Agenda Item 6.4.2 | 24/05/2023 | Quality and Safety Committee | Learning and actions following a death in Maesteg Hospital

FOI Status:	Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Richard Hughes, Deputy Executive Director of Nursing
Presented By:	Greg Dix, Executive Director of Nursing & Deputy Chief Executive
Approving Executive Sponsor:	Greg Dix, Executive Director of Nursing & Deputy Chief Executive
Report Purpose	Please Select: For Discussion For Noting
Engagement undertaken to date:	Across care group, sites and within corporate teams.

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Impact will rest with output and associated reporting structures described in presentation.
Related Health and Care Standard	Governance, Leadership & Accountability
Has an EQIA been undertaken?	No, this is a review of facts and exciting arrangements.
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Please Select: Inspiring People Improving Care

Lessons Learned

Learning and actions following a death in Maesteg Hospital

Assessment

The RCA made a number of recommendations following the investigation which were subsequently evidenced as completed:

1. Local feedback to relevant staff
2. Shared learning across the CTMUHB
3. Environmental risk assessment training, including roles and legal responsibilities for all staff
4. Staff to use electronic referrals for work requested for estates, and for those who hold managerial responsibility to initiate them and escalate as required.
5. Development of a strategy to support ongoing documentation training and audit, mandatory training to be reviewed and considered regarding upskilling of risk assessments and risk analysis.
6. Audit of documentation to ensure that CTMUHB documents are in use.
7. Staff who undertake Datix investigation to be supported by relevant training, and a consideration of peer review to provide an environment around shared learning and to support good practice.
8. Regular clinical supervision to be incorporated, or maintained.
9. Mandatory safeguarding training compliance to be audited.
10. There are two dementia champions within the ward staff, this process continues, to support staff in effective care planning.
11. All staff to be aware of their role in escalating concerns, and to be aware of the policies that underpin this.
12. Regular team meetings to continue, with agendas and minutes to ensure that relevant information is shared with all members of the ward team who may not be present and that these are available for scrutiny if required.
13. Information booklet containing information about Llynfi ward for patients and families, on admission.

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Additional elements to consider (Recommendations)

Awareness and oversight of the Deprivation of Liberty Safeguards have improved in recent months with partnership working between our safeguarding professionals, clinicians and the DoLS practitioner team.

Welsh Government have now confirmed substantive (recurrent) funding to maintain the current oversight (leadership team) for DoLS within CTM and enable substantive recruitment to the necessary posts.

Using the learning from the incident, the Unscheduled Care Group is currently reviewing the estate across our three acute sites to ensure where required, wards are furnished with the appropriate equipment to control access in and out of the ward environment where it is necessary and proportionate to do so.

As the organisation transition out of the previous ILG structure to the newly established care groups, it is recognised of the significance in the changes to team leadership described in the RCA. The care group Directors, supported by corporate teams are ensuring staff are supported to report and escalate concerns where required to do so.

Care group Nurse Directors and Corporate Nursing leaders are in the process of developing a central database for audit and compliance to improve the oversight and availability of information and associated learning (AMaT).

Care group and site based leadership teams are collaboratively engaging with the corporate teams in the formation of operational reporting structures on quality and patient safety metrics whilst also developing and triangulating the opportunities to share learning and ensure robust governance. This work is coexisting in the development of the Harm Free Care Board and Improving Care Board.

Both the Deputy Executive Director of Nursing and Assistant Director for Quality Governance are overseeing the implementation of the Duty of Candour and Quality Act in CTM. Progress is being made with Candour processes fully operational and monitored by our central teams. Work is underway in the preparation for the implementation of the 6 quality dimensions (STEEEP) and 5 enablers in our quality and patient safety reporting mechanisms from ward to board.

Recommendation:	**The Board or Committee are asked to:**
To consider the actions directly associated with the RCA as evidenced and closed with lessons learned now being considered across the organisation as described in the presentation.	• *Consider the narrative outlined in the presentation.* • *Note the future work and prospective governance arrangements at operational levels.* • *Consider whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.*