EVIDENCE SUMMARY – Code A

BASICS

DOCUMENTS

Document No	Title
2.8	National service framework (NSF) for older people – Short summary
2.6	National service framework (NSF) for older people
I 1.1	Department of medicine for elderly people – Wednesday lunchtime meetings/timetable
I 1.2	Friday lunchtime journal club sessions/timetable
I 1.3	Clinical assistant teaching sessions/study day sessions
I 2.1	Post registration education prospectus from the University of Southampton School of Nursing and Midwifery 2001/2002
I 2.3	Intermediate care training and development for nursing staff in PHCT community hospitals – Update – Feb 2001
I 3.1	Programme of training events for Portsmouth Healthcare NHS Trust
I 3.2	PHCT training on demand leaflet and index of titles
I 2.4	Clinical nursing development – Promoting best practice in Portsmouth Healthcare NHS Trust 2000-2001
I 2.5	Royal college of nursing – Gerontological nursing programme/community hospitals proposal for integrated work based learning
I 2.6	An evaluation on clinical supervision activity in nursing throughout Portsmouth Healthcare NHS Trust
I 3.4	Valuing diversity training and a diversity matters leaflet
I 4	Staff performance review guidance
I 5	Policy statement – Training and education
D 2.1	Consultant memo: Gosport war memorial hospital
D 2.2	Winter escalation plans elderly medicine and community hospitals - Portsmouth Healthcare NHS Trust
D 2.3	Excerpts from the on-call file
I 2.2	Alert course outline
I 3.3	E-learning programme
D 3.1	The development for clinical supervision for nurses at Gosport and Fareham
D 3.3	Supervision arrangement consultant timetable
D 3.2	GWMH – Nursing supervision arrangements
F 1	Trust management structure
F 2.1	PHCT baseline assessment and action plan 2000/2001
F 2.2	PHCT assessment and action plan 2001/2002
F 3.1	Portsmouth district prescribing formulary 2001 (not complete)
F 3.2	Compendium of drug therapy guidelines for PHCT and PHT 1998
F 4.1	Control and administration of medicines by nursing staff policy - 1997

F 4.3	PHCT policy for the assessment and management of pain
F 4.2	Medicines policy – District wide final draft - version 3.5, August 2001
F 5.1	Administration of medicines – community hospitals programme for updating qualified staff 1997 – still current
F 5.2	PHCT Administration of controlled drugs - The checking role for support workers – Guidance note for ward/clinical managers 1997 – still current
A 4.1	PHCT User involvement development: A framework
A 4.2	A report on a future PALS service for Gosport and Fareham PCT
A 4.3	Details of an 'analysis of complaints meeting' as part of the patient involvement strategy at PHCT
A 5.1	PHCT 2001/02 SAFF cost and service pressures
A 5.2	Fareham and Gosport primary care groups – proposal to establish a PCT for Fareham and Gosport – July 2001
A 2.1	A letter regarding the 2000-2003 HiMP – Isle of Wight, Portsmouth and South East Hampshire HA
A 2.2	Fareham PCG letter regarding HiMP update and supporting documentation
A 2.3	Gosport PCG letter regarding HiMP update and supporting documentation
A 3.1	Fareham and Gosport PCGs proposal for intermediate care and rehabilitation services

ABBREVIATIONS

Abbreviation	Description
HimP	Health Improvement Programme
PHCT	Portsmouth Healthcare NHS Trust
T&D	Training and development
AED	Automated external defibrillators
NSAIDs	Non-steroidal anti-inflammatory drugs
TOD	Training on demand
CHD	Coronary heart disease
NSF	National service framework
RCN	Royal college of nursing
PCTs	Primary care trusts
GWMH	Gosport war memorial hospital
PHT	Portsmouth hospitals trust
QAH	Queen Alexandra Hospital
QA	Queen Alexandra
DNR	Do not resuscitate
SJH	St James' Hospital
AMH	Adult mental health
TTOs	Medication to take out?
BNF	British national formulary
RHH	Royal Hospital Haslar
HCSW	Health care support worker
SAFF	Service and financial framework
IAHSP	Institute of applied health and social policy

WHO'S WHO

Title	Name	Dates
FRCP – Consultant Geriatrician - Appears to convene the study days for medical supervision/clinical assistant training	Dr A Lord	Unknown
Senior Nurse Specialist, Elderly Services	Jane Williams	12th February 2001
Senior Nurse, Gosport War Memorial Hospital	Toni Scammell	12th February 2001
Practice Development Co-ordinator, Petersfield Community Hospital	Jo Odell	12th February 2001
Clinical practice development co-ordinator	Mary Golden	December 1999
Consultant geriatrician	Dr Althea Lord	19th November 2001
Senior nurse co-ordinator	Toni Scammel	19th November 2001
Clinical assistant	Dr Jane Barton	20th December 1998
Quality manager	Lesley Humphrey	20th December 1998
Medical director	Ian Reid	16th November 2001
Chairman of the formulary and medicines groups	Dr G Venkat-Raman	September 2001
Quality director	Pam Grosvenor	January 1997
Project manager quality	Sue Frogley	November 2001
General manager, Fareham and Gosport PCG	Pat Rimmer	May 2000
Service development manager, Gosport PCG	Elizabeth Emms	October 2001
Service development manager, Fareham PCG	Rachael Boyns	October 2001

1 TRUST CONTEXT

2 MANAGEMENT OF HEALTHCARE

2.1 TRUST STRATEGIC MANAGEMENT

2.1.1 Leadership

2.1.2 Accountabilities and Structures

The following groups are accountable to Portsmouth Healthcare NHS Trust board, undated:

- Business case panel
- Financial audit panel
- Clinical governance panel
- Risk management group
- Finance and performance panel
- Pay and remuneration panel
- Mental health panel (F1.1).

Portsmouth Healthcare NHS Trust district medicines and formulary group have shared membership with the trust medicines and prescribing committee, together comprising medicines management. The district medicines and formulary group is led by the medical director and the trust medicines and prescribing committee is led by the medical director and the clinical risk adviser (F1.1).

The district medicines and formulary group also has shared membership with the clinical governance panel who, in turn, are accountable to the trust board. The trust medicines and prescribing committee also has shared membership with the risk management group, which is accountable to the trust board. The risk management group and the clinical governance panel have shared minutes, undated (F1.1).

2.1.3 Strategic Direction and Planning

PHCT has supplied a paper on SAFF cost and service pressures, containing an analysis of anticipated cost pressures facing PHCT in 2001/2002. Analysis is provided on the basis of national cost pressures, local issues and ongoing commitments. Appendix one provides a breakdown of the cost pressures for each area and appendix two provides a calculation of inflation funding requirement 2001/2002. Appendix three covers SAFF priorities which include dual diagnosis, assertive outreach, CAB advocacy and primary care liaison (A 5.1).

National cost pressures to be funded via SAFF include pay awards 2000/01 and 2001/02, superannuation, mental health issues, AMH service capacity, the elderly people's NSF, the learning disability white paper, nursing home charges and other national issues. Local issues include the following:

- Intermediate care funding shortfalls

- Instrument decontamination/sterilisation
- Sick children's service district wide
- Physiotherapy and podiatry district wide
- Bed/equipment replacement
- Speech and language therapy school policy impact
- Leigh house specialist service capacity
- Loss of under spending budgets to PCTs
- Dual diagnosis service beyond March 2001
- AIDS/HIV
- Medical loans
- Medical records strategy implementation
- Pharmacy security at St James'
- Learning disability community homes and
- Elderly medicine clinical nursing establishment (A 5.1).

The ongoing commitments of PHCT are specialist registrar posts, king villa upgrade revenue costs and learning disability issues. The paper also outlines other funding pressures including place of safety arrangements, prison HIMPs, the implementation of NSF protocols and access to treatment in accordance with royal college recommendations. A table of mental health pledges is also included (A 5.1).

SAFF priorities for Portsmouth and South East Hampshire learning disability partnership board 2001/02 are also provided. The total cost of the priority issues for 2001/02 is £380,000. As this level of funding may not be available, further prioritisation is as follows:

- Complex needs care planner and sexual offenders service - £65,000
- Short term care project manager and additional services - £90,000
- Advocacy - £50,000
- Children in transition - £175,000 (A 5.1).

2.1.4 Health Economy Partnerships

2.1.5 Patient and Public Partnerships

2.2 SERVICE STRATEGIC MANAGEMENT

2.2.1 Leadership

2.2.2 Accountabilities and Structures

GWMH has action-learning meetings for which notes have been provided from June to November 2001, as well clinical managers' meetings, November 2001 (D 3.2). Minutes of Sultan and Daedalus ward meetings have also been supplied, April to August 2001 (D 3.2).

2.2.3 Strategic Direction and Planning

Notes of an action-learning meeting held on 11th June 2001 at GWMH are provided. A revised self-administration programme assessment tool was considered where patients would sign an acceptance form when, and if, the patient medication assessment tool was agreed. A syringe driver prescription for pain management was also discussed and considered suitable for the client group. The related prescription chart is to be implemented as soon as approval is finalised. Attendance at a regional benchmarking group was also noted (D 3.2).

Notes of an action-learning meeting held on 8th October 2001 at GWMH are supplied. The incomplete survey of bleep calls, and the reasons for this, were discussed and attributed to the confusion of patients on wards. Reception cover at weekends and bank holidays were considered along with feedback regarding nursing documentation. Staffing projections were also highlighted (D 3.2).

The minutes of a clinical manager's meeting, 12th November 2001, from GWMH are provided. A new ward provision list was given to those present. Support service issues were outlined. The need to improve communication with relatives was also discussed, all of which was being documented. It was felt that communication had improved and that contact of relatives was now clear in the documentation. The patient survey action plan was also mentioned along with ward feedback, which will be distributed to ward staff along with ward action plans. The lack of HCSW training was flagged up and is being addressed (D 3.2).

Other issues mentioned in the minutes of the clinical manager's meeting, 12th November 2001, include:

- All clinical managers have 24-hour accountability, this was apparently already clear
- Staff are not always informed about recent issues
- A new harassment and bullying policy had been produced
- Patients were sometimes being transferred to Sultan ward while they awaited a bed on Daedalus ward, and this was a concern (D 3.2).

Continuing care transfer information (produced by the continuing care forum) was highlighted as useful for wards to use when receiving patient information from the transferring ward. Clinical managers took this away to discuss with their own staff (D 3.2).

Minutes of a Sultan ward meeting, 10th April 2001, have been provided. The crown prosecution service is mentioned in relation to an investigation of the claim that records

were being destroyed inappropriately. The system has, apparently, since been rectified. However, staff were told to be aware of visitors and questions. The minutes state that 'staff need to be aware of communication needs with patients and relatives and thereby hope/aim to alleviate worries'. ENB and mental health course availability is also mentioned as well as changes to catering (D 3.2).

Minutes of a Sultan ward meeting, 2nd May 2001, have also been supplied. They note the emergency procedure, catering, new resuscitation guidelines, that care plans should be left at the end of beds to be countersigned and that eating is not allowed on the ward – otherwise disciplinary action will be taken (D 3.2).

Notes from a team leaders meeting, 5th April 2001, are given for the Daedalus ward. Issues arising include:

- The confusion concerning the current ward round split
- The named nurse split could be used with greater effect with specific areas of care, namely communicating with relatives, discharge planning, referrals and other actions, discharge letters and dressings
- The need to move patients between different teams was flagged up as problematic
- The decision to incorporate clinical supervision in team meetings was also agreed (D 3.2).

Ward objectives were also outlined including the introduction of a night duty rotation as of 6th May 2001, the use of a discharge-planning sheet for all patients, a re-organisation of nursing notes and paperwork and a revision of pre-printed care plans. It was also agreed that booking and recording of training could be transferred to team leaders (D 3.2).

The notes from a Daedalus ward meeting, 6th August 2001, have been supplied. It has been noted that nurses raised concerns regarding staffing levels on the ward, particularly that 10 risk event forms have been completed in the last week describing incidents that have occurred. A backlog in administration has been flagged up and addressed (D 3.2).

The minutes also note pressure from QA elderly services to fill bed-blocking forms, a request was made for a simpler form for unaltered information. The amount of out of hours bleep calls that trained nurses have to deal with was raised, particularly the amount of requests for records/visiting times/patients needing GPs etc. It was suggested that an auxiliary could carry out this role and this can be further discussed. Nurses working in their weekends off was raised as problematic and tiring, and the option of bank staff was suggested in response (D 3.2).

2.3 CLINICAL GOVERNANCE

2.3.1 Clinical Governance Strategy

2.3.2 Trust Organisational Responsibilities for Clinical Governance

2.3.3 Ward Clinical Governance Arrangements

2.3.4 HA Role as moves to PCT

A proposal to establish a Fareham and Gosport PCT from the PCGs has been supplied, July 2001, produced in conjunction with Isle of Wight, Portsmouth and South East Hampshire Health Authority (A 5.2).

The proposal highlights the vision for Fareham and Gosport, which includes delivering health improvement, developing primary care, commissioning secondary care, developing community based services, working with social services and working with non-statutory partners. It also outlines the following:

- The benefits of primary care trust status
- Service provision – which will include district nursing and health visiting, physiotherapy and community rehabilitation among others
- A profile of Fareham and Gosport
- Partnerships – covering primary care, NHS trusts, local authorities and public service users and carers
- Improving service quality
- Management arrangements and
- Managing resources (A 5.2).

Discussions are ongoing on arrangements for palliative care, elderly medicine and elderly mental health. The 'well established' arrangements and structures for clinical governance at PHCT will help form the basis, the proposal states, for clinical governance in the PCT. PHCT have also been leading work on ensuring that PCTs meet their HR obligations as employers (p 5 A 5.2).

A consultation document on the proposal for a Fareham and Gosport PCT has also been supplied, July 2001, the purpose of which is to establish the impact of the proposals on local services. The document includes an executive summary, a short version of the proposal, what the next steps are, the consultation arrangements and how to comment on the proposals. It also includes maps, a glossary of terms used and how to obtain information if you wish to become a non-executive board member of a PCT (A 5.2).

An NHS consultation document, September 2001, has been supplied covering 'proposals for the transfer of management responsibility for local health services in Portsmouth and South East Hampshire from Portsmouth Healthcare NHS Trust to local Primary Care Trusts and West Hampshire NHS Trust' (A 5.3).

The NHS consultation document includes:

- An executive summary
- A background to the proposals and the planned benefits

- Current organisational arrangements
- The review undertaken by the institute of applied health and social policy (IAHSP)
- The proposed transfer arrangements for clinical services
- An option appraisal
- The proposed transfer arrangements for premises and facilities management services, whereby GWMH would become part of Fareham and Gosport PCT
- The proposed transfer arrangements for non-clinical support services
- The arrangement for the transfer of clinical services and the dissolution of Portsmouth Healthcare NHS Trust
- The next steps and
- Consultation arrangements and how to comment on the proposals (A 5.3).

A PHCT dissolution project proposal has also been supplied, undated. It covers the following:

- Work to date,
- Key decisions required
- The role of PHCT in managing the dissolution
- The role of successor organisations and the health authority
- The role of the regional office
- The project structure
- Key tasks
- Early transfer of services
- Shadow running
- The project launch date
- Conclusions
- The next steps.

A checklist of high level tasks and the lead project teams responsible for these has also been provided (A 5.3).

3 QUALITY OF PATIENT CARE

3.1 QUALITY INDICATORS

3.1.1 Staff Attitude

3.1.2 Effectiveness and Outcomes

3.1.3 Access to Services

3.1.4 Organisation of Care

3.1.5 Humanity of Care

3.1.6 Environment

3.2 STAFFING AND ACCOUNTABILITY

3.2.1 Workforce and Service Planning

3.2.2 Medical Staffing & Accountability

3.2.3 Nursing Staffing and Accountability

3.2.4 AHP Staffing and Accountability

3.2.5 Other Staffing and Accountability arrangements

3.2.6 Out of Hours Arrangements

A memorandum from PHCT for 'senior managers on call' has been supplied, 29th September 2000. The memo alerts senior managers to a new divisional on-call bleep effective from 2nd October 2000, gives the new number, requests the old number to be destroyed and asks managers to ensure all staff are aware of the change (D 2.3).

A memo regarding the health centre has been provided, date and source unknown. It outlines that nursing staff are not responsible for the health centre and that in the event of an intruder alarm or fire alarm being activated, 9-999 should be called. The porters hold keys and emergency services should be met by the door. Contact numbers are also given (D 2.3).

A memo outlines security arrangements, date and source unknown. It states the porter should ensure all doors and windows are locked outside ward areas. Nursing staff should check the lounges after patients are settled, TVs should be unplugged and fires switched off, fire exits should be accessible and cigarettes extinguished and the police should be called if intruders are suspected (D 2.3).

A memo regarding duty doctors outlines procedures in the Sultan, Daedalus and Dryad wards and the minor injuries unit, date and source unknown. In the Sultan ward, patients are looked after by their own GP and the after hours emergency number for the practice should be contacted. For the Daedalus and Dryad wards, patients come under the care of

Dr Barton and if required after hours the practice number should be contacted. For the minor injuries unit, now closed, GPs cover their patients on a 24-hour basis, although Cosham Deputising Service frequently cover for GP practices (Healthcall). An emergency number is given (D2.3).

The memo also refers to requests from doctors that any equipment or dressing borrowed should be logged, and drugs should not be provided unless in an emergency situation (D 2.3).

A further memo refers to bed availability in the Sultan ward, date and source unknown. It states that during the 'handover' period, 8.15pm-8.30pm, it should be known what beds are available should a doctor request an admission during the night. The bed statement book can also be referred to for this purpose. Refused admission should be logged in the Bed State Book. Admissions to the elderly service beds are dealt with by the geriatric office and the Mulberry ward arrange their own admissions (D 2.3).

A memo regarding the use of GPs for the Mulberry ward outlines what to do in the case of call outs and emergency call scenarios, date and source unknown (D 2.3).

There are also memos regarding the kitchen safety alarm, dates and sources unknown. With regards to the latter, it is noted that under no circumstances is the kitchen to be opened to staff outside normal working hours (D 2.3).

Memos in relation to the 'emergency procedure in the event of telephone system failure' for GWMH and for the estates services emergency call-out maintenance facility are also supplied, dates and sources unknown (D 2.3).

An out of hours procedure for obtaining medical records is provided, date and source unclear. It gives the bleep number at the main hospital records department at QAH, a short guide to file numbering and a floor plan of the medical records department (D 2.3).

3.2.7 Team working

3.2.8 Recruitment and Retention

3.2.9 Schemes of Delegation

3.3 GUIDELINES, PRACTICES & PERFORMANCE MANAGEMENT

3.3.1 Patient Transfer

An urgent consultant memo for all medial and nursing staff on Daedalus and Dryad wards at GWMH has been provided, dated 19th November 2001. It outlines what to do in the event of a suspected fracture and/or dislocation in a patient on the ward. Guidelines are as follows:

(1) Ensure the patient is comfortable and pain free

(2) Call out the Staff Grade or duty doctor (out of hours)

(3) If after a medical examination a fracture and/or dislocation cannot be confidently excluded an urgent X-Ray must be arranged. If this is not possible at GWMH, the

patient must be transferred to the nearest A&E department irrespective of the time of day

(4) If, for any reason, this is not done this must be discussed with the next-of-kin and documented in the medical and nursing notes

(5) If there is any concern about making the right decision the duty geriatrician should be contacted via the QA switchboard (D2.1).

A similar urgent memo was circulated for the Daedalus and Dryad wards at GWMH from the same consultant on December 20th 1998. The only instruction that was different was number (2) which directed staff to contact Dr. Jane Barton or the duty doctor (D2.1).

Portsmouth Healthcare NHS Trust have provided a copy of their winter escalation plans for elderly medicine and community hospitals, undated. The document outlines the process for dealing with bed shortages in elderly medicine, which has a consistent bed occupancy of 90-95%. Elderly medicine should contact community hospitals, PHT and the nominated executive director, and community hospitals will be asked to identify the number of empty beds and patients who could be discharged at short notice (D2.2).

Community hospital managers should alert rehab teams and transfers of patients should ideally be within the patient's locality. Patients who are willing to be transferred to a different locality can then be identified and, in extremis, transfers to other locations may be necessary without consultation. GPs will be alerted if their beds in community hospitals are needed and patients requiring emergency medical admission will be admitted to PHT in the first instance if there are beds available (D2.2).

The document also notes that elderly medicine should take account of bed shortages in PHT. PHT will be responsible for notifying it's alert stats to elderly medicine in this instance and elderly medicine will, in turn, alert the community hospitals (D 2.2).

There are three levels of escalation to alert status. The duties of eldely medicine, community hospitals and therapy services, for each of these levels, are outlined in the plan from level 1 to level 3 - red alert status (D 2.2).

Red alert status is defined as total occupancy of QAH, St Marys and Haslar Hospitals of over 100%, with trolley waits in A&E of over 12 hours. The processes for dealing with this, including occurrences during out of normal working hours, are specified. Processes for referrals of elderly patients for inpatient admissions are included in these red alert guidelines (D 2.2).

Staffing contingency arrangements, both day and night, are given in the appendix of the plan along with monitoring advice, and the duration of the arrangements is specified as 2-4 weeks in agreement with other staff while other resolutions are planned (D 2.2).

3.3.2 DNR

3.3.3 Palliative Care

3.3.4 Nutrition and Fluids

3.3.5 Patient Records

3.3.6 Trust Performance Management Arrangements

3.3.7 Service Performance Management arrangements

3.3.8 Staff performance Management arrangements

Portsmouth Healthcare NHS Trust have provided staff individual performance review guidance dating from March 1995 to April 2001 as well as a related procedural statement for April 2001 (I 4).

3.4 MEDICINES

Portsmouth Healthcare NHS Trust district medicines and formulary group have shared membership with the trust medicines and prescribing committee, together comprising medicines management. The district medicines and formulary group is led by the medical director and the trust medicines and prescribing committee is led by the medical director and the clinical risk adviser (F1.1).

The district medicines and formulary group also has shared membership with the clinical governance panel who, in turn, are accountable to the trust board. The trust medicines and prescribing committee also has shared membership with the risk management group, which is accountable to the trust board. The risk management group and the clinical governance panel have shared minutes, undated (F1.1).

A medicines policy – incorporating the I.V. policy - for PHT, PHCT and the RHH has been supplied, August 2001. The policy is the district wide final draft – version 3.5 and covers the following areas:

- Accountability – by staff group, individuals, managers and in terms of substances hazardous to health regulations.
- Prescribing – in terms of responsibilities, requirements of prescription writing, controlled drugs for TTOs and outpatients, pharmacists continuation of drug therapy, medication to take out, TTO prescriptions for outpatient, accident and emergency, day case surgery or day attenders and medical gases.
- Stationery and record keeping – covering permitted prescribing stationery and controlled stationery.
- Stock control and storage – including medicines procurement, medicine stock ordering by wards and departments, storage, stock control, security, controlled drugs, storage error, losses and discrepancies, obtaining medication during pharmacy hours and obtaining medication outside pharmacy hours.

- Dispensing – in terms of responsibility, provision of medication for parenteral administration, dispensing error and prescription charges.
- Distribution and delivery – within the same hospital, between hospitals and peripheral units, surgeries and clinics and in relation to chemotherapy.
- Administration and checking – covering records, controlled drugs, cytotoxic chemotherapy, radiopharmaceuticals, supply and administration of medicines by patient group directions, self –administration by patients or carers and patient's own medication.
- Disposal of unwanted drugs – covering general pharmaceutical waste, cytotoxic and radiopharmaceutical waste and controlled drugs.
- Education and training – in relation to the administration of medicines, intravenous therapy and epidural therapy, CPD, avoidance of adverse incidents and adverse medication incidents.
- Risk management – covering adverse drug reaction reporting, defective product reporting and parenteral therapy infusions.
- Clinical trials
- Individual responsibilities – for nurses, both professional and managerial, bank and agency nurses, students, midwives and student midwives, operating department practitioners and assistants, clinical support staff, doctors, dentists and pharmacists.
- Definitions and glossary
- Affiliated documents
- Directorate or specialty policies – which include medicines policies for orthopaedics and theatre practitioners (F4.2).

The policy is due for review in October 2002 (F 4.2).

The policy review group comprises of individuals from PHT, PHCT and RHH and it states that comments on the policy should be directed to the editor (F 4.2).

A policy for the assessment and management of pain has been provided by PHCT, dated May 2001. The policy aims to 'identify mechanisms to ensure that all patients have early and effective management of their pain and distress' (p1). The policy provides a framework for all staff and has been approved by the appropriate professional group (F 4.3).

According to the policy it is the responsibility of all professionals and support staff involved in care, both directly and indirectly, to ensure that patients/clients have their own pain and distress assessed initially and an ongoing care plan effectively planned with timely review dates. Patients/clients must also be informed, through discussion, of the proposed ongoing care and any need for mechanical intervention (F 4.3).

All professionals are responsible for:

- Assessment

- Planning
- Implementation of action plans
- Evaluation
- Clear documentation
- Liaison with the multi-professional team (F 4.3).

Nurses are specifically responsible for the administration of prescribed medication. Medical and dental staff are specifically responsible for appropriate prescribing of medication and clear unambiguous completion of the prescription sheet. PAMs are specifically responsible for prescription of therapies and providing appropriate aids. Service lead groups are responsible for ensuring that pain management standards are implemented in every clinical setting, that necessary resources and equipment are available, that systems are in place to determine and access appropriate training, that qualified nurses can evidence their competencies and that standards are being maintained by regular audit and monitoring (F 4.3).

Initial pain assessment requirements include ensuring that systems are in place for local pain assessment and documentation methods to be implemented. All qualified nursing and medical staff should have the required skills to undertake the assessment and have the required training to implement and monitor the 'pain standards' (F 4.3).

All professional staff are required to exercise professional judgement, be guided by verbal and non-verbal indicators from the patient or carer and document the site and character of the pain. Staff must also share information with the care team, plan ongoing care where possible and ensure that documented evidence supports patient care and clinical practice (F 4.3).

The requirements for prescribing for pain include:

- A clear unambiguous written prescription by medical staff following diagnosis
- An appropriate prescription given the patients' current circumstances
- That the rationale for medication administered by continuous infusion is clearly documented
- That all prescriptions for drugs administered via a syringe be documented on the sheet for this purpose
- That systems are in place to ensure staff have access to appropriate medication guidance and the analgesic ladder
- That systems are in place to ensure staff have the skill to implement all of the above (F 4.3).

PHCT-wide documentation to support the policy has been provided including:

- A sample of how to complete a 'syringe driver variable dose prescription' sheet with special instructions for analgesics

- A copy of a syringe driver record chart
- A 'pain management cycle' chart
- Copies of audit forms for assessing standards in pain assessment and management - these list the target group, method, audit criteria, audit objectives, a time frame, the sample and the auditors
- An analgesia ladder (F 4.3).

The analgesia ladder indicates the drug doses for different levels of pain, instructions on how to calculate the opiate dose, what to do once the patient is stable, what to remember when administering pain killers, how to evaluate the effects of analgesia and how to observe for any side effects. It also lists sources of advice (F 4.3).

The systems to support this policy, the document notes, should be subject to annual audit and should feature in annual clinical governance plans and reports. The policy also lists further supporting documents and is due for review in May 2003 (F 4.3).

I suggest the review team look at this document – particularly the supporting papers attached at the end.

3.4.1 Prescribing

A prescribing formulary has been provided by Portsmouth district, October 2001, although it is noted as incomplete. The formulary is for PHT, PHCT, GPs, Portsmouth and S.E Hampshire HA and the Royal Haslar Hospital (F 3.1).

The Portsmouth district formulary contains the BNF for categories 1 to 6, 7 and 10 and the secondary care formulary for all other BNF sections. The formulary was produced as a result of a combined effort and is intended for use in both primary and secondary care sectors. **The categorisations are as follows:**

- **GP and hospital use**
- **GP only**
- **Hospital use only**
- **Hospital initiated**
- **Formal shared care agreement with GP** (F 3.1).

Cross reference to trust prescribing guidelines for the use of certain drugs are given. There are also published compendia of adult and paediatric drug therapy guidelines which are available on the wards and from the pharmacy department. The document notes that medicines not listed will be held in pharmacy stock and a consultant's signature is required for such medicines to be ordered and supplied (F3.1).

The formulary outlines that some British drug names are changing to the international non-proprietary name and that both names are included. It also welcomes comments, which should be directed to the principal pharmacist clinical services at PHT (F 3.1).

The formulary list abbreviations and gives a brief outline of formulary management as follows:

Non-formulary usage

Drugs that are not included in the formulary cannot be prescribed by PHT staff, as determined by the trust board in October 2001

Specialist Use

Some drugs are restricted to use only by designated specialists or individual clinicians. Use outside these restrictions is not permitted

Dosage forms

Where dosage forms are stated, usage is restricted to these forms. Where no forms are stated, all forms are available for use (F 3.1).

The formulary lists all the drugs by the BNF section under which they fall. It states the category/categories under which they may be used, for example hospital use only or primary care use only. It points the reader in the direction of further useful guidelines. It also states, where necessary, trust guidelines in using specified drugs, and instances where certain drugs may only be used for certain patient groups, for example in cardiology or paediatrics (F 3.1).

Drugs treatments listed in the formulary include:

- Diuretics (p17)
- Allergic disorders (p 22)
- Analgesics (p25)
- Drugs used in diabetes (p 30)
- Fluids and electrolytes (p42)
- Drugs for the relief of soft tissue inflammation (p 48) and
- Local anaesthesia (p63) (F 3.1).

I suggest the review team read this document (F 3.1). Particularly in reference to specific drugs mentioned in other documents/contexts, firstly, in terms of whether it is listed and secondly, in terms of what the guidelines are.

PHCT and PHT have provided a compendium of drug therapy guidelines, 1998 although it is still current. The compendium is a collection of guidelines from both trusts on prescribing, administering and handling medicines and is clearly labelled as being 'FOR ADULT PATIENTS ONLY' (F 3.2).

The compendium states each guideline has been prepared by a group of experts and that all clinical guidelines have been approved by senior consultants in the relevant field. It is envisaged the compendium should be available in all clinical areas to enable consistency in

the availability and use of information by junior doctors, nurses and pharmacists moving between specialties. It is stated the compendium will be updated and re-issued annually (is the 1998 compendium the most up to date one provided, if so this clearly is not happening?). Finally, the compendium states that new information appears constantly and may need to be taken into account when following the guidelines (F 3.2).

The contents pages of the compendium lists each clinical guideline or policy by BNF section, it also lists general guidelines in relation to, for example, substance abuse by patients or staff, self-medication and enabling protocols for pharmacists. It also points readers in the direction of guidelines available elsewhere. The guidelines listed include:

- Acute diarrhoea (p1)
- ACE inhibitor initiation in elderly patients with heart failure (p7)
- Inhaler devises (p18)
- Confusion in the elderly (p38)
- Patient controlled analgesia (p47)
- Pneumonia, hospital-acquired (p69)
- Subcutaneous fluid replacement (p98) (F 3.2).

3.4.2 Administering

Portsmouth Healthcare NHS Trust have supplied their policy for the control and administration of medicines by nursing staff, January 1997. The policy provides a general framework which applies to all qualified nurses working within the trust. It is recognised, however, that because of the diversity of situations and client groups involved there may need to be special arrangements which reflect local needs (F 4.1).

The policy states that registered nurses are accountable for their own practice in the administration of medicines to patients and are legally responsible for:

(1) The correct storage, handling and safe keeping of all medicines and other pharmaceuticals in clinical areas

(2) The maintenance of records and registers' (F 4.1).

Registered nurses also have a professional responsibility to adhere to the professional code of conduct (UKCC June 1992), the scope of professional practice (UKCC June 1992) and the standards for the administration of medicine (UKCC October 1992). Every nurse should, the policy states, have a personal copy of these documents for reference (F 4.1).

Service managers should be responsible for ensuring that nurses have necessary resources for carrying out these functions safely and that the necessary guidance and up to date training is available to them, particularly after any absence from practice (F 4.1).

Detailed requirements as set out in the UKCC document standards for the administration of medicines draw attention to the following points in particular:

- The need for the nurse to exercise her/his professional judgement and to apply her/his knowledge and skill when administering a drug
- The importance of checking the following are correct:
    - The drug
    - The concentration and the dose
    - The route of administration
    - The time
    - The patient's name.

All of the above should be clearly stated on the drug/chart prescription sheet (F.4.1).

The policy also states the identity of the patient must be clearly established and there must be a reliable system to ensure this happens in all hospital settings. In the case of controlled drugs, two people must be involved in administration of the drug and in recording in the controlled drug register (F 4.1).

Student nurses may administer drugs under the direct supervision of a registered nurse, except those given intravenously. Health care workers may only check controlled drugs if they have been assessed as competent. Medicines should not be administered without a written prescription which conforms to the trust's requirements. The only exceptions are:

- Medicines that can be administered without prescription by a registered nurse. These are on an approved list agreed with the lead consultant for the specialty and must be recorded and signed.
- Verbal order by the doctor which is recorded and signed by the nurse taking the message. The prescription must be written by the doctor within 24 hours (F 4.1).

If a prescribed drug cannot be given as ordered, the doctor should be informed. The nurse should take all reasonable steps to ensure the patient has taken the drugs administered, which should be given directly to the patient. There must be a written protocol for patients administering and storing their own medicines, but the nurses retain responsibility for ensuring medication is taken as prescribed. Drugs errors must be reported as follows:

(1) Immediately to the doctor in charge of the patient

(2) To the clinical manager or service manager

(3) To the patient (and relative, where appropriate)

A risk event form must also be completed in the case of a medication error (F 4.1).

There should be local arrangements for the supply and storage of drugs and how they can be obtained in an emergency. A register of relevant staff signatures should also be kept, to help ensure identity on patients' records. Patients who require medicines on discharge

should be given seven days supply (or a complete course if this is shorter). Patients' own medicines are the property of the patient and should not be taken away without permission. Any nurse in charge of a ward, administering or carrying medicines is responsible for the security of those drugs at all times. Nurses should not write out lists of patients' medicines for the patient, carer or GP. This should be done by a pharmacist or doctor (F 4.1).

The UKCC standards will be used as the basis for an audit tool to check practice and the policy should have been reviewed in January 1998 (F 4.1).

A programme for updating qualified staff regarding the administration of medicines in community hospitals is provided by Portsmouth Healthcare NHS Trust, March 1997. The programme outlines that a member of staff should be able to:

- Produce a copy of UKCC guidelines
- Show evidence of understanding the guidelines
- Show evidence of knowledge of what constitutes a legal prescription
- Outline checking procedures for non-controlled and controlled medication
- Demonstrate evidence of knowledge of dose and strength of commonly used drugs
- Demonstrate evidence of knowledge of the side effects of commonly used drugs currently on the trolley
- Identify sources of drug information
- Identify process to be followed in the event of a drug error
- Complete minimum of one supervised drug round without error
- Demonstrate knowledge of the safe storage of drugs (F 5.1).

An assessment report is then written regarding the individuals' competencies as measured against these criteria (F 5.1).

PHCT have provided a guidance note for ward/clinical managers entitled 'the administration of controlled drugs – the checking role for support workers', February 1997 – still current. The note covers who should complete the programme, when the training should be carried out, who is responsible for ensuring that training is completed and for checking the HCSW is competent, who carries out the training and how frequently refresher courses should be run (F 5.2).

A booklet has been supplied, along with the guidance note, which is intended to provide a record of training for HCSWs who are competent to assist a qualified nurse with the administration on controlled drugs. The booklet includes questions for HCSWs to answer as part of the training (F 5.2).

3.4.3 Drug Review

Medicines management at Portsmouth Healthcare NHS Trust has provided the following baseline assessment and action plan 2000/2001, undated, as part of organisational controls standards (F 2.1):

Category	Baseline score	Maximum achievable score	Lead manager/s	Action begun at September 2000
			Ian Reid	
Accountability arrangements	65	100	Standard to be reviewed with PHT pharmacy	X
Medicines control	60		Services and detailed action plan to be developed	
Storage and handling	50			
Aseptic dispensing	85			
Containers and packaging	100			
Prescriptions	80			
Controlled drugs	100			
Disposal	95			
Clinical trials	80			
Incident management	100			
Handling, prescribing development	100			
Pharmacist cover	100			
Continuing professional development	60			
Risk management process	30	100		
Legislation and guidance	80	100		
Resources	100			
Key indicators	20	100		
Management system	0			
Internal audit	10	100		

Overall score	72	%		

NB – all cells left blank were not completed in the baseline assessment and plan sent by Portsmouth Healthcare NHS Trust

The assessment did not identify priorities in terms of risk level - high, medium or low - and no actions appear to be completed. No actions appear to have begun and there is no action to date (This is odd) (F 2.1).

Portsmouth Healthcare NHS Trust have faired very badly in terms of the management system, internal audit, key indicators, and the risk management process. There are also relatively low scores for storage and handling and medicines control (F 2.1). **I recommend the review team look at this document.**

Portsmouth Healthcare NHS Trust have also provided an assessment and action plan for the medicines management standard 2001/2002, undated, which can be summarised as follows (F 2.2):

Category	Score (%)	Action	Priority	Responsibility	Costs	Future costs
Accountability arrangements	65	Chart being produced	High	Medical director	£0	None
Medicines control	70					
Storage and handling	70	Drug cupboards that do not meet storage requirements to be replaced	Medium	Divisional managers	£10,000	Costs in 2002/2003
Prescription charges for drugs appliances	80	No action to be taken. Cost is greater than benefit	Low			
Unlicensed aseptic dispensing	85	No policy – low risk	Low	Pharmacy and Portsmouth Hospitals		
Prescription, supply and administration	85	AMH – Some supply of TTOs	Medium	Divisional manager and pharmacy	£0	None
Controlled drugs	100					
Disposal	95					
Clinical trials	80	Will be covered by Joint District Meds Policy	Medium	Pharmacy and Portsmouth Hospitals	£0	None
Incident management	100					
Dispensing	100	As Prescription, supply and	Medium	Medical	£0	None

arrangements		administration		director		
Continuing professional development	60	Part of HR strategy	Medium	Medical Director	£0	None
Risk management	70	Will be included in development of Risk Register	Low	Risk management group and Divisional Managers	£0	None
Legislation and guidance	80	Internet access to become more widely available to clinicians	Low	IT manager		Costs in 2002/2003
Resources	100	SJH pharmacy review ongoing	Medium	PHT pharmacy services managers	£60,000	Costs in 2002/2003
Key indicators	95					
Management system	75					
Internal audit	100					
Overall score	83					

NB – Cells were left blank on document sent by PHCT

The projected scores for the management system, internal audit, key indicators and the risk management process have risen dramatically from the 2000/2001 assessment. The storage and handling and medicines control projected scores have also risen, as has the overall score from 72 to 83 per cent. However, not all the lower scoring criteria have been actioned, for example the medicines control and management system seem to have been overlooked (so how will they rise?) (F 2.2). **I recommend the review team look at this document.**

3.4.4 Drug Recording

3.5 COMMUNICATION AND COLLABORATION

3.5.1 Patients

PHCT have supplied a user involvement development framework, undated. In line with 'The New NHS, Modern and Dependable', 'A First Class Service', 'Clinical Governance, Quality in the new NHS' and the NSF for mental health, PHCT are addressing user involvement as set out by the South East Regional Office (A 4.1).

The document states there is 'little point in establishing trust wide PALS' as PHCT will cease to exist by April 2002. However, the main PALS expectations, and having a patient's forum, will be taken forward on an experimental basis within St James' Hospital and the department of elderly medicine (A 4.1).

The documents notes that 'user involvement has been a feature in policy documents for many years, yet much of the evidence suggests that the reality is tokenism rather than active participation...' (p2 A 4.1).

The paper does recognise that for services to be patient centred, user involvement is essential. The framework hopes to enable individual services to be self sufficient in meeting these aims. The framework contains some explicit requirements within a flexible approach, whereby implementation can be tailored to the specific needs of each client group. The key is to build effective relationships and this should include users input from the beginning (A 4.1).

The framework covers the following aspects of user involvement:

- Supporting effective user involvement
- Communication and information
- The user experience
- Advocacy
- Service developments and
- Tools and techniques for user involvement (A 4.1).

The document also outlines the monitoring and reporting arrangements for the framework. The framework will be monitored through formal quarterly reviews and there will be ongoing developmental reports. Also an annual report will be required from each service and achievements will be monitored by the clinical governance panel (A 4.1).

A report on a future PALS service for Fareham and Gosport PCT has been supplied, November 2001, and is in accordance with government guidelines. The proposal for structural integration includes:

- A partnership board for health – the strategic body for the Fareham and Gosport PALS
- The patient/client forum and independent patient forums – which will create successive agendas to cover the trust and social care dimension (A 4.2).

A diagram of a possible future PALS structure is supplied, as well as the structure of Fareham and Gosport PCT. Draft terms of reference for a district wide public and patient involvement group are included along with a health authority public and patient involvement diagram (A 4.2).

The paper proposes an independent review panel for health and social care complaints that will relate advocacy services to patients' circumstances, and a structure for PALS implementation. The paper also lists events, documents and updates with regards to user involvement and PALS at other sites and services in PHCT and district wide (A 4.2).

Details of patient surveys, as part of the patient involvement strategy at PHCT, have been supplied, November 2001. Following five patient complaints in 1998/1999, a workshop was held in February 2001 and emerging themes were discussed (A 4.3).

One of the agreed action plans was to introduce a patient survey. This is given to patients on discharge and is run on a quarterly basis. Results are collected and discussed among all clinical managers and written up as an action plan. Each ward is also given a copy of the individual results from their area in order that any necessary action can be implemented (A 4.3).

The feedback from the patient survey for each ward was as follows (A 4.3):

Daedalus ward

Liked Best	Liked Least	How could your stay in hospital be improved?
▪ Friendly staff ▪ Food ▪ Service of nurses ▪ Able to go out with relatives ▪ Good care and attention ▪ Cup of tea in morning ▪ Physiotherapy ▪ Visiting times ▪ Nice furnishings ▪ Good chairs, suitable for patients ▪ Freedom ▪ Being able to keep dignity ▪ Help given on difficult days ▪ Staff seeing me as an individual	▪ All tablets together ▪ Going to sleep and waking confused ▪ Menu could be more varied ▪ Breakfast in bed, propped up by pillows ▪ Sitting on commode for too long ▪ Waiting too long in one position ▪ Food ▪ Way I have been treated by some nurses ▪ Length of stay boring ▪ Conversation between nurses about their private lives	▪ Chairs for the toilets, so patients could sit down and wash themselves ▪ Consistent number of nurses at all times ▪ Food improved ▪ More help getting dressed ▪ More cups of tea ▪ More stimulation

Dolphin day hospital

Liked best	Liked least	How could your stay be improved?
▪ Caring day ▪ Good relationships and treatment	▪ The waiting	

▪ Friendly atmosphere ▪ Food excellent		

Dryad ward

Liked best	Liked least	How could your stay in hospital be improved?
▪ Nursing care ▪ Seeing staff work as a team ▪ Being looked after well ▪ Being given a choice ▪ Courtesy and consideration of staff	▪ Seeing staff run around ▪ No staff ▪ Noise from swing doors banging	▪ Keeping noise down ▪ Special dietary needs for no solids! ▪ Getting enough nourishment?

Sultan ward

Liked best	Liked least	How could your stay in hospital be improved?
▪ Staff helpful ▪ Kindness ▪ Felt safe ▪ Regular cups of tea ▪ Hygiene care ▪ Ward clean ▪ Buzzer call at night very good ▪ Food ▪ Staff always there to help you, day or night ▪ Happy conversation ▪ Atmosphere very comfortable and pleasant ▪ Small ward areas –	▪ Putting on staff when they can do it for themselves ▪ Lack of physiotherapy ▪ Food ▪ Too hot in ward ▪ Strong tea ▪ Early morning start ▪ Having to use bed pans ▪ Shouting by staff ▪ Air mattress ▪ Smelly pillows ▪ Poor hygiene with cutlery ▪ Not always getting	▪ Increase staff levels ▪ Slight improvement of meals ▪ Possibility of more privacy ▪ More plugs for wash hand basins ▪ More time to chat to nurses ▪ TV by each bed

ample space between beds ▪ The garden	the food requested ▪ Restriction to smoking ▪ Not enough tea	

For every ward, patient feedback is often conflicting (A 4.3).

The Gosport and Fareham PPCT proposal states that 'many of the services currently provided by Portsmouth Healthcare NHS Trust have well established and active user and care involvement groups, to assess client satisfaction and to assist in service reviews' (p 8 A 5.2).

3.5.2 Relatives and Carers

3.5.3 Primary Care

3.5.4 Acute Sector

3.5.5 With Health Authority

3.5.6 With Haslar Hospital

3.5.7 With Social Services

3.5.8 With Local Nursing Homes

3.6 END OF LIFE

Portsmouth Healthcare NHS Trust guidance on organ donation has been provided, undated, outlining the process to go through following the death of a patient who indicated they wanted to donate organs for transplant (D 2.3).

GWMH have supplied a procedure for post mortem examinations, undated, detailing the process for the coroners post mortem, and relatives and medical officers requests for post mortem examinations (D 2.3).

3.6.1 Arrangements for Patients

3.6.2 Arrangements for relative/cares

3.6.3 Arrangements to Support Staff

3.6.4 Cultural, Spiritual needs

3.7 SUPERVISION AND TRAINING

A policy statement regarding training and education has been provided, undated, for Portsmouth Healthcare NHS Trust. The statement details the purpose, scope, principles and requirements of the policy as well as audit standards that support the policy. There is also

guidance on funding and a procedural statement for management training and development. The policy is due for review in April 2002 (I 5).

Portsmouth Healthcare NHS Trust have provided a 'training on demand' (TOD) leaflet which includes an index of titles, March 2001. The leaflet states the TOD series is intended to provide managers and others with a means of delivering training sessions in a range of topic areas to their own staff at an appropriate time and place. Topics covered include record keeping for healthcare professionals, working with the data protection act, fire safety and working in partnership among others. A brief outline of each of the 16 courses offered is given, detailing the aims of the course and its target audience. Group size may be between 4 and 10 participants for all packs and details are given of how to obtain a TOD pack. TOD packs are available to team co-ordinators, clinical managers, ward managers, administration managers and others who have responsibility for groups of staff (I 3.2).

A programme of training events for Portsmouth Healthcare NHS Trust 2000-2001 is also supplied. Events and courses offered include a national certificate of healthcare supervision, dealing with complaints, loss, death and bereavement, nursing management of diabetes and training in relation to the mental health act (I 3.1).

A 'Diversity matters' leaflet has been provided by Portsmouth Healthcare NHS Trust, undated. It outlines trust policies that underpin *diversity matters,* and its definition and scope. Guidance is given on how to raise concerns, and information regarding further help and advice is also given, including legislation and other trust leaflets (I 3.4).

A 'valuing diversity' training paper from Portsmouth Healthcare NHS Trust, undated, has been supplied. The aim is to enable participants to review their current knowledge and understanding with regards to the treatment of diversity at work, and to create a plan to implement appropriate change. The paper outlines the objectives of the workshop and the programme details (I 3.4).

A catalogue of interactive e-learning training programmes at St. James' has been supplied, November 2001. Courses covered include, report writing, constructive criticism, body pressure management and body temperature management (I 3.3).

3.7.1 Medical Supervision and Training

Portsmouth Healthcare NHS Trust have supplied supervision arrangement consultant timetables, from April 1998 to July 2001. The document relates to the supervision of junior medical staff and notes that consultant ward rounds at GWMH are an opportunity for supervision between the consultant and the clinical assistant. The timetables list each day of a Monday-Friday week and the name of the consultant supervising as well as who and where they will be supervising (D 3.3)

The department of medicine for elderly people have provided a timetable for their Wednesday lunchtime learning meetings. It is unclear whether this is for Portsmouth Healthcare NHS Trust and/or if it is exclusive to one trust or hospital. The document lists dates, the name of the doctor and the sponsor involved, contact telephone numbers and the venue, but not the topics covered. Dates are listed from January 1997 to September 2001. Sponsors include individuals from Orion Pharma, Sanofi-Synthelabo, Proctor and Gamble, Pfizer, Norgine and such like (I1.1).

The department of medicine for elderly people have also provided a timetable for their Friday lunchtime journal club. It is unclear whether this is for Portsmouth Healthcare NHS Trust and/or if it is exclusive to one trust or hospital. The document lists dates, the name of the doctor and the sponsor involved, contact telephone numbers and the venue, but not the topics covered. Dates are listed from July 1999 to August 2001. Sponsors include individuals from Celaxa, Servier laboratories, Lilly, GlaxoWellcome, AstraZeneca, Shire and such like (11.2).

Portsmouth Healthcare NHS Trust department of medicine for elderly people, QAH, has sent memoranda for clinical assistant teaching sessions in elderly medicine. Invitees comprise clinical assistants, staff grades and consultants. The courses cover the following topics and invitations require response via a slip:

- Osteoporosis and falls – 14th November 2001
- The NSF for older people – 18th September 2001
- Heart failure in Portsmouth – CHD NSF - 27th March 2001
- Pain management - joint meeting with the pain clinic, addressing chronic pain, low back pain and neuropathic pain – 1st February 2000
- Update on strokes – 22nd June 1999
- NSAIDs (?) and the upper GI tract – 13th January 1999
- Fractured neck of femur – Rehabilitation and care pathways – 10th November 1998
- Getting the best out of the cardiac echo – 8th July 1998
- Valvular lesions and indications for treatment – 14th January 1998
- Hyponatraemia – 10th July 1997
- Assessment of a dizzy patient – 14th May 1997
- Incontinence – 13th November 1996 (11.3)

Portsmouth Healthcare NHS Trust have also supplied examples of topics covered in 'Study Days' including:

- Parkinson's Disease – Ways without drugs
- Management of depression and dementia in the elderly (11.3).

3.7.2 Nursing Supervision and Training

A progress report on training and development for nursing staff in PHCT community hospitals relating to intermediate care has been supplied, 12th February 2001. The service manager/senior nurse, training and development projects lead and Havant and Petersfield community hospitals produced the report. In anticipation to some changes to bed use as a result of immediate care, three related trust-wide projects have been ongoing since summer 2000. The aim was to identify and implement training and development for nursing staff to increase their skills base to help meet the needs of a changing patient group (12.3).

The three projects are:

- The ALERT course – The acute life-threatening event, recognition and treatment course. A multi-professional one-day training course which aimed to train staff in helping to avoid unnecessary physical deterioration and deaths through the use of simple, preventative therapies. Training was provided by staff trained by the post-graduate school of medicine at the University of Portsmouth. For community hospitals, one training team was based in Gosport and Fareham and the other in Havant and Petersfield. Training was co-ordinated in these localities for February and March 2001 and was targeted at community hospitals nursing staff and GPs who work in the hospital. The plan is to extend the training to a rolling programme and include, for example, physiotherapists and occupational therapists (12.3).

  An ALERT course outline has been provided, October 2000, produced by the University of Portsmouth. The course covers, assessing the critically ill patient, the blue and breathless patient, the hypotensive patient, the patient with a disorded conscious level, the oliguric patient, the patient in pain, organisational and communication skills and a brief introduction to the ethics of acute care. The latter module covers the principles of ethics, informed consent, DNR orders and withholding and withdrawal of treatment (1 2.2).

- The AED course – Review of medical emergency response and the use of automated external defibrillators (AED) in community hospitals (1 2.3).

- "Acute skills" and rehabilitation updates. A baseline of skills and competencies have been identified which will require nursing staff to meet the challenges relating to possible changes in bed use, for example from continuing care beds to more acute rehabilitation. This will include IV training and updates, internal ECG training and cannulation skills. Rehabilitation workshops have been provided (1 2.3).

The progress report notes that training and development opportunities related to these projects have been extended to staff at Gorseway Nursing Home and that Rembrandt staff were included in the AED project. It was identified that staff on the Unit were recruited having the baseline competencies identified by the T&D project group. It also notes there are a team of ALERT trainers in the department of elderly medicine included in the community hospitals project. Much of the equipment needed to support the increased response has been provided as part of the intermediate care bids (1 2.3.).

A post-registration education prospectus has been provided from the University of Southampton School of Nursing and Midwifery, 2001/2002. It covers diplomas, degrees and professional awards in topics ranging from basic moving and handling, medical nursing, chronic disease management, nursing elderly people to care and rehabilitation of disabled people and continuing care of the dying patient and family (1 2.1).

A clinical nursing development paper has been provided from Portsmouth Healthcare NHS Trust for promoting best practice, dated January 1998. The paper outlines an initiative which aims to enhance the quality of nursing care across the trust. The two objectives are identified as follows: to identify from research the components of nursing practice that are likely to contribute to the most effective and equitable patient, client and resident care, and as a consequence to suggest a programme of nursing development (1 2.4).

The rationale behind the paper is as follows:

- Nursing practice within the trust is variable
- The White Paper emphasises achieving high quality clinical practice that is evidence based, patient centred and measurable
- To "*guarantee high quality to patients*" as set out in A First Class Service: Quality in the New NHS
- As the largest single occupational group in the trust, a systematic approach to the development of nursing skills and practice is essential
- Nurses provide a significant proportion of direct patient care, so this care must be consistently good (l 2.4).

A sum of £80,000 has been identified to support the initiative. The paper makes clear that without strong clinical leadership, issues such as quality development and evidence-based practice are difficult to integrate into normal nursing care. Appendix A of the paper comprises a review of evidence on excellence in nursing practice that covers goals, clinical supervision, evidence-based practice, communication and collaboration, record keeping, clinical leadership, organisation of care, organisational features, management of change, impact on policy changes, workload and environment (l 2.4).

Three major aspects identified as having an influence on practice include the use of clinical supervision, the use of research evidence and the use of clinical leaders. Nurses selected for training will subsequently lead clinical nursing in their own areas - Appendix B outlines the criteria for selection to the clinical leadership programme. Managerial lines of responsibility will remain unaltered. A steering group will oversee the programme. Potential clinical leaders will be recruited from existing staff. An initial training programme will prepare individuals for their new roles (l 2.4).

The training programme is the core of the initiative – Appendix C of the paper provides an outline of the clinical leadership programme. Clinical nurse leaders, with their managers and colleagues, will develop action plans to improve nursing care. They will also help co-ordinate clinical supervision and clinical effectiveness; each of which will have a trust nursing lead. The clinical nursing development group will meet regularly to share aspects of good practice to identify emergent issues to a trust nursing strategy/clinical governance group. The programme will be facilitated by the nursing director and the clinical practice development co-ordinator (l 2.4).

The programme will be evaluated independently, which will include identifying measures for improvement. The programme was due to end in June 1999 (l 2.4).

The review team may find this document of relevance.

A proposal for an integrated work based learning and practice development project between RCN's gerontological nursing programme, Portsmouth Healthcare NHS Trust, PCTs and Portsmouth University has been provided, dated 2001. It states that the project would maximise the opportunity for innovations in practice to be implemented in the department of elderly medicine and community hospitals (l 2.5).

The overall strategic intention is for a three-year programme of development in the department of elderly medicine, metal health services and community hospitals and mental health services for older people. It is thought local clinical effectiveness and clinical governance agendas could be enhanced by the programme, in line with current policy developments (l 2.5).

The aim of the integrated project is that senior nurses will effectively develop evidence-based nursing practice within their teams. The objectives include establishing a shared vision for nursing practices in services for older people, understanding staff perceptions, developing an agenda for change, collaboratively evaluating the impact of the programme - including dissemination - enabling academic credit to be given to nursing staff for work based learning and to encourage recruitment and retention of well-qualified staff (l 2.5).

At a clinical level the integrated project aims to develop a person-centred approach. The organisational aim is to develop a learning organisation. The approach adopted combines the following areas of work:

- Reflective practice through professional supervision
- Competency facilitation and development
- Practice development through organisational programmes
- Flexible packages of learning
- Accreditation (l 2.5).

Activities will include:

- Distance learning modules
- Action learning sets
- Practice developments
- Seminars, master classes and workshops – a 2001/2002 programme for the latter is incorporated in the paper
- Critical companionship (l 2.5).

In the long term Portsmouth Healthcare NHS Trust wishes to participate in the programme of accreditation being developed by the RCN institute, details of which are provided in the paper (l 2.5).

Management and team roles are also outlined in the paper and all items have been costed. A project plan has been provided detailing key activities, the timescale and any related comments (l 2.5).

An evaluation of clinical supervision activity in nursing throughout Portsmouth Healthcare NHS Trust has been provided, December 1999. The evaluation addressed three main issues, the numbers of staff participating in clinical supervision, staff views about supervision and their ideas about the future and the level of preparation undertaken by those acting as supervisors (l 2.6).

The evaluation outlines the methodology, results, a discussion and recommendations. It also notes the distribution of the questionnaire, key questions used and some overall responses by group (l 2.6).

A total of 805 (32.5%) questionnaires were returned. Almost twice as many qualified than unqualified staff returned their questionnaires. However, the overall response rate was low. Key findings include:

- 60% of all respondents were receiving clinical supervision. Of these, 66% of qualified respondents and 73% of unqualified staff reported being 'quite' or 'very' satisfied with their present arrangements
- 92% of qualified staff and 90% of unqualified staff thought all nursing staff should receive clinical supervision
- The most common frequency for supervision was monthly
- 3% of the unqualified respondents were acting as supervisors – this was identified as a cause for concern
- 29% of the qualified respondents were acting as supervisors with 75% of them having received some sort of preparation for this role. Preparation ranged from discussions with managers to workshops
- The largest response rate was from child health
- The 3 groups receiving the highest levels of supervision were substance misuse, child and family therapy and health visiting
- Substance misuse and health visiting staff reported the highest levels of satisfaction
- Learning disabilities/social care and elderly medicine reported the lowest levels of satisfaction
- Relatively small numbers of staff in each area were acting as supervisors (l 2.6).

The evaluation suggests the overall response rate was low because, at the time, there was confusion among managers and nurses as to what clinical supervision was. Requests for workshops and general awareness raising sessions are reportedly increasing. The evaluation makes the following 8 recommendations:

- Preparation for more of the supervisors across all nursing groups
- Ensuring protected time is allocated to enable effective clinical supervision
- Ensuring a standardised education and training programme
- Exploring the potential for multi-disciplinary clinical supervision
- Research into measuring the effectiveness of clinical supervision
- An agreement to introduce clinical supervision to all qualified staff within the next two years
- Whether it is appropriate or acceptable for unqualified staff to be acting as clinical supervisors
- Undertaking further surveys to monitor the continued implementation of clinical supervision (l 2.6).

Have any of these recommendations been made? Have they been evaluated? Have things improved? Review team may want to look at this document.

Information on the development of clinical supervision for nurses at Gosport and Fareham has been supplied. The document, undated, provides a brief overview of activities that have taken place involving nursing staff at Gosport and Fareham. Portsmouth Healthcare NHS Trust, according to the document, has been working to introduce systems for clinical supervision to all nurses across the trust for the past 5-6 years. The approach adopted has been initial introductory workshops, skills based workshops and helping to 'lead' in

identifying the best ways of introducing clinical supervision. The document notes that several nurses have participated in the activities but that many have been prevented from doing so due to practical problems which will need addressing (D 3.1).

GWMH have provided information on nursing supervision arrangements, April to November 2001. Supervision arrangements are variable for each area, except for students and overseas nurses, and the arrangements are detailed by ward, for clinical managers and for H Grade (D 3.2).

Details of supervision sessions from Portsmouth Healthcare NHS Trust, September and October 2001, have also been provided listing each component involved and the resultant actions. Components covered involve complaints about attitudes, ward level organisation, off duty arrangements and concerns about staff training (D 3.2).

3.7.3 AHP Supervision and Training

3.7.4 Other Staff Supervision and Training

3.7.5 Induction

3.7.6 Mandatory Training

4 HOW LESSONS HAVE BEEN LEARNED

4.1 COMPLAINTS

4.1.1 Trust Management of Complaints

The PHCT user involvement development framework states that 'complaints are most easily resolved when dealt with at the time that the problem occurs' and that an open, approachable relationship is conducive to problems being aired as they occur, November 2001 (p 4 A 4.1).

4.1.2 Ward Management of Complaints

4.1.3 Trust Lessons learned

4.1.4 Ward Lessons learned

4.1.5 Complaints training

5 SPECIFIC POLICIES

The national service framework for older people sets new standards of care for all older people, whether they live at home, in residential care or whether they are being cared for in a hospital (March, 2001). It aims to ensure:

- High quality care and treatment, regardless of age
- Older people to be treated as individuals, with respect and dignity
- Fair resources for conditions which most affect older people
- Easing the financial burden of long-term residential care (2.8).

Older people, though, are not a homogenous group. All services should reflect the diversity of the population they serve (2.6).

Decisions on treatment will be made on the basis of clinical need, not age. There will be more specialist staff. More investment will go towards reducing delays for joint replacements and cataract operations and a new emphasis will be given to preventing and treating strokes and speeding up recovery. There will also be new investment to modernise wards to provide single sex accommodation, reduce noise and provide on-site rehabilitation equipment (2.8).

New teams and services will enable more older people each year to be treated at home. This will need better co-ordination between the NHS and social services and every older person who needs it will receive a one-stop assessment service and have their own individual care plan. Rehabilitation services will be improved and there will be more respite care available for carers (2.8).

Better coordination will also improve care and support for those with mental health problems and their families. There will also be fairer access to effective drugs for conditions such as Alzheimers (2.8).

There will be a new emphasis on promoting healthy lifestyles and greater efforts to prevent health problems, for example the 'flu' vaccination and advice on how to prevent falls in the home (2.8).

Quite significantly, older people will be given a voice in their own treatment and in the overall services provided. This will require the patient being given full information. There will be an older patients' champion in every patients' forum and a health professional given specific responsibility for improving services for older people (2.8).

The eight national service framework standards are:

- Standard One – Rooting out age discrimination
- Standard Two – Person-centred care
- Standard Three – Intermediate care
- Standard Four – General hospital care
- Standard Five – Stroke
- Standard Six – Falls
- Standard Seven – Mental health in older people
- Standard Eight – Promoting an active and healthy life in older age (2.8).

The Medicines Management Booklet, as part of the NSF, exists to ensure that medicines prescribed to older people do not cause them unnecessary illness by being inappropriately, excessively, or inadequately prescribed. It will also ensure that medicines are prescribed to older people to allow them to gain the maximum benefit in terms of duration and quality of life (2.6, p23)

Particular action to be taken on medicine use and prescribing for older people includes:

- Prescribing advice and support for individual prescribers. PCGs and PCTs can improve quality and cost-effectiveness of prescribing
- Active monitoring of treatment to ensure that medicines are effective, adequate and appropriate, and to detect medicines-related problems
- A review of repeat prescribing systems
- A medication review with individual patients and their carers
- On-going education and training, including research updates, learning from complaints and audit and suicide risks from medication (2.6, p24).

Standards are to be achieved through local mechanisms – HImPs, joint investment plans, clinical governance frameworks, best value and the integration of health and social care (2.6, p25).

The timetable of local action is that by the 30th June 2001:

- Local arrangements for involving older people and their carers in the implementation of the NSF should be in place
- A clinical and practice champions lead for professional development should be identified as well as an elected member/non-executive director to lead for older people in each organisation
- A chief officer with responsibility for leading implementation in each geographical area should be identified
- Local arrangements for the implementation of the NSF should be established
- 2002/03 plans for clinical governance, best value and information for health are to reflect NSF milestones (2.6, pp25-6).

6 ANYTHING ELSE THAT DOESN'T SEEM TO FIT

6.1 FIRST THING

A letter from the secretary to the public health specialist for Isle of Wight, Portsmouth and South East Hampshire HA, which refers to the district wide 2000-2003 HiMP, is provided (A 2.1).

A letter from the service development manager of Fareham PCG, October 2001, which refers to updating the local HiMP until 2005, has been supplied. It has been distributed to the following people:

- General manager, the potteries
- Senior dental officer, Gosport health centre
- Associate clinical director, Nutrition and dietetic services, St Mary's Hospital
- Acting midwifery services manager, Blake ward, GWMH
- Service manager, older persons, Fareham and Gosport social services
- Fareham borough council
- Fareham community action
- Service manager, community hospitals, GWMH
- Service manager, adult mental health, the potteries
- General manager, learning disabilities, the potteries
- Operational manager, family planning services, St Mary's Hospital
- Service manager, elderly mental health, St Christopher's Hospital
- Service manager, podiatry, St Christopher's Hospital
- Service manager, OT, St Christopher's Hospital
- Speech and language therapist, Lee Health Centre
- Service manager, the potteries
- Superintendent physiotherapist, Hill park clinic

The letter states that Fareham health improvement programme and modernisation plan 2002-2005 needs to capture work that is being undertaken locally to improve the health of the local population and to support the delivery of targets within the NHS Plan, the Cancer Plan and NSFs (A 2.2).

The first stage of the process involved a local stakeholders conference, details of which are attached to the letter. Local priorities highlighted include CHD, stroke, perinatal mortality,

promoting independence, developing primary care, accidents, social inclusion and equalities, mental health, asthma, cancers and reducing waiting lists and times (A 2.2).

The letter also notes that the wide variety of work planned by local agencies will need capturing in order to deliver the key priorities identified. Therefore, the letter requests a summary of information that details work to be undertaken and timescales for action. A copy of the 2000-2002 HiMP is attached to help achieve this (A 2.2).

A letter from the service development manager of Gosport PCG, October 2001, which refers to updating the local HiMP until 2005 is supplied. The distribution list has not been provided. The letter states the Gosport HiMP and modernisation programme 2002-2005 needs to capture work that is being undertaken locally support the development of the Government's modernisation agenda. As in Fareham, the letter requests a summary of information detailing work planned by local agencies including timescales for action. A copy of the 2000-2002 HiMP is provided to help achieve this. The local priorities identified in the 2000-2002 HiMP closely match those identified at the stakeholder conference in Fareham. It does not appear that a stakeholder conference to carry out this aim has taken place at Gosport (A 2.3).

6.2 SECOND THING

Fareham and Gosport PCGs have supplied a proposal for intermediate care and rehabilitation services, May 2000. The document notes that service objectives for the latest district wide joint investment plan for older people cross agency boundaries. The objectives include:

- Promotion of independence and prevention of disability
- Avoidance of preventable admissions
- Better use of hospital capacity through improved assessment, use of staff, physical capacity and discharge planning (A 3.1).

An integral part of the service proposal is the development of a community enabling service (CES). The CES would provide a single point of contact for the delivery of all rehabilitation programmes in community settings. The service would focus on patients over 65 and be multi-agency. The following conditions, it is proposed, could potentially be managed by the CES as well:

- Falls
- Fractured neck of femur
- Complex orthopaedic conditions
- Elective surgery
- Amputees
- Other surgical patients
- Strokes (A 3.1).

The CES proposal would aim to free up a maximum of 15,000 acute hospital bed days. Currently, GWMH provides 36 continuing care beds, 8 slow stream beds and 22 GP beds. This would be reconfigured as follows: Daedalus ward to provide 24 community rehabilitation beds, Dryad ward to provide 20 continuing care beds and 24 GP beds to continue to be provided on Sultan ward (A 3.1).

The proposal outlines how the CES would be comprised, the development and delivery of the service, its availability and funding requirements both recurring and non-recurring. The paper notes it is envisaged that after twelve months the management responsibility for the CES will transfer to a service manager within PHCT (A 3.1).

A final monitoring report for intermediate care has also been provided, March 2001, source unknown. The report focuses on schemes that finished in March and were funded for the winter months only. Lessons for future investment, which are also relevant to implementing the NSF for older people, include:

- Geriatric team managing outliers at QAH
- Occupational therapists in A&E – which was identified as efficient and effective practice
- Use of green meadows residential care home for EMI short stay
- EMI team at QAH (A 3.1).

Geriatric team managing outliers at QAH

Patient issues, particularly the impact of multiple moves, handovers and premature decision-making were identified as problematic. Clinical issues identified as problematic included attitudes of staff in general medicine and on the host ward to outliers, multi-disciplinary notes being taken apart, lack of 'joined-up' ward rounds, communication problems and concerns about a lack of knowledge about nursing older people. Organisational and management issues include concerns about accountability but also recognising that the medical assessment unit works well and could have a specific prevention role (A 3.1).

Use of green meadows residential care home for EMI short stay

There were three groups where a short stay in EMI residential care was identified as beneficial both to carers and the service user:

(1) To give the carer respite

(2) To care for the service user while the carer is unable to give care

(3) To provide a safe place for assessment following a crisis.

Enhanced management costs, however, would need to be included were the scheme to be developed on a more permanent basis (A 3.1).