Head of Nursing acknowledged these remain a challenge but detailed review on admission was having an impact together with 2 hourly rounds and the excellent 'pups' signs (these pictorial signs of dogs indicate risk of pressure sores) seen all over the wards. |
| **Emergency Medicine** | **Emergency Department (ED)** | Queuing of patients in the emergency department corridor and action taken to reduce risk i.e. patient flow initiatives, funding for queue nurses over winter, and the sourcing of private ambulance services to support the queue at peak times was discussed |
| | | The current IT system (iSOFT) needs to be more cohesive and there was acknowledgement that alternative systems were in use in other ED departments. There was agreement that there was a clear place for such an IT system to be used within the ED department, but that it needed to be clinically driven. |
| | | The issue of inappropriate speciality referrals to the ED department was highlighted by senior staff. |
| | | It was acknowledged that the ED was performing very well and to further improve the performance, the department could benefit from reconfiguration and the provision of additional diagnostic capability. |
| | **Medical Assessment Unit (MAU)** | MAU had been voted runner up on 3 occasions by Royal College of Physicians, for 'team of the year'. |
| | | It was noted, that MAU had in recent months, achieved VTE assessment on over 90% of patients admitted through the unit. |
| | **General** | The Non-Executive Directors commented positively with regards to the overall quality and attitude of the staff working within the Emergency CSC and recognised these were highly performing departments. |
| | **Hospital Operations Centre** | Operational meetings were observed demonstrating exchange of information regarding predicted patient admissions, transfers and discharges and appropriate patient flow plans for the day. The pressure on bed numbers at peak periods was noted. |