Borders NHS Board

VALE OF LEVEN HOSPITAL INQUIRY REPORT UPDATE - JULY 2015

Aim

The aim of this paper is to provide NHS Borders Board with assurance that NHS Borders has undertaken a rigorous multi-disciplinary review and progress has been made against the 65 health board recommendations in the Vale of Leven Hospital Inquiry Report.

Background

On the 24th November 2014, the public inquiry report was published of the investigation into the occurrence of *C. difficile* infection at the Vale of Leven Hospital from 1 January 2007 onwards.

Between January 2007 and December 2008, *C difficile* infection was implicated in the death of 34 patients at the Vale of Leven Hospital.

From January 2008 to December 2014, NHS Borders have demonstrated an 82% reduction in the number *C. difficile* infections by calendar year. This will continue to be monitored and reported to each Clinical Governance Committee. We are currently on trajectory to meet the 2015/2016 HEAT Target

Summary

The Scottish Government requires all Boards to provide an update against the 65 recommendations. The Infection Prevention & Control Team collated responses on behalf of NHS Borders with support from colleagues across the organisation and submitted NHS Borders update to the Scottish Government on 24th June 2015.

The following table provides a summary of NHS Borders current position against the 65 recommendations for Health Boards:

Descriptor	**Number of actions**
Fully Implemented	56
Mostly Implemented	6
Partially Implemented	3
Not Started	0
TOTAL	**65**

All outstanding actions are on schedule for completion by December 2015, with responsibilities assigned to the appropriate individuals. These actions are detailed in the Infection Control Work Plan, by which progress against these actions is monitored and

reviewed. Due to significant progress already made against the outstanding actions, the risk to the organisation in relation to implementation is low.


Response to Vale of Leven hospital Inquiry

Sustained compliance with all completed actions will continue to be monitored by various methods including audit, leadership inspections/walkrounds, spot checks and other observational activity.

Recommendation
The Board is asked to **note** this update.

Policy/Strategy Implications	To provide assurance of ongoing focus on the recommendations made in the Vale of Leven Hospital Inquiry Report and assure the Board of the quality of patient care.
Consultation	There is no requirement for consultation.
Consultation with Professional Committees	As with all Board papers, this update will be shared with the Area Clinical Forum for information.
Risk Assessment	Due to significant progress already made against the outstanding actions, the risk to the organisation in relation to implementation is low.
Compliance with Board Policy requirements on Equality and Diversity	Equalities Scoping Template has been completed and submitted to the Equality e-mail inbox. Full impact assessment is not required.
Resource/Staffing Implications	The resource implications of this update have not been assessed.

Approved by

Name	Designation	Name	Designation
Evelyn Rodger	Director of Nursing and Midwifery, Interim Director of Acute Services		

Author(s)

Name	Designation	Name	Designation
Sam Whiting	Infection Control Manager	Lynsey Milven	HAI Quality Improvement Facilitator

RESPONSE TO VALE OF LEVEN HOSPITAL INQUIRY REPORT

GUIDANCE FOR COMPLETING TEMPLATE

PLEASE READ THIS BEFORE COMPLETING THE TEMPLATE

1. RECOMMENDATIONS

Lord Maclean's inquiry report made 75 recommendations, 9 for Scottish Government, 1 for Crown Office and 65 for Health Boards. The Cabinet Secretary for Health, Wellbeing and Sport, Shona Robison has accepted all 75 recommendations. Health Boards are asked to make an assessment of progress using the template attached.

The template has been pre-populated with the 65 Health Board recommendations by chapter and signposts you to the relevant pages in Lord MacLean's main report. This will enable you to refer to additional information, see the recommendation in context and gain a better understanding of what it means in practice before you start your assessment.

2. CURRENT POSITION - UPDATED

In this section you should update where you the Board is now following the response provided in January 2015 against each of the 65 recommendations. As before, please answer as succinctly as possible and if the recommendation has now been started or delivered please provide supporting evidence. If you have not already done so, please can you identify examples of good practice at the end of the document which could be shared with others. We may showcase innovative working practices in our final response to Lord Maclean's report.

3. WHAT MORE NEEDS TO BE DONE?

If more needs to be done and you are currently not on track please set out the reason why and the planned key steps to be taken which will influence delivery of the recommendation.

Your response should take account of the following factors:

- Are you delivering 'in the spirit' of the recommendation rather than to the letter?
- Is the work being reviewed and under development?
- Are you considering/testing out new ways of doing things?
- Has the work started but still to be evidenced?

3. TIMESCALES FOR IMPLEMENTATION OF RECOMMENDATIONS

Having considered what more needs to be done please provide your best estimate of when you expect the recommendation to be fully implemented. If full implementation is likely to take a phased approach please provide timescales for this and the interim key milestones.

4. DELIVERY STATUS

Using the descriptors below what is your overall assessment of the updated delivery status for each recommendation?. Your overall analysis of the information presented in the other parts of the template should inform your decision. It is important that this assessment accurately describes the current situation to enable an open and transparent response to Lord MacLean's report. Please be aware of the new procedure to ask the ACF, APF and Local People Involvement Network to consider.

DESCRIPTORS

Fully Implemented (F)	➢ Policy in place ➢ Health Board taking action ➢ Being monitored/evidenced
Mostly Implemented (M)	➢ Policy in place ➢ Health Board taking action ➢ Not yet fully evidenced ➢ Close but not 'perfect fit' ➢ More can be done
Partially Implemented (P)	➢ Policy/discussions started ➢ Different ways of doing things/testing ➢ More can be done ➢ No evidence yet
Not Started (NS)	➢ Yet to begin

5. SIGN OFF

Completed templates should be signed off by your Area Clinical Forum, Area Partnership Forum, Local Public Involvement Network and Board Chief Executive and returned to billy.wright@scotland.gsi.gov.uk mailbox by 24th June 2015.

RESPONSE TO VALE OF LEVEN HOSPITAL INQUIRY REPORT
65 HEALTH BOARD RECOMMENDATIONS – ASSESSMENT OF PROGRESS TEMPLATE

NAME OF HEALTH BOARD……NHS Borders……..

Please send completed return, signed off by Chief Executive, ACF, APF and Local Public Involvement Network, to Billy Wright at billy.wright@scotland.gsi.gov.uk by 24th June 2015

Telephone Enquiries to: Billy Wright 0131 244 5997

CHAPTER 7 – NATIONAL POLICIES AND GUIDANCE – PAGES 95-107

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
3. Health Boards should ensure that infection prevention and control policies are reviewed promptly in response to any new policies or guidance issued by or on behalf of the Scottish Government, and in any event at specific review dates no more than two years apart.	NHS Borders maintains an Infection Control Manual incorporating individual policies with review dates. Some of the policies had been scheduled for a 3 yearly review. These reviews have now been rescheduled to become two years apart. **Evidence:-** Policy review schedule submitted to every meeting of the ICC. Performance scorecard.	Due to the revised schedule, this will be completed by September 2015.	30/09/2015	M

CHAPTER 9 – THE CREATION, LEADERSHIP AND MANAGEMENT OF THE CLYDE DIRECTORATE – PAGES 117-130

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
7. In any major structural reorganisation in the NHS in Scotland a due diligence process including risk assessment should be undertaken by the Board or Boards responsible for all patient services before the reorganisation takes place. Subsequent to that reorganisation regular reviews of the process should be conducted to assess its impact upon patient services, up to the point at which the new structure is fully operational. The review process should include an independent audit.	NHS Borders has not been subject to any major structural reorganisation.		Completed	F
8. In any major structural reorganisation in the NHS in Scotland the Board or Boards responsible should ensure that an effective and stable management structure is in place for the success of the project and the maintenance of patient safety throughout the process.	NHS Borders has not been subject to any major structural reorganisation.		Completed	F

CHAPTER 10 – CLINICAL GOVERNANCE – PAGES 131-152

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
9. Health Boards should ensure that infection prevention and control is explicitly considered at all clinical governance committee meetings from local level to Board level.	The Infection Control Manager (ICM) attends the Board Clinical Governance Committee and is a member of the ICC, Clinical Executive Operational Group, and divisional clinical governance committees. The Infection Control Committee is a formal sub-group of the Clinical Executive Operational Group and receives copies of all minutes. Infection control is also represented and reported to the divisional clinical governance groups across NHS Borders. Bi-monthly infection control reports are also submitted to NHS Borders Board and published on the internet. The Senior Charge Nurse (SCN) Quality Dashboard ensures data transparency from Ward to Board. **Evidence:-** Minutes of meetings, infection control reports.		Completed	F

CHAPTER 11 – THE EXPERIENCES OF PATIENTS AND RELATIVES – PAGES 153-168

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
10. Health Boards should ensure that patients diagnosed with CDI are given information by medical and nursing staff about their condition and prognosis. Patients should be told when there is a suspicion they have CDI, and when there is a definitive diagnosis. Where appropriate, relatives should also be involved.	Infection Control Nurses (ICN) communicate *Clostridium difficile* infection (CDI) diagnosis to ward staff, advise on precautions, patient management and provide ward staff with a leaflet to give to the patient. Patient documentation includes a tick box to confirm dissemination of patient information leaflet. ICNs also insert a CDI sticker into the patient notes to support clinical management of the patient. The CDI sticker has been updated to include confirmation that diagnosis and prognosis has been communicated to the patient/relative. CDI communication process with Mental Health and Community Hospitals has been reviewed. **Evidence:-** CDI patient notes, ICN clinical notes, CDI sticker.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
11. Health Boards should ensure that patients, and relatives where appropriate, are made aware that CDI is a condition that can be life-threatening, particularly in the elderly. The consultant in charge of a patient's care should ensure that the patient and, where appropriate, relatives have reasonable access to fully informed medical staff.	ICNs communicate CDI diagnosis to ward staff, advise on precautions, patient management and provide ward staff with leaflet to give to patient. The leaflet explains that the condition can be life threatening. Patient documentation includes a tick box to confirm dissemination of patient information leaflet. ICNs also insert a CDI sticker into the patient notes to support clinical management of the patient. The ICN pro-forma documentation for follow-up of CDI patients includes a check that the patient has been informed. **Evidence:-** CDI patient notes, ICN clinical notes.		Completed	F
12. Health Boards should ensure that when a patient has CDI patients and relatives are given clear and proper advice on the necessary infection control precautions, particularly hand washing and laundry. Should it be necessary to request relatives to take soiled laundry home, the laundry should be bagged appropriately and clear instructions about washing should be given. Leaflets containing guidance should be provided, and these should be supplemented by discussion with patients and relatives.	ICNs communicate CDI diagnosis to ward staff, advise on precautions, patient management and provide ward staff with leaflet to give to patient. Depending on individual circumstances, some patient clothing is processed by NHS Borders laundry facilities or private laundry facilities. Senior Charge Nurses (SCNs) have been instructed to provide an alginate bag to relatives washing foul/infected patient laundry at home together with instructions. An updated patient leaflet on washing clothes at home has been distributed to all wards. **Evidence:-** Communication to SCNs.		Completed	F

CHAPTER 12 - NURSING CARE – PAGES 169-214

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
13. Health Boards should ensure that there is a clear and effective line of professional responsibility between the ward and the Board	NHS Borders has clear managerial and professional lines of accountability. **Evidence:-** Organisational structure.		Completed	F
14. Health Boards should ensure that the nurse in charge of each ward audits compliance with the duty to keep clear and contemporaneous patient records, and that there is effective scrutiny of audits by the Board	An organisation wide audit of health records is completed every 2 years and reported through the Clinical Board Governance Groups. The effectiveness of this approach has been reviewed and as a result, the Director of Nursing has commissioned, to replace the previous audits, all inpatient wards to perform an audit of 1 sets of notes per week which will be included on ward dashboards. **Evidence:-** Audit report. Ward dashboards, BGH & Primary & Community Services Quarterly Performance Reviews	The audit tool for undertaking the weekly case note review is being updated	Already commenced - for completion by 30/06/2015	M
15. Health Boards should ensure that nursing staff caring for a patient with CDI keep accurate records of patient observations including temperature, pulse, respiration, oxygen saturation and blood pressure.	Patient observation charts are well established within the BGH, Mental Health and community hospitals. Should a patient in Mental Health require oxygen saturation monitoring it is anticipated that their clinical condition would be such that they would transferred to an acute hospital facility. **Evidence:-** Nursing documentation.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
16. Health Boards should ensure that the nurse in charge of each ward reports suspected outbreaks of CDI (as defined in local guidance) to the Infection Control Team	Wards notify ICNs when they have symptomatic patients prior to any diagnosis. ICNs communicate CDI diagnosis to the ward and maintain surveillance and conduct investigations as required. **Evidence**:- ICN clinical notes.		Completed	F
17. Health Boards should ensure that where there is risk of cross infection, the nurse in charge of a ward has ultimate responsibility for admission of patients to the ward or bay. Any such decision should be based on a full report of the patient's status and full discussion with site management, the bed manager, and a member of the Infection Control Team. The decision and the advice upon which the decision is based should be fully recorded contemporaneously.	Patients are isolated based on symptoms rather than waiting for diagnosis. The Nurse in Charge of a ward or department has the responsibility to risk assess and position patients within their clinical environments. When insufficient isolation rooms are available, bed management, ward staff and infection control agree prioritisation of patients to be isolated and support the decision making of the Nurse in Charge. Any decision to admit to an empty bed is taken on the basis of the balance of risk between, patient needs, infection, patient flow and bed capacity. Outbreak meetings are convened when there is suspicion of cross transmission with representation from affected clinical areas. A daily hospital safety brief is convened with representation from all wards including community hospitals and infection control.		Completed	F

	There is no evidence of cross transmission of CDI in NHS Borders. **Evidence:-** ICN clinical notes, daily hospital safety brief.			
18. Health Boards should ensure that there is an agreed system of care planning in use in every ward with the appropriate documentation available to nursing staff. Where appropriate they should introduce pro forma care plans to assist nurses with care planning. Health Boards should ensure that there is a system of audit of care planning in place.	NHS Borders has established acute nursing assessment documentation including an adult acute unitary patient record and patient assessment documents. The national care plan will be reviewed when available. **Evidence:-** Nursing assessment, adult unitary record, nursing observation documents.	A Documentation Review Group has been established with a focus on the introduction of specific care planning documentation and reviewing the use and relevance of existing risk assessment to inform care planning. A 90 day improvement approach has been adopted from the beginning of June 2015 to update the existing documentation. A unitary record for Mental Health is being developed.	31/08/2015	P
19. Health Boards should ensure that where Infection Control Nurses provide instructions on the management of patients those instructions are recorded in patient notes and are included in care planning for the patient.	Specific CDI case documentation is used by ICNs with clinical information also recorded on ICNet. ICNs record their guidance and instructions in the acute patient notes along with a CDI guidance sticker. Advice to Mental Health and Community is generally provided via telephone in the first instance following the same prompts and instructions as the acute site. The ICN's document the advice that has been provided and prioritise community/mental health visits as appropriate. **Evidence:-** CDI patient notes.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
20. Health Boards should ensure that where a patient has, or is suspected of having, *C.difficile* diarrhoea a proper record of the patient's stools is kept. Health Boards should ensure that there is an appropriate form of charting of stools available to enable nursing staff to provide the date, time, size and nature of the stool. Stool charts should be continued after a patient has become asymptomatic of diarrhoea in order to reduce the risk of cross infection. Health Boards should ensure that all nursing staff are properly trained in the completion of these charts, and that the nurse in charge of the ward audits compliance.	Stool charts are available in the wards and ICNs remind ward staff to commence use of a stool chart for patients with CDI. Infection Control Nursing pro-forma for following up on patients with CDI includes a check that a stool chart is in use. **Evidence:-** Nursing documentation.		Completed	F
21. Health Boards should ensure that a member of nursing staff is available to deal with questions from relatives during visiting periods	The nurse in charge of the ward is visible and is responsible for ensuring staff engagement with patient's relatives and carers. **Evidence:-** feedback from patients, relatives and carers.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
22. Health Boards should ensure that any discussion between a member of nursing staff and a relative about a patient which is relevant to the patient's continuing care is recorded in the patient's notes to ensure that those caring for the patient are aware of the information given.	Further work is required to improve reliability and consistency. **Evidence: -** Patient notes.	A section of the unitary patient record has been designed specifically for recording communication with patients, relatives and carers. This will be tested with an acute ward prior to rapid spread.	30/09/2015	M
23. Health Boards should ensure that a nurse appointed as Tissue Viability Nurse (TVN) is appropriately trained and possesses, or is working towards, a recognised specialist post-registration qualification. Health Boards should ensure that a trainee TVN is supervised by a qualified TVN.	NHS Borders does not have a Tissue Viability Nurse (TVN). NHS Borders has implemented a range of education, documentation and processes to improve nursing knowledge and application of best practice in relation to tissue viability. We have agreed a robust model across NHS Borders linked to appraisal and successful attainment of competencies for registered and non registered nurses. Education for link nurses has been revitalised and a bespoke model using tele-health for the management of complex wounds is being negotiated with NHS Grampian.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
24. Health Boards should ensure that where a TVN is involved in caring for a patient there is a clear record in the patient notes and care plan of the instructions given for management of the patient	NHS Borders does not have a TVN. NHS Borders has implemented a range education, documentation and processes to improve nursing knowledge and application of best practice in relation to tissue viability. Specialist advice is recorded within the unitary care record. **Evidence:-** Patient notes.		Completed	F
25. Health Boards should ensure that every patient is assessed for risk of pressure damage on admission to hospital using a recognised tool such as the Waterlow Score in accordance with best practice guidance. Where patients are identified as at risk they must be reassessed at the frequency identified by the risk scoring system employed. Compliance should be monitored by a system of audit.	A Preliminary Pressure Ulcer Risk Assessment is completed on admission to each ward and on a daily basis thereafter. If the patient is considered at risk of developing a pressure ulcer they are commenced on a SSKIN Care Bundle. Waterlow screening and assessment is also carried out to inform care of the patient. Monthly clinical quality indicator audit compliance is reported through the SCN Quality Dashboard. Leadership walkrounds include a review of patient notes and compliance with patient assessment criteria. **Evidence:-** Leadership walkround documents, Patient notes, SCN Quality Dashboard, Board Spotlight Report.		Completed	F

26. Health Boards should ensure that where a patient has a wound or pressure damage there is clear documentation of the nature of the wound or damage in accordance with best practice guidance, including the cause, grade, size and colour of the wound or damage. The pressure damage or wound should be reassessed regularly according to the patient's condition. Compliance should be monitored by a system of audit.	Wound Assessment charts are utilised for wound management. Care plans are completed for each wound to support a consistent approach and clearly define the rationale for the choice of wound products. Pressure ulcer data for both inherited and developed damage is reported on to Datix to align with Scottish Patient Safety Indicator (SPSI) data collection. A root cause analysis (RCA) tool has been implemented to investigate all grades of developed pressure ulcers. wound management. Every Grade 2 or above pressure injury is reported on DATIX and staff are offered a 'case review' by a team of external (to the ward) nurses. 'Champions'/links have been identified on each ward. Training/Study days to increase levels of education and understanding of terminology, assessing, managing and monitoring wounds have commenced **Evidence:-** Wound assessment charts, wound care plans, Datix records, RCA documentation.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
27. Health Boards should ensure that where a patient requires positional changes nursing staff clearly record this on a turning chart or equivalent. Compliance should be monitored by a system of audit.	SSKIN documentation is utilised to record positional changes with compliance monitored through monthly clinical quality indicator audit compliance, Leadership walkrounds and reported through the SCN Quality Dashboard. **Evidence:-** SSKIN documentation, Leadership walkround documents, Clinical Quality Indicators (CQI).		Completed	F
28. Health Boards should ensure that all patients have their nutritional status screened on admission to a ward using a recognised nutritional screening tool. Where nutritional problems are identified further assessment should be undertaken to determine an individual care plan. Appropriate and timely referrals should be made to dieticians for patients identified as being in need of specialist nutritional support.	A MUST nutritional care assessment is undertaken within 24 hours of admission to hospital and on a weekly basis thereafter. Person centred care plans are developed which include recording of appropriate referrals. Monthly audits are undertaken by wards as part of the leading better care clinical quality indicators work. Leadership walkrounds involve a review of patient notes including completion of the MUST assessment. **Evidence:-** MUST documentation, Leadership walkround documents, CQIs.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
29. Health Boards should ensure that there is appropriate equipment in each ward to weigh all patients. Patients should be weighed on admission and at least weekly thereafter and weights recorded. Faulty equipment should be repaired or replaced timeously and a contingency plan should be in place in the event of delays.	MUST nutritional care assessment is undertaken within 24 hours of admission to hospital and on a weekly basis thereafter which includes weighing or estimating weight of patients as per guidance. Each community hospital has scales and they are also available across all inpatient areas in BGH. A service contract is in place for one maintenance & calibration of scales visit per annum. The company also carries out repairs - but it doesn't have a guaranteed response time. Contingency plans involve escalation of concerns through line managers. **Evidence:-** Nursing documentation.		Completed	F
30. Health Boards should ensure that where patients require fluid monitoring as part of their critical care, nursing staff complete fluid balance charts as accurately as possible and sign them off at the end of each 24-hour period.	Fluid balance charts are included and completed as part of the nursing observation documents. **Evidence:-** Nursing observation documents.		Completed	F
31. Health Boards should ensure that the staffing and skills mix is appropriate for each ward, and that it is reviewed in response to increases in the level of activity/patient acuity and dependency in the ward. Where the clinical profile of a group or ward of patients changes, (due to acuity and/or dependency) an agreed review framework and process should be	The Nursing & Midwifery workforce tools are mandated and NHS Borders prepared an action plan which was presented to Board in April 2014 with a commitment to report annually thereafter. There is a paper scheduled for the June 2015 Board meeting. No adjustments have been made to nursing establishments that would		Completed	F

in place to ensure that the appropriate skills base and resource requirements are easily provided.	remove nurses from clinical areas, indeed NHS Borders progressing investment in supervisory senior charge nurses. Work is also underway to re-introduce a patient dependency scoring system for use at ward level which will enable staff in charge to make decisions about the dependency of their patient in balance with their bed capacity and staffing resource. NHS Borders continues to engage nationally with the Nurse Bank Group and Scottish Government. NHS Borders is currently implementing a public display outside each ward which is updated daily with details of planned staffing compared with actual staffing. At the daily Hospital Safety Huddle, short notice staffing changes are identified and assessment undertaken regarding supplementary staffing. **Evidence:-** Data from workforce and workload tools, patient dependency tool. Schedule developed for bi-annual reviews.			

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
32. Health Boards should ensure that there is straightforward and timely escalation process for nurses to report concerns about staffing numbers/skill mix.	NHS Borders has systems and processes in place to support escalation of concern in relation to staffing, linked with capacity management and patient flow. There is a daily morning meeting with nurse management and representatives of all Wards at 8:30am where patient safety concerns including staffing can be raised. NHS Borders run a nursing workforce tool annually. There is a formal process for review and authorisation of requests for additional staffing. Critical incidents or cause for concern are also logged by staff on Datix. **Evidence:-** Hospital bleep holder and Site Manager notes, Datix records. Daily hospital safety brief.		Completed	F
33. Health Boards should ensure that where a complaint is made about nursing practice on a ward, this complaint is investigated by an independent senior member of Nursing Management	Formal complaints and concerns are received through the Patient Feedback and Complaints Team. Independent investigation is achieved by the responsible Service Manager leading on the investigation of the complaint and the compilation of a response, working with any staff involved in the patients care.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
	As part of existing and reviewed governance structures, ways to improve how learning is shared across all areas is integrated in meeting agenda. **Evidence:-** Actions from complaints and incidents are included as agenda items in subject specific groups e.g., documentation, tissue viability, food, fluid and nutrition to ensure organisation-wide actions and shared learning.			

CHAPTER 13 - ANTIBIOTIC PRESCRIBING – PAGES 217-227

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
34. Health Boards should ensure that changes in policy and/or guidance on antimicrobial practice issued by or on behalf of Scottish Government are implemented without delay.	NHS Borders has an established Antimicrobial Management Team (AMT) which oversees the rapid implementation of antimicrobial guidance and policy which is a formal sub-group of the Area Drugs and Therapeutics Committee (ADTC). **Evidence:-** AMT Minutes and papers.		Completed	F

CHAPTER 14 - MEDICAL CARE – PAGES 229-262

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
36. Health Boards should ensure that the level of medical staffing planned and provided is sufficient to provide safe high quality care.	The level of medical staffing is maintained through existing governance structures and in accordance with local and national standards. Each service is subject to productivity and benchmarking review which considers demand and capacity including skill mix. NHS Borders has an established locum policy, escalation process and vacancy control process to support safe and effective cover of all staff groups. Gaps and absences are individually risk assessed and action taken accordingly. **Evidence:-** Human Resources documents.	All services to complete a Productivity and Benchmarking review. Consider development of a SOP to determine how medical gaps are addressed.	31/12/2015	M
37. Health Boards should ensure that any patient with suspected CDI receives full clinical assessment by senior medical staff, that specific antibiotic therapy for CDI is commenced timeously and that the response to antibiotics is monitored on at least a daily basis.	The clinical condition of a patient is assessed and monitored by the Consultant and their team with support from the Consultant Microbiologist/Infection Control Doctor (ICD) and IPCT. **Evidence:-** Patient notes, ICD clinical records.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
38. Health Boards should ensure that clear, accurate and legible patient records are kept by doctors, that records are seen as integral to good patient care, and that they are routinely audited by senior medical staff.	There is an annual audit of case records through the Clinical Governance and Quality Department in all inpatient areas. The audit is of compliance with standards on record keeping. **Evidence:-** Audit documents.	Implement actions to improve compliance based on audit findings.	31/12/2015	M
39. Health Boards should ensure that medical and nursing staff are aware that a DNAR decision is an important aspect of care. The decision should involve the patient where possible, nursing staff, the consultant in charge and, where appropriate, relatives. The decision should be fully documented, regularly reviewed and there should be regular auditing of compliance with the DNAR policy.	DNACPR forms are in operation across all areas. Regular audit is carried out through the mortality review process of all deaths which occur in the BGH. Leadership walkrounds also review the presence of DNACPR forms in the notes across NHS Borders. It is routine practice for ambulance staff to ask for DNACPR before transfer of patient. DNACPR is also captured in medicine in the post take ward round process. **Evidence:-** Leadership walkround documentation, patient notes, mortality review documents.	Confirm that Surgical division incorporate DNACPR review into patient assessment documentation. Confirm that Community Hospitals incorporate DNACPR discussions in Multi-disciplinary Meetings. Review the transfer document within the Borders and between health boards to incorporate DNACPR prompt. Clarify DNACPR arrangements and responsibilities for day hospital attenders in Mental Health and Community Hospitals.	31/12/2015	M
40. Health Boards should ensure that the key principles of prudent antibiotic prescribing are adhered to and that implementation of policy is rigorously monitored by management.	NHS Borders has established policies to support antimicrobial stewardship. NHS Borders has established policies to support antimicrobial stewardship. Compliance with antimicrobial policies is audited and reported to the AMT.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
	Antimicrobial policy compliance is now included in updates to Clinical Governance Committee and Board. **Evidence:-** Minutes and papers of AMT, Clinical Governance Committee and Board.			
41. Health Boards should ensure that there is no unnecessary delay in processing laboratory specimens, in reporting positive results and in commencing specific antibiotic treatment. Infection control staff should carry out regular audits to ensure that there are no unnecessary delays in the management of infected patients once the diagnosis is confirmed.	Samples are collected from acute wards at regular intervals throughout the working day and delivered to the Laboratory. For urgent samples, wards either deliver the samples themselves or bleep the Laboratory porter who collects samples for processing urgently. Samples are collected from Community Hospitals once a day Monday to Thursday and twice a day on a Friday. Non-urgent samples taken at weekends or Public Holidays are stored in the refrigerator until the courier is available on the next working day. Urgent samples such as suspicion of CDI are transported to the laboratory 7 days per week for rapid processing. From receipt, the Laboratory can process samples within 24 hours, 7 days a week. Positive results are given to the ICNs and/or the Consultant Microbiologist. Out of hours samples are reported to the		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
	on-call Microbiologist who will either contact the ward or ask the Laboratory to contact the ward on their behalf. Positive results from the weekend are also followed up by the ICN on the next working day. Consideration is given to available clinical information when testing samples. Timescale from symptoms through to commencement of treatment for a recent CDI community case was reviewed and found to have no delays. **Evidence:-** Laboratory SOPs, transport delivery and collection schedules.			

CHAPTER 15 - INFECTION PREVENTION CONTROL – PAGES 263-368

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
42. Health Boards should ensure that all those working in a healthcare setting have mandatory infection prevention control training that includes CDI on appointment and regularly thereafter . Staff records should be audited to ensure that such training has taken place.	Infection Control training is mandatory for all staff employed by NHS Borders. **Evidence:-** Mandatory Training Policy, audits of compliance with Standard Infection Control Precautions (SICP).	The infection control training will be updated to incorporate information about CDI.	31/07/2015	P
43. Health Boards should ensure that Infection Control Nurses and Infection Control Doctors have regular training in infection prevention and control of which a record should be kept.	All ICNs have or are working towards an MSc in Infection Control. ICNs and ICD attend national educational events organised by Health Protection Scotland, The Infection Prevention Society, Scottish Patient Safety Programme, Scottish Antimicrobial Prescribing Group. **Evidence:-** Records of attendance at national training events, e-learning modules, PDP records.		Completed	F
44. Health Boards should ensure that performance appraisals of infection prevention and control staff take place at least annually. The appraisals of Infection Control Doctors who have other responsibilities should include specific reference to their Infection Control Doctor roles.	Annual appraisals including objective setting and PDP's are carried out for all members of the IPCT using e-KSF. The appraisal process for the Consultant Microbiologist has been revised to specifically incorporate the ICD duties. **Evidence:-** Infection Control Team Scorecard and Work Plan.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
45. Health Boards should ensure that where a manager has responsibility for oversight of infection prevention control, this is specified in the job description.	NHS Borders has a designated ICM with relevant job description. **Evidence:-** ICM job description.		Completed	F
46. Health Boards should ensure that the Infection Control Manager (ICM) has direct responsibility for the infection prevention control service and its staff	The ICM directly line-manages the Team. **Evidence:-** IPCT line management structure.		Completed	F
47. Health Boards should ensure that the ICM reports direct to the Chief Executive or, at least, to an executive board member.	The ICM reports directly to the Director of Nursing and Midwifery, Interim Director of Acute Services who is the Executive Director with responsibility for HAI. **Evidence:-** ICT line management, ICM job description.		Completed	F
48. Health Boards should ensure that the ICM is responsible for reporting to the Board on the state of HAI in the organisation.	Healthcare Associated Infection Reporting Template (HAIRT) is submitted to bi-monthly to NHS Borders Board meeting. **Evidence:-** Board meeting papers and minutes.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
50. Health Boards should ensure that there is 24-hour cover for infection prevention and control seven days a week, and that contingency plans for leave and sickness absence are in place.	NHS Borders has an established 24/7 service with control of annual leave to provide resilience to the impact of unplanned leave. Out of hours cover is through an on-call Consultant Microbiologist rota in partnership with Consultants in other Health Boards. There is an established contingency plan to maintain cover during periods of unplanned leave. **Evidence:-** Infection Control contingency plan, IPCT performance scorecard.		Completed	F
51. Health Boards should ensure that any Infection Control Team functions as a team, with clear lines of communication and regular meetings	The IPCT function as one team with clearly defined roles and responsibilities with daily safety briefings and regular team meetings. **Evidence:-** Action tracker, work plan, minutes, safety brief, IPCT performance scorecard.		Completed	F
52. Health Boards should ensure that adherence to infection prevention and control polices, for example C. difficile and Loose Stools Policies, is audited at least annually, and that serious non-adherence is reported to the Board.	The IPCT undertake an annual audit programme of compliance with the SICPs. Additional specific audits are undertaken in response to any identified concerns. Audit results are now reported to the Board Clinical Governance Committees. **Evidence:-** Committee papers and minutes.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
53. Health Boards should ensure that surveillance systems are fit for purpose, are simple to use and monitor, and provide information on potential outbreaks in real time	NHS Borders has established real-time infection surveillance systems. Infection Control is co-located with the Microbiology Laboratory and benefit from rapid notification of Laboratory results including presumptive and equivocal results. ICNet software provides automated notification to the ICNs of positive samples from the Laboratory and this data is linked to patient information from Trakcare. The IPCT convene a daily Safety Brief with the ICNs and ICD to review new MRSA cases, CDI cases and other infection issues, concerns or new Datix incidents. Compliance with the safety brief is reported in the IPCT Scorecard which is considered during performance reviews. Statistical Process Control (SPC) charts are used to report surveillance data to Board Committees. **Evidence:-** ICNet data, committee papers and minutes, IPCT Scorecard.		Completed	F
54. Health Boards should ensure that the users of surveillance systems are properly trained in their use and fully aware of how to use and respond to the data available.	All Infection Control staff involved in surveillance have attended specific training provided by Health Protection Scotland on surveillance. **Evidence:-** Staff Personal Development Plan (PDP) records.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
55. Health Boards should ensure that numbers and rates of CDI are reported through each level of the organisation up to the Chief Executive and the Board. Reporting should include positive reporting in addition to any exception reporting. The Chief Executive should sign off the figures to confirm that there is oversight of infection prevention and control at that level.	Infection Control Monthly Report is circulated across NHS Borders as well as updates provided bi-monthly to the Board. A monthly e-mail which includes CDI data is circulated across the organisation including the Chief Executive. The e-mail includes voting buttons for confirmation that the e-mail has been read. **Evidence:-** Surveillance e-mail, infection reports.		Completed	F
56. Health Boards should ensure that infection prevention and control groups meet at regular intervals and that there is appropriate reporting upwards through the management structure.	NHS Borders has a clear committee governance structure up to the Board including the Infection Prevention and Control groups which all meet on a regular scheduled basis. **Evidence:-** Infection Control governance structure.		Completed	F
57. Health Boards should ensure that the minutes of all meetings and reports from each infection prevention and control committee are reported to the level above in the hierarchy and include the numbers and rates of CDI, audit reports and training reports.	Minutes of the ICC are submitted to the Clinical Governance Committee. Quarterly infection control reports are submitted the Clinical Governance Committee which includes audit data and infection rates. Bi-monthly infection control reports are also submitted to NHS Borders Board. **Evidence:-** Clinical Governance Committee papers/minutes, Board papers and minutes.		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
58. Health Boards should ensure that there is lay representation at Board infection prevention and control committee level in keeping with local policy on public involvement.	Membership of the ICC includes a member of public. **Evidence:-** ICC Terms of Reference, ICC minutes with attendance records.		Completed	F
59. Health Boards should ensure that attendance by members of committees in the infection prevention and control structure is treated as a priority. Non-attendance should only be justified by illness or leave or if there is a risk of compromise to other clinical duties in which event deputies should attend where practicable.	The ICC Terms of Reference includes the specific provision for members to nominate a deputy if unable to attend. The Terms of Reference for the ICC have been reviewed to ensure appropriate representation. A process has been developed to escalate instances where a member has failed consistently to attend. Attendance will be regularly reviewed at ICC meetings. **Evidence:-** ICC Terms of Reference.		Completed	F
60. Health Boards should ensure that programmes designed to improve staff knowledge of good infection prevention and control practice, such as Cleanliness Champions Programme, are implemented without undue delay. Staff should be given protected time by managers to complete such programmes.	Infection Control training is already mandatory for all staff. Where additional training needs are identified for specific staff groups, the planning process considers ease of access and support for staff to attend. Recent examples include training on cleaning solutions and training on Personal Protective Equipment (PPE) for Ebola being delivered in clinical areas to avoid		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
	staff having to leave their working environment. **Evidence:-** Training records.			
61. Health Boards should ensure that unannounced inspections of clinical areas are conducted by senior infection prevention and control staff accompanied by lay representation to examine IPC arrangements including policy implementation and cleanliness.	Joint inspections of clinical areas by Senior Infection Control staff, Domestic Services Manager (SM) and members of public are now established. Leadership Walkrounds include members of public. **Evidence:-** Leadership Walkround documents, domestic services monitoring records.		Completed	F
62. Health Boards should ensure that senior managers accompanied by IPC staff visit clinical areas at least weekly to verify that proper attention is being paid to infection prevention and control	Weekly inspections of clinical areas by the ICM and Associate Director of Nursing are established. **Evidence:-** Visit schedule.		Completed	F
63. Health Boards should ensure that there is effective isolation of any patient who is suspected of suffering from CDI, and that failure to isolate is reported to senior management.	NHS Borders policy is to isolate patients suffering from CDI. Patients are isolated based on symptoms rather than waiting for diagnosis. Nurses in Charge of wards highlight concern and the need for action and escalation at daily Board Rounds and Ward Safety Briefs. An overview of inpatient issues in relation to infection control is achieved through the daily Hospital Safety Huddle which includes Community Hospitals, Bed Management, Discharge Team, SCNs, Nursing/Operational		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
	Management and infection control. When insufficient isolation rooms are available, bed management, ward staff and infection control agree prioritisation of patients to be isolated. Outbreak meetings are convened when there is suspicion of cross transmission with representation from affected clinical areas. A protocol has been implemented to report to senior management failure to isolate patients with CDI:- 1) Monthly infection control reports include information about isolation of patients. 2) If patients with confirmed or suspected CDI cannot be isolated, the ICN escalates to the site bleep holder in order to minimise the risk of spread and to coordinate implementation of safe practice to optimise staff and patient safety; prior to planned isolation. **Evidence:-** ICN clinical notes, Management of Patients with *Clostridium difficile* Policy.			

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
64. Health Boards should ensure that cohorting is not used as a substitute for single room isolation and is only resorted to in exceptional circumstances and under strict conditions of dedicated nursing with infected patients nursed in cohort bays with en-suite facilities.	It is not NHS Borders policy or practice to cohort patients with *Clostridium difficile*. **Evidence:-** ICN clinical documentation, Management of Patients with *Clostridium difficile* Policy.		Completed	F
65. Health Boards should ensure that appropriate steps are taken to isolate patients with potentially infectious diarrhoea.	Patients are isolated based on symptoms rather than waiting for diagnosis. When insufficient isolation rooms are available, bed management, ward staff and infection control agree prioritisation of patients to be isolated. Outbreak meetings are convened when there is suspicion of cross transmission with representation from affected clinical areas. Infection Control attend the daily hospital safety huddle. **Evidence:-** ICN clinical notes, Outbreak meeting notes.		Completed	F
66. Health Boards should ensure that the healthcare environment does not compromise effective IPC, and that poor maintenance practices, such as the acceptance of non-intact surfaces that could compromise effective IPC practice, are not tolerated.	The IPCT completes an annual infection control audit programme of compliance with the national SICPs. In addition, regular spot checks of clinical areas are undertaken. There are also regular cleanliness monitoring and estates monitoring audits reported nationally through Health Facilities Scotland (HFS).		Completed	F

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
	Leadership inspections include environmental checks. NHS Borders has also completed an environmental risk assessment on the risk register to support prioritisation of refurbishment works. **Evidence:-** Audit reports, monitoring reports, ICC papers, infection control Board papers.			
67. Health Boards should ensure that, where a local Link Nurse system is in place as part of the IPS system, the Link Nurses have specific training for that role. The role should be written into job descriptions and job plans. They should have clear objectives set annually and have protected time for Link Nurse duties.	Not applicable – NHS Borders does not have a local link nurse system in place.		Completed	F

CHAPTER 16 - DEATH CERTIFICATION – PAGES 371-379

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
68. Health Boards should ensure that where a death occurs in hospital the consultant in charge of the patients care is involved in completion of the death certificate wherever practicable, and that such involvement is clearly recorded in patient records. Regular auditing of this process should take place.	Death certificates completed for all deaths within the BGH are audited through a mortality review process. This review includes the recording of consultant involvement in death certification. In Community Hospitals all deaths are certified by GPs. **Evidence:-** Data from mortality reviews.		Completed	F
69. Health Boards should ensure that if a patient dies with CDI either as a cause of death or as a condition contributing to the death, relatives are provided with a clear explanation of the role played by CDI in the patient's death.	It is considered to be routine practice to discuss the completion of the death certificate with relatives. However further clarity/guidance has recently been provided to all medical staff in relation to death certification. The Infection Control Nursing documentation has been amended to include a prompt to remind staff to discuss CDI contribution to patient death. The introduction of documentation specifically for recording communication with patients and carers will further support the recording of compliance with this recommendation. **Evidence:-** ICN documentation.		Completed	F

CHAPTER 17 - INVESTIGATIONS FROM MAY 2008 - PAGES 381-391

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
72. Health Boards should ensure that a non – executive Board Member or a representative from internal audit takes part in an Internal Investigation of the kind instigated by NHSGGC	Non-executive Board Members fulfil a range of governance roles in NHS Borders. Non-executive Board Members have participated in meetings with relatives to report back the outcome of Significant Adverse Event Reviews. **Evidence:-** Committee meetings - membership and attendance records.	Develop clear guidelines including criteria for undertaking an internal investigation requiring participation of a non-executive Board Member.	30/09/2015	P
73. Health Boards should ensure that OCT reports provide sufficient details of the key factors in the spread of infection to allow a proper audit to be carried out, as recommended in the Watt Group Report.	NHS Borders publish reports following each outbreak providing detail on action taken to address key factors in the spread of infection and any lessons learned following an outbreak as recommended in the Watt Group Report. **Evidence:-** NHS Borders Norovirus Outbreak Reports.		Completed	F

CHAPTER 18 - EXPERIENCES OF C.DIFFICILE INFECTION WITHIN AND BEYOND SCOTLAND – PAGES 393-410

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
75. Health Boards should review such reports to determine what lessons can be learned and what reviews, audits or other measures (interim or otherwise) should be put in place in the light of these lessons.	NHS Borders governance processes include reviews of national reports to identify any local learning. **Evidence:-** Vale of Leven gap analysis, Northern Ireland CDI outbreak gap analysis, Mid Staff gap analysis.		Completed	F

BEST PRACTICE EXAMPLES/ADDITIONAL INFORMATION

Please use this space to tell us about **best practice examples** linked to any of the 65 recommendations which you would be willing to share with others and possibly have published as part of the response to Lord Maclean's report. ***If you have provided examples as part of your January 2015 return or, in response to Fiona McQueen's letter of 11 March 2015, then no further action is required***. We will contact you at a later date if further information is needed.

Please also use this space to provide **additional information** you would like to share which is not covered in the template.

BEST PRACTICE EXAMPLE(S)	**ADDITIONAL INFORMATION**
CHAPTER/RECOMMENDATION NUMBER:	

THANK YOU FOR TAKING THE TIME TO COMPLETE THE TEMPLATE

Please send completed return to Billy Wright at billy.wright@scotland.gsi.gov.uk **by 24th June 2015**

Sign off: Chief Executive/APF/ACF/LPIN: ……  **….**

Date: ……23.06.2015……..