Comments on report – third draft.

Page 9. I think we already agreed that we should be a bit more specific here about the reason for the police interest and involvement, and I think we need to do this for line 16 as well.

Page 12. I wonder if we should outline the process for handling GP disciplinary matters, [perhaps we should include the actual policy, if there is one, as an appendix], just because it may help lay people, and NHS staff, understand the limitations of investigating GPs – eg, that they could only look at prescribing in general practice. While we will be going on to say that the trust could have used another policy, ie their own, it may clarify a little, the lack of real action once the trust had decided to utilise the GP route. I wouldn't waste a lot of time on this, just if it was relatively easy to do.

Page 13. Line 8 - Are we clear about what system we would have expected the RO to have? If so, perhaps we should say so. Also, we could make as a recommendation the need for SHAs to be overt about what should be reported to them. If the hospital's case is typical, it seems that RO s differed in their own involvement.

Page 14. – this may just be a matter of lay-out, but we need to make sure it is clear the second para is still taking about the national situation.

Page 15 line 9 – suggest ' National standards, entitled Essence of Care, provide benchmarks for assessing nursing practice against fundamental aspects of care such as nutrition, maintenance of tissue viability, and ensuring privacy and dignity. Produced by the DoH, these have been widely disseminated across the NHS.

Page 17. 2nd para – esp. lines 16 – 20. The management arrangements are not quite clear from this. I know we talked about a chart further on in the report; maybe that would help here.

Page 18 – line 2 – I wondered if we should say what was included in these reviews. That will be important if we go on to say later, what the PCT should be reviewing.

Page 21 line 8 – suggest ' there is lack of clarity' rather than confusion – as some people may have been

confused but others weren't. It's just that it wasn't clear to us! [see how pedantic I can be!]. Line 16 - this is a bit of a sweeping statement and something the rest of the NHS has so far failed to do. It would be better if we were clear about the parameters of performance the PCTs should be evaluating [the so-called balanced score -card] IE: finance, activity, patient satisfaction & well-being, treatment outcomes and IWL's for staff. Have I remembered them all? What the PCT needs to do with this list is to agree with hospital, what measures can be used directly, or as proxy, for assessing each parameter, and then how often, and by whom, etc, the evaluation should take place. Also, we should encourage the PCT and the hospital managers, to share these performance measures with all front-line staff so that everyone is clear what aspects of care are valued. This provides a chance for the PCT to show that they value softer areas of care such as day-time opportunities for older people, thereby ensuring the hospital pays attention as well. It would also help discussions during SaFF rounds too, as priorities can be clarified and agreed.

Page 23 - lines 14 - 19. Do we need to differentiate between concerns about drugs and amounts used, and method of delivery, ie syringe drivers? I'm not too sure about this.

Page 27 line 18 - I think you got these down on Tuesday already, but they were: watching & listening to nurses mobilise patients, [nurse was walking pt down ward corridor], asking staff for examples of how they handled particular patient situations, observing meal-times and drug rounds, etc, etc.

Page 29 - Line 3 - I think you got this as well. I observed two drug rounds, both carried out appropriately.

Page 30 - I think you got the comments about incontinence and nutrition guidelines - same for Page 33 about med accountability.

Page 35- Line 13- We do need to say something about Dr B concerns re workload and payment, but we also need to make clear that the two are really unrelated, ie. If the growth in workload was such that it was compromising patient care, because of lack of medical time, no amount of additional money would help, unless she was asking speciality for more doctor input. [I don't think she was, was she?]; more money for the Practice, would not have had an impact. Also, neither time nor money can

make up for lack of knowledge, particularly if this is not recognised by the person, so they would not seek training. [the ignorant ignorant!]. In this case it is the Dr B's knowledge of prescribing that is at issue.

I think we dealt with pages 36 & 37.

Page 38 line 6
Suggest:

Arrangements for Nurse Management
Ward nurses are managed by a G grade clinical manager, who reports to an H grade senior nurse. This nurse covers the three wards caring for older people, and she is managed by the general manager for the F & G division, who herself, reports to both the director of nursing and the operations director.

All qualified nurses are personally accountable for the own clinical practice and their managers are responsible for implementing systems and environments that promote high quality nursing care and patient well-being.

The director of nursing is ultimately accountable for the standard of nursing practice within the trust.

Page 39 line 4-7, did we say we would take this out altogether? Or maybe we could say something like

' The PCT should aim to build on the efforts made to incorporate clinical supervision into nursing practice by ensuring that the system is evaluated against a range of key benchmarks. The latter must include measures to assess whether patients are receiving a better standard of care as a result.'

Page 42 - line 11

Suggest section begins with:
Caring for older people involves input from many professionals who must co-ordinate their work around the needs of the patient. Good teamwork forms the cornerstone of high quality care for those with multiple and complex needs, and the extent to which professionals are working together in teams offers an insight into the standard of care prevalent in any setting.

Page 45 line 9, I think this has now been dealt with previously.

Page 57 - Comments re nursing homes – we also got this from the district nurse I interviewed – that patients' condition was good on discharge, and communication with wards good.
Line 14 – suggest – 'CHI found much enthusiasm for involving patients and users, though this had not yet translated into operational practice' .