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Dear Colleague

CQC report following a recent inspection at the Great Western Hospital

I wanted to keep you informed about a recent inspection of the Great Western Hospital by the Care Quality Commission in December. As you will be aware, the CQC have been carrying out an expanded range of inspections and they have visited the Trust on a number of occasions during 2011. Their latest visit involved visiting wards to look at the use of bed spaces, reviewing safety processes in theatres and the issue of patient nutrition and hydration.

As the Local Involvement Network, I thought it was important that you and your members received information about the outcome of the visit and what we are doing in response to the issues raised.

It is worth noting that in any visit to such a large organisation the team of Inspectors only visit a small number of areas so what they look at on a given day can only ever be a snapshot of what we do and the service we provide. We take the inspections very seriously and in the past have shared actions we have been taking following previous visits from the CQC.

In this latest visit they highlighted a number of areas which we need to focus on during 2012/13. The two main areas covered in the report can be found below:

- Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights (looking at Theatres)
- Outcome 05: Food and drink should meet people's individual dietary needs (looking at nutrition and hydration issues)

Nutrition and hydration

The report highlights a lack of consistency with how we measure and record the fluid intake of patients. We all know the importance of good nutrition and hydration for patients and their long term recovery.

We know of many areas of the Trust where fluid intake is recorded clearly as evidence that patients are receiving the fluid they require. I do not feel that patients are not getting the nutrition and fluids they need when they are cared for by us, but we do need to make sure we are good at documenting this to demonstrate that we have carried out all of the relevant risk assessments on patients. In some areas we need to make sure that this same approach is applied across all areas so that we can clearly demonstrate our patients have the nutrition and fluids they need throughout their stay.

It is an area we have been working on for some time with the introduction of a range of measures to reduce the risk of malnutrition and dehydration in hospital. For example the red jug initiative, the trialling of a new water hydrant device on Jupiter Ward and providing extra support for patients for eating and drinking. The Council of Governors will be monitoring this area and become more involved in this issue as one of the key quality indicators for the Trust.

As you and your members will be aware, recording information regularly and accurately in patient notes is essential, it is not about box ticking but about providing an accurate record of patient care and we will be spending some time looking at how we can record and audit this type of information in a meaningful way.

Theatres

Following two Never Events last year in the theatres, the Inspectors also looked at this area to see how safety processes are being embedded to ensure we are doing everything we can to reduce the risk of mistakes like these from happening.

The Inspectors raised the issue of consistency with how Team Briefs are carried out prior to surgery led by the relevant surgeon and involving all team members. They looked at areas such as the safety checklists the teams run through prior to and after surgery and the report highlights a number of areas where Inspectors saw these checks being carried out in a well organised way but there was some inconsistency in how these checks are applied in other areas.

We have been using the World Health Organisation Safer Surgery Checklist for a number of years and prior to the visit, following the Never Events, we re-launched the Safer Surgery Checklist across the theatres to strengthen safety processes in what is a high pressure environment.

We now have a named Surgeon (Mr Adam Brooks) whose role it is to champion the checklist within the Trust, and in future it will be the individual Surgeon's responsibility to ensure the appropriate checks are carried out. This line of accountability and responsibility, I feel, will help us tighten up processes and procedures to reduce the risk of mistakes in the future.

We know we can never eliminate mistakes altogether, by our nature, the work we do at the Trust is often high risk but we continue to look for ways to reduce the chances of mistakes happening by focussing on work practices, processes and procedures.

Extra bed spaces

The report also covered the use of extra bed spaces. Since previous inspections we have provided these areas with extra amenities to bring them in line with regular bed spaces. As previously committed, it is our aim to limit the use of bed spaces rather than them becoming the norm. This is difficult when we have been so busy over recent weeks but we continue to work towards this aim.

Next steps

We are required to prepare an action plan to address all of the points the CQC have raised. Following the Swindon HOSC meeting in November and the request to form a small working group to monitor progress of the action plans, this latest inspection will be looked at as part of that group.

A full copy of the report will be available from Wednesday on the CQC website at: www.cqc.org.uk but should you have any questions regarding any of this please let me know.

Should you need any further information please do not hesitate to contact me.

Yours sincerely

A handwritten signature in blue ink that reads "Nerissa Vaughan". The signature is written in a cursive style with a large, looped 'V' at the end.

Nerissa Vaughan
Chief Executive