

Meeting:	Brighton and Sussex University Hospitals NHS Trust Board of Directors
Date:	29th March 2016
Board Sponsor:	Chairman
Paper Author:	Chairman
Subject:	Board Walk-Rounds

Executive Summary

This report summarises the observations from the Chairman's visits to the Emergency Departments at PRH and RSCH on 8th and 26th February and discussions with staff and patients on those visits; and further visits to Out-Patients at the County and wards at PRH.

Staff at RSCH had experienced two particularly busy and difficult weeks, which had a significant impact on staff morale at the time of the Chairman's visit and this was also reported through the ED staff meeting. The changes to level 5 and the implementation of the single clerking model were discussed with the clinical lead in the ED and Clinical Director of the Acute Floor.

Executive and Non-Executive Directors also visited Children's Services, Maternity Services and Level 5 on 21st March, and key issues will be reported verbally to the Board.

Links to corporate objectives	This report focuses on the objectives of <i>excellent outcomes and great experience</i>
Identified risks and risk management actions	Key issues and risks arising from the Board Walk-Rounds are described in the report
Resource implications	None specific to recommendations in this report
Report history	None
Appendix	None

Action required by the Board

The Board is asked to discuss the report and highlight any further issues for review.

Report to the Board of Directors, 29th March 2016 Board Walk-Rounds

Introduction

The Chairman visited the Accident and Emergency Department (ED) at Princess Royal Hospital (PRH) on 8th February and the ED at the Royal Sussex County Hospital (RSCH) on 26th February.

On 8th February, the Chairman visited PRH ED from 2.00 pm and discussed the status of the ED with the Consultant in Emergency Medicine. This discussion was necessarily brief as the Department was very busy with high patient attendances and with shortages of nursing staff on the shift.

At the time of the visit, there were four patients in the cohort area, who were being cared for. The cubicles were full of patients who appeared acutely ill. The Chairman talked to the families of three waiting patients and also two of those ambulatory patients waiting. Whilst all would have preferred more speed, none adversely commented on the level or quality of care and attention they were getting. The area seemed clean and tidy. There is a clear shortage of storage.

The Chairman visited RSCH ED on 26th February, arriving at 07.30 am and leaving at 10.45 am. The Urgent Care Centre (UCC) had one patient only who was in discussion with a Doctor, on arrival and three patients on departure. From discussion with two of the patients in the UCC, they were content with their care.

In majors, there was no cohorting at 08.00 am or at 10.45 am. Not sure if it is cleaning or maintenance but the area seemed to me to need repainting.

The Chairman also attended a staff meeting attended by 15 nurses between 8.00 and 9.00. The pressures on the ED in the previous weeks had a significantly negative impact on staff morale, with concerns about perceived safety risks to patients and staff ~~shortages.~~ shortages. A member of staff talked of their shock from a particular patient event. Staff also talked about the impact of agency restrictions and financial constraints but felt they had they "best team I have worked with".

The Chairman had a separate discussion with the ED Clinical Lead separately to hear his feedback, including the impact of single clerking. He was confident in delivering the pathway with the change to single medical teams, relaying of three acute medical take areas, creation of four extra triage bays etc. However, this was not assisted by the delays in procurement. He confirmed that we were meeting the time to initial and subsequent assessment guidelines.

The visit included a walk-round the department with ~~the Medical Director~~ the Divisional lead clinical director, Clinical Director for the Acute Floor and Level 5 Project Lead. This included the potential project areas for change, subject to financing & procurement and the imminent relaying of the UCC so Doctors go to patients, with Doctors not being fixed in examination rooms.

There is an apparent shortage of storage.

There were no cohorting patients on departure, free cubicles but some 12 hour challenges approaching.

The Clinical Director led a visit to ICU on level 5 and then on level 7 which was very busy but displayed the calm feeling you need to have in ICU showing our clinicians are in charge.

There are ~~Despite our~~ concerns regarding about the need for more ICU space, although it appears that nationally ours is one of the larger departments.

RSCH Outpatients visit – 4th March

There were three clinics: Infectious diseases, Respiratory and Maxillo-Facial (Max Fax). There were 15+/- patients waiting; no waiting at reception desks; and no apparent waiters for phlebotomy.

The clinics seemed to be running to time except MaxFax which was running 45+ minutes behind. There were apologies and the time estimate was displayed on the white board. Two patients spoken to, waiting on the left and right of the main door, were happy with their clinical care, and the staff in outpatients, but complained about the wait they had had for appointments, and the working of the hub in handling changes and communication.

The waiting area was clean but needs maintenance ;maintenance; but the refreshment area in the middle needed cleaning and tidying up.

Princess Royal Hospital – 9th March 2016

On 9th March, a visit was undertaken at PRH, with the matron MSK, Plumpton and Twineham Wards and the SOTC.

Plumpton Ward is the short-stay medical pathway to discharge. The Chairman visited the recreation and dining room area, & then the wards. There were six patients present in the recreation area, and two patients spoken to were both recovering from respiratory issues; and their discharge from hospital and recovery was taking longer than they wished. Both were happy with their care however, although not always with the food.

A number of issues arose from observation of the wards, and discussion with the ward manager, nursing staff and Health Care Assistants (HCAs). There were 10 nursing vacancies, although 5 new international nurses were due to start in April. There was no ward clerk at the time of the visit, no pharmacy visits, the bathroom floors were stained, and new chairs were needed for the dinner table. The ~~nurses~~nurses' room also needed to move from the treatment room which was due to happen in late March (safety risk). As a result of there not being a ward clerk, the nurses and ward manager spend a lot of time on discharge administration.

Two ward rounds take place a week but a Doctor visits every day and the ward has a system to chase for individual patients. The ward manager discussed the benefits of a dedicated Doctor for the ward, although this is unlikely to happen. There were also difficulties in getting community support in place. The ward was clean but cluttered due to lack of storage.

The list of needed maintenance has been passed onto the exec lead.

The corridor to Plumpton needs better signage (coming) I am told and is not the easiest surface for patients, who are less mobile, to walk. There were leaks in two places with water puddles and it needs repainting.-

The Chairman was informed subsequent to the visit that many of the issues above had been addressed or had plans to address them shortly

Emergency Department

The Chairman also visited the Emergency Department and talked to the Consultant, lead nurse and junior. The department was very busy but with two cubicles free; there was no cohorting, and no obvious dignity issues. The area was clean and relatively tidy but there was a lack of storage space. One patient ~~briefly~~ who had just arrived - come in with breathing problems was complimentary about the nurses and paramedics, and with no complaints about waiting. The walk-in area had 5 patients waiting, one paediatric. They had been waiting for around half an hour to an hour; ~~the paediatric~~ the paediatric patient was observed to be seen in triage ~~during this time~~ before the Chairman left.

Rapid Access Clinic for Older People (RACOP)

Three patients were waiting in RACOP, with reasonable flow. The area was clean and reasonably uncluttered. There was a calm controlled atmosphere. Further observation of RACOP was undertaken on 14th March from 4pm to 8pm. The unit was not busy and there were unused facilities/beds for new patients. A&E was busy but there were no patients waiting on trolleys. If all the patients in RACOP had been sent to A&E, it would have resulted in severe pressure. RACOP was clean, well ordered; patient accommodation was ready for new patients. It appeared well staffed for the current (then) workload with a band 7 and support nurses; there were at least two junior/middle grade Drs coming into see patients. Staff were available to help patients and families on arrival, patients were immediately moved into beds/chairs depending on their acuity etc.

An elderly patient, who had had multiple co-morbidities, including COPD, discussed her care, which was observed to be good over this 4 hour period. This included her clinical and personal care, and food and drink. The patient was discharged just before 8pm and the RACOP service was observed to be doing what it was designed to do, stabilising a patient over whom a GP had concerns, who was then discharged home rather than admitted to hospital. The patient told me that she had had previous admission with similar symptoms and had been kept in for weeks; she was very happy to be discharged.

Outpatients

Out-patients was quite because of the junior ~~doctors~~ doctor's industrial action, unrushed and tidy but very few appointments.

Xray

There were 3-4 patients waiting in x-ray and no real delays.

Twineham

Twineham provides care for fractured neck of femur (FNOF) patients. The ward manager was very proud of the change she has seen delivered since the June reconfiguration. A FNOF patient admitted through A&E is on ward within 70 minutes. The ward manager advised that timely discharge was sometimes compromised by shortfalls in of community care, and the war also has a number of medical outliers.

The ward is large with 43 beds and appeared cluttered due to the significant need for aids and equipment near patients and lack of storage. This adds to the problems with cleaning. The ward was currently 5 nurses short.

Many Around 35 of the 43 patients at the time had some element of dementia. There was a separate area at the end of the ward for female patients with serious dementia with staff sitting in the areatearea to help confidence. The male patients with dementia were also together but not in a dementia friendly environment.

Nursing staff are encouraged to do their notes and administration on the ward to improve communication. There were equipment shortages and requests for new equipment. The list has been passed on.

The discharge lounge is well used.

There were clear male/female toilets in the right place which looked clean. The ward's signs need replacing with patient friendly signs and colour coded areas to help patients navigate.

There were 3 used mattresses awaiting collection in the corridor outside the ward; they had been there some time and their collection was chased.

Conclusion

The overall conclusion from the Chairman's visits was that he would be happy for any family-his family members to be treated or admitted in all the areas visited.

Julian Lee
Chairman
March 2016