

# Report to the Meeting of the Oxford Health NHS Foundation Trust

# Board of Directors

**For Approval**

# PAPER

**BOD 52/2015**

(Agenda Item: (7)

Agenda item

**29 April 2015**

**Quality and Safety Report**

**For Information**

This report outlines current progress, including areas of concern or priorities across our trust in relation to quality and patient safety for quarter 4 (2014/15). It draws on reports that have been submitted to the Integrated Governance (Quality) Committee and the Safety Committee where these reports were reviewed in detail. The areas covered are:

1. Patterns of reported incidents
2. Serious incidents requiring investigation
3. Infection prevention and control
4. Trust wide internal status report against CQC Outcomes
5. Harm reduction projects

**Recommendation**

The Board is asked to note the report.

**Author and Title:**

Tehmeena Ajmal, Head of Quality and Safety; Rebecca Kelly, Learning from Incidents Lead; Helen Bosley, Infection Prevention Control Matron; Jill Bailey, Consultant Nurse and Safer Care Lead.

**Lead Executive Director:** Ros Alstead, Director of Nursing and Clinical Standards

1. *A risk assessment has been undertaken around the legal issues that this paper presents and there are no issues that need to be referred to the Trust Solicitors.*
2. *This paper provides assurance and evidence against the Care Quality Commission Outcome: 4, 5, 7, 8 and 16.*

**Quality and Safety Report**

**1. Incidents**

The level of incident reporting has increased over the last three quarters and is now at the highest level than at any time over the last two years. This is positive as the higher the level of incident reporting the better the safety culture within teams.

The numbers of reported green and yellow incidents (low/minor injury or property damage) continues to represent the highest proportion of total reported incidents. There have been fifty five deaths reported this quarter. After refreshing the figures for last quarter the numbers were also fifty five.

In Q4 59 deaths were reported. This is the highest number reported by quarter over the year. Sixteen of these were expected deaths. Thirty six were unexpected deaths in the community. Sixteen were SIRI reportable at the time of writing this report. All of the unexpected deaths occurred in the Adult and Older Adult Directorates.

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| --- | --- | --- | --- | --- | --- |
| **Row Labels** | **1** | **2** | **3** | **4** | **Grand Total** |
| **D01 Expected Death In Community** | **1** | **4** | **10** | **5** | **20** |
| **D02 Expected Death In Oxford Health Hospital** |  | **2** | **6** | **4** | **12** |
| **D03 Expected Death In Acute Hospital Eg. JR** | **1** | **4** | **12** | **7** | **24** |
| **D04 Unexpected Death In Oxford Health Hospital** | **3** | **3** |  |  | **6** |
| **D05 Unexpected Death In Acute Hospital Eg. JR** | **3** | **5** | **8** | **5** | **21** |
| **D06 Unexpected Death In Community** | **18** | **14** | **14** | **36** | **82** |
| **D07 Unexpected Death After Discharge** |  | **1** | **1** | **2** | **4** |
| **D08 Unexpected Death In Prison** | **2** |  |  |  | **2** |
| **Grand Total** | **28** | **33** | **51** | **59** | **171** |

There are total of 248 teams that have not reported an incident in Q4. It is the case that a significant number of teams will be very small (particularly in the Older People Directorate) and may not have witnessed a patient safety incident. Nevertheless the 2014 staff survey indicated that 34% of respondents had witnessed an error, near miss or incident in the last month.

|  |  |
| --- | --- |
|  | **Number of departments that haven't reported an incident (q4)** |
| **Adult Directorate** | **19** |
| **Children & Young People Directorate** | **24** |
| **Older Peoples’ Directorate** | **175** |
| **Corporate Directorate** | **30** |
| **Total** | **248** |

At the time that this report was run there were 2159 incidents in web-holding. 1165 of these incidents are waiting for manager’s review. The remaining numbers of incidents in web-holding are as a result of a number of factors. The largest factor is that the quality and risk team have been under capacity and this has resulted in approximately 878 incidents that have not yet been “merged”. There are plans in the team to address this and they would not expect to have more than 100-150 incidents in web-holding waiting to be merged at any one time. In addition there are approximately 114 incidents that are “under review” or “returned to author”.

**Incident type**

1. **Health** was the most commonly reported incident in Q4. This cause group is used primarily for reporting pressure ulcers (avoidable and unavoidable). The increase in Q4 may be accounted for by the significant numbers of inherited Pressure ulcers reported.
2. **Violence and aggression** is the second highest incident reported in Q4. The number of violence and aggression incidents has increased in Q4 to the highest over the last four quarters.
3. **Medication incidents** were the third highest type of reported incident in Q4. There was an increase of reported incidents this quarter of 265 compared 205 last quarter.
4. **Self Harm** was the fourth highest type of incident reported in Q4. There were 327 incidents reported in Q4 representing a further increase from Q3.
5. **Fall Related** were the fifth most commonly reported type of incident in Q4. The numbers of reported falls have fallen to the lowest number for the last two years.
6. **Communication/Confidentiality** were the six most commonly reported type of incident in Q4. There was an increase in these types of incidents from 151 in Q3 to 206 in Q4.
7. **Security related incidents** were the fifth most commonly reported type of incident in Q4. Reported incidents have fallen to the lowest level in the last year

the following two charts show the spread of incidents by division (quarters 1-3 based on the previous reporting structure on Ulysses) and by directorate (quarter 4 based on the new reporting structure on Ulysses). This now reflects the new directorate team structure.

Older people’s services have the highest number of reported incidents, which is to be expected the largest number of patients are seen in their services.

**2. SIRIs**

The total number of SIRIs in Q4 is twenty seven which is a sharp increase from Q2 and the highest it has been over the last two years. Despite this, the total number of SIRIs in 2014-15 is the lowest over the last three years.

In quarter 4 there have been:

* Eleven confirmed or suspected suicides.
* Three unexpected deaths. All three were reported by different community mental health teams and there is nothing to indicate the cause of death is either suspicious or suspected suicide.
* Three avoidable grade 3 or 4 pressure ulcers
* One fracture of a patients wrist on an older adult ward
* One assault by a community patient on a neighbour
* The death of an eighteen month old child.
* A significant breach of confidential information
* A failure to act upon test results and manage ketoacidosis in an insulin dependent patient
* An NHS 11 incident where a visit was delayed and the patient subsequently died.
* One incident of a patient sustaining a fracture (likely self-inflicted) and not receiving timely care. This SIRI is being managed through the complaints process.
* One incident of a pregnant patient on section 17 leave who refused to return. This is being managed through a multiagency review.
* One incident of a patient in the community falling, carers failed to summon help or medical review the patient and fell again later fracturing their collarbone.
* One incident of a patient in the 136 suite substantially damaging the 136 and putting it out of commission for some time.
* In Q3 we reported that there had been no avoidable grade 3 /4 pressure ulcers reported in Q3. Refreshing figures and accounting for delays in notification after the last data was run the numbers of pressure ulcers to report has changed. In Q 3 there were four avoidable pressure ulcers and in Q4 there have been three.

The number of suspected suicides in Q4 has further increased from six in Q3 to eleven in Q4 which is above the median. The trend however continues downwards and 2014-15 has reported the smallest number of suspected/confirmed suicides in the last four years. All of these reported deaths occurred in the community. There have been a total of 24 in the Adult Directorate, two in the Older Peoples Directorate (mental health) and two in the Children and Young Peoples Directorate.

Ten suspected suicides have occurred in Bucks and ten in Oxford. Chiltern team had the largest number with six (one each in the first two quarters and two each in the second two quarters) and Oxon N&W AMHT the fewest with two (both of which occurred in the first two quarters of this year). The Adult Directorate have undertaken a service review in the Chiltern team and made a number of recommendations to improve working practice and address high referral and capacity issues in the team.

The days between deaths that meet the criteria for inpatient deaths are 192, 153 and 439 (and counting). The quality account indicator for this year which is set at 300 days has been achieved. There was one unexpected death reported of an inpatient in a low secure mental health unit. The death was attributed to natural causes in Q2.

**Table 6: inpatient suicides by year**

|  |  |
| --- | --- |
| **Year** | **Inpatient** |
| **2009/10** | **1** |
| **2010/11** | **1** |
| **2011/12** | **0** |
| **2012/13** | **1** |
| **2013/14** | **2** |
| **2014/15** | **0** |

There are a total of one hundred and six out of date actions from SIRI investigations. Thirty two of these are a year or more out of date with the majority likely to be no longer relevant as services have undergone significant change. Capacity issues within the team may account for some of the actions not being closed on time. Also actions may have been closed by Directorates but the risk team not advised. Nevertheless this does indicate a problem as full assurance cannot be given that all changes are being delivered in practice.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | Out of date actions timeframe | Number | | In date | 16 | | 0-5 months | 51 | | 6-11 months | 21 | | 12-18 months | 11 | | 19 plus months | 21 |  |  |  | | --- | --- | | Directorate | Out of date actions | | Children & Families | 5 | | Mental Health Services | 47 | | Community Services | 21 | | Specialised Services | 13 | | **Total** | **86** | | |  |  |  | | --- | --- | --- | | Directorate | Within Date | N/A | | Children & Families | 8 |  | | Mental Health Services | 4 | 4 | | Community Services | 4 |  | | Specialised Services | 0 |  | | Total | 16 |  |  |  |  |  |  | | --- | --- | --- | --- | | Actions completed - within target | | | | | **Q4** | **Q3** | **Q2** | **Q1** | | 12 | 13 | 11 | 6 | | 111 | 109 | 95 | 33 | | 122 | 122 | 115 | 78 | | 10 | 9 | 9 | 15 | | 9 | 9 | 9 | 9 | | **264** | **262** | **239** | **141** | |

**Learning Events:**

A learning event is scheduled for June 2016 in relation to medication management. Eighty delegates are expected to attend including some users. Due to the unprecedented demand we have been able to secure funding with the Learning and Development team to put the event on at Unipart in Oxford.

**Risk Notes:** There have been three risk notes and one reissued action note in Q4 2014-5

* Photographic recording of injury to patients
* Providing written information for medication to Children Young people and their parents or carers.
* End of Life Care
* Action note 1: Medical Devices Asset Labels: reissued Action note

**Being Open Duty of candour**

In Q4 2014-15 there were ten SIRI panels, four record reviews that went to the weekly review meeting or the new Record review panels and one incident which further investigation resulted in a request for downgrade. Of the four record reviews one was escalated to a full RCA following the initial review of records. Three of the investigations are still underway at the time of this report and having gone to panel and needing further work and family liaison to take place.Of the remaining:

* Six had family members who contributed to the investigation and requested feedback
* One the contact was made via liaison via GP
* One was not contacted due to an ongoing criminal investigation
* One sent a letter sent post review
* One was contacted but received no response.
* One patient was in custody and had no family
* One there were no family contact details available

**Themes from SIRIs**

In many cases the findings of the reviews are that the issues noted were not thought to be root causes to the incidents. Nevertheless issues raised include:

* Family involvement in care planning was raised again. This included the family’s perceptions of their involvement. Communication and involvement of family members/carers is an ongoing theme that will form part of the Quality account objectives for 2016-17.
* Documentation, risk assessment and care planning and updating of risk assessments was also raised again. In one case the risk assessment had not taken into account key risks. It is hoped that the new care records will support staff in being able to improve the quality of documentation.
* The mental capacity Act was raised in two SIRIs. In particular these were related to ensuring formal and detailed capacity assessments were undertaken and recorded when making decisions about care when patients are declining treatment.
* Staff workload in particular the issue of part time working in the AMHT, participation in step up and out of hours work impacting on contact with ongoing clients.
* One SIRII noted the lack of consideration of safeguarding concerns which has been raised in the past.
* One SIRI noted the rapidity of discharge and lack of clear aftercare planning following discharge.
* One SIRI noted the lack of a medical review which has been raised in the past.

**Good practice** noted included:

* Evidence of effective team work was noted on more than one occasion
* Evidence of good communication and liaison was raised on more than one occasion. This included liaison with the family and GP and sharing of care plans
* Thorough risk assessment
* Considered and detailed management of medication
* Evidence of sensitively managing complex issues relating to confidentiality
* Timely and appropriate assessments
* Clear communication processes
* Detailed documentation
* Assertive follow up including step up care and crisis response including timely medication review.
* Management of the level of acuity and complexity of patients on a ward
* Responsive medical contact
* Flexible efforts to maintain engagement. This has been noted on a number of occasions

**Staff Support:** Following outcomes of staff surveys and serious incident investigations a working group was established to develop a proposal for supporting staff after critical incidents. A staff psychological debriefing service, comprising suitably trained staff from all Directorates in the Trust and overseen by the Trust Head of Spiritual & Pastoral Care has now been established and was formally launched on 2nd March 2015.    This service offers facilitated group or individual debriefs between 1 and 2 weeks after critical incidents, with an offer of follow up sessions if required.

**3. Infection Prevention and Control**

This is a summary report for Quarter 4, January-March 2015 for the infection prevention and control team (IPCT). It reflects progress against the annual work programme.

**Management and Organisation**

Weekly updates are provided for senior managers of the Trusts performance. The Trust board continue to receive monthly updates on infection prevention and control issues and surveillance organisms. A quarterly CQC compliance and progress report is submitted to the Safety Committee.

**Surveillance**

*Clostridium difficile infection (CDI)*

**Older People Services**

There have been 3 confirmed cases of *Clostridium difficile* in Q4 in older peoples services.

The threshold this year is 8 cases and the Trust concluded the year on 7 cases.

**January 2015-** 1 case for a patient on Wenrisc ward, Witney hospital

**February 2015 –** 1 case for a patient on Amber ward, Whiteleaf centre

**March 2015 –** 1 case for a patient on City ward, Fulbrook centre

Robust RCA’s have been completed and any learning identified communicated back to clinical teams and discussed in training for staff.

Each RCA is reviewed by the monthly health economy CDI meeting, with representation from the OUH, Public Health England and commissioners.

All CDI cases have been reviewed and the 7 cases have been assessed as unavoidable.

**Cases of CDI in Community Hospitals**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **January 2015** | **February 2015** | **March 2015** |
| Total number of cases per month | 1 | 1 | 1 |
| Total cases in year | 5 | 6 | 7 |
| Outcome from monthly case review | Unavoidable | Unavoidable | Unavoidable |

There were no cases of CDI in mental health.

*MRSA and MSSA bacteraemia*

There was a pre 48 hour MRSA bacteraemia patient identified on assessment in EMU on 6th January. The patient was admitted to ward 2, Abingdon. A post infection review meeting was held with the CCG and the case was deemed unavoidable. There are some actions points identified which are being addressed.

There were no cases of MSSA bacteraemia in the Trust.

*E.Coli bacteraemias*

**January 2015**– No cases

**February 2015** – No cases

**March 2015 -** 1 pre 48 hour community case, admitted to Abingdon ward 1 under EMU care.

All cases have had a thorough RCA completed and any learning points identified and discussed within the service. These infections require mandatory reporting but do not have a target

**Outbreaks**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Location** | **Dates** | **Management** | **Cause** | **No. of cases** |
| Bicester hospital | 2-8th January 2015 | IPCT management with PHE advice | Confirmed Influenza A | 4 patients and 8 staff |
| Opal ward, Whiteleaf centre | 12-20th March 2015 | IPCT management with full terminal clean before the ward resumed normal operations. | Possible norovirus outbreak | 8 patients and 2 staff |

**Audit programme**

**Environmental Audits**

Environmental audits continue and overall demonstrate good compliance with infection prevention control standards.

**Hand hygiene**

Hand hygiene audits scores average in the community hospitals for Q4, continue to demonstrate excellent compliance of 99%. Bare below the elbows was 100%.

Hand hygiene in mental health wards is continuing bi monthly as well. The overall compliance score for the hand washing technique for Q4 was 94 %. Bare below the elbows was 95%.

**Training**

Training numbers continue to be a challenge. The Trust has set the target of 90% of all eligible staff to complete infection prevention control training. The current figure is 82% of staff are in date with training requirements. Training is also available via the E learning programme and work book for staff to access.

**CQC compliance/national directives**

Outcome 8 Cleanliness and Infection Control is monitored quarterly via the IPCT and governance team. Overall, areas are demonstrating good compliance with this outcome, except the numbers of staff trained in infection prevention and control remain below the target of 100%. There are also some concerns regarding audit results and decontamination record keeping.

**Environmental cleanliness**

Monitoring and audit reports are submitted to the facilities teams.

ATP environmental cleanliness monitoring continues monthly in community hospitals and older adult mental health wards.

**Decontamination**

Decontamination compliance remains generally high with appropriate processes in place including external contracts. One area of non-compliance remains poor documentation of cleaning records.

**4. Trust wide status report against CQC outcomes – internal position**

**Trust wide safety and suitability of premises**

* Annual ligature audit of all wards completed and consistency checked in Dec 2014. Following discussion with clinical and senior staff a programme of work has been identified and currently out to tender.
* Plans are in place to carry out full site surveys in 2014 identifying works to be undertaken for inclusion on 2015/16 capital programme works relating to compliance with Disability Discrimination Ace requirements.
* All refuse areas across Trust have been reviewed and work is underway to ensure they meet national waste standards. Some clinical waste bin stores need capital works included in 2015/16 capital funding programme

**Information governance**

As a result of two data protection breaches the Information Commissioner has provided a form of undertaking for the Trust with respect to certain data protection matters. Actions relating to procurement outstanding. In the last 12 months the trust has had two incidents and is likely to have a third incident reported to the ICO.  There does not seem to be any common themes.

**Trust wide monitoring and review of staffing levels (inpatients)**

Six wards are identified as having the most difficulties with achieving staffing levels between April 2014-Feb 2015 these are: Vaughan Thomas, Opal, Sandford, Wenrisc, Cotswold House Marlborough and Kingfisher. The main reason is due to vacancies related to recruitment difficulties in some geographical areas and some specialties. Vacancies are being monitored and managed on a weekly and monthly basis with the Executive Team. Following a campaign of recruitment the trust wide vacancy rates have been falling for the last four months, however a large number of staff are still currently going through pre-employment checks therefore have not started in their new roles yet, the wards should start to feel a significant improvement in staffing numbers from April 2015. The secondary reason for staffing challenges is due to a rising level of sickness which is being actively examined with support from HR advisors so that solutions can be worked through.

**Management of medicines across the Trust**

* Continued work on localised practice and storage issues and completeness of daily checks in all areas.
* Medicines reconciliation - clinical standard in development.
* All Patient Group Directions (PGD) are current and signed off. System introduced to monitor/ govern use in practice which will be supported by new generic training.
* Drug cupboard replacement work has been undertaken to ensure storage is complaint with the national recommendations. There are currently two wards non-compliant (Woodlands and Cotswold House Oxford).
* Management of medical gases: working group established chaired by the Chief Pharmacist which reports to the Drug and Therapeutic Group. Actions being taken include ensuring procurement is in place, e-learning package and policy.
* Published net formulary: this is a national requirement, the net formulary was due to be updated by 31st March 2015 but this has slipped to the 31st May 2015.
* Learning from medicine incidents: work is underway to improve the data quality and analysis of information. Most frequently reported incidents are around delayed/ omitted doses and incorrect does for high risk drugs.

**Completeness of patient records**

* There is evidence to show variable quality and completeness of patient records across the trust. This does not mean the care being delivered is not of a high quality but how this care is documented (and demonstrated) is an area for improvement.
* Work to introduce the new electronic health record will support and help clinicians to more easily record the care and treatment they have agreed and are working with for each patient. However additional work is required to ensure everyone values the importance of good record keeping and training is provided.

**End of life care**

An independent audit was completed in Feb 2015 by TIAA. The following key action areas will be led and monitored by the trusts one chance to get it right taskforce group: awareness by staff of the end of life care pathway that replaced the Liverpool Care Pathway, staff training, completeness of notes, care plans and DNA CRP forms as appropriate, information for families and parents and access to health records for all of multi-disciplinary team including agency staff.

**Trust wide nutrition: screening, assessing needs and taking appropriate action**

Evidence from audits show a lack of consistent assessment and monitoring of nutrition and hydration needs, and patient needs being fed through to care planning. A nutrition action group was established in August 2014 to coordinate improvement work to include a new trust nutrition and hydration policy with clear nutrition standards and staff training to raise awareness and appropriate use of nutrition screening tools.  Accurate recording will be supported by the new electronic health care record.

**Delayed Transfers of Care across Community Hospitals**

High number of delayed transfers of care particularly in Abingdon, Didcot and Witney which remains challenging. A high number of delays are the responsibility of OCC and relate to their capacity, so progressing integration work is essential to address these problems. Choice delays represent about a third of all delays in terms of family agreeing discharge (property disregard funding and private funders). A revised choice policy has been signed at board level by the whole system and implemented alongside training across the community hospitals. The discharge pathway steering group is monitoring the impact of actions across the whole system.

**Identifying and supporting carers, parents, family members**

As the trust works through the triangle of care accreditation process developed by the carers trust some gaps are being identified in support to carers, trust wide themes are around a lack of consistent and routine carer awareness training for staff and standardised information given to identified carers incl. information about local carer support services.

**Staff feedback**

There has been a decline in some results for key findings in the recent 2014 staff survey (n=1646) with issues identified around staff working extra hours, experience of work related stress, work pressure, less staff feeling satisfied with quality of work/ patient care they are able to deliver, an increase in staff experiencing harassment, bullying or abuse from other staff, and a decrease in the belief the trust provides equal opportunities for career progression or promotion. Each directorate and the trust wide health and well-being group are identifying priorities to address in 2015/16.

**5. Harm reduction projects**

The Highfield Unithas implemented a project coordinated by the safer care team to reduce the incidents of serious violence/aggression leading to prone restraints. Their initial target in March 2014 was achieved, and the second target was to reduce incidents of violence and aggression by a further 25% by March 2015. To support this, and as part of the Sensory project, a Sensory Assessment & Care Plan was implemented in September 2014 with a new focus on considering how patients manage when feeling overwhelmed and distressed. The OT has been involved in assessing new admissions and the case team have been reviewing the assessment and formulating a care plan together and liaising with parents. Patients have welcomed the use of a sensory ladder which communicates to the team how they are feeling and what may help in that moment. Data suggests that the level of prone restraints has steadily decreased, with the odd outlier. These outliers relate to specific incidents requiring a specific and individualised response.

Sandford ward is currently completing an audit to measure the number of restraints occurring on the ward, which shall be compared to the actual numbers reported on incident forms. It is felt that even though high numbers are already being reported by the ward, that in reality, the number of PMVA incidents is much higher.

There has been a successful reduction in incidents of violence and aggression on Watling Ward (medium secure forensic service) as part of safer care work

The CAMHS unit at Marlborough House Swindon (Tier 4 children service) has initiated a safer care project. The specific aim of the project was to reduce incidents of deliberate self-harm (DSH) requiring intervention by 50% by the end of June 2015.

In June 2014 the safer care project commenced on the ward. The first Plan Do Study Act (PDSA) commenced in July 2014 which tested the impact of having two members of staff in communal areas. This was in response to both staff and young people feeling unsafe at times in these areas of the ward. Narrative collected from young people during the project has revealed enhanced feelings of safety and the young people have also observed that formal observations are now less common on the ward. Staff also report a greater sense of psychological safety.

In August 2014 a PDSA was designed to ensure that a nurse was rostered 9-5 to attend the case management meetings and to systematically provide feedback to the young person, the family and the ward team within agreed time frames. In October 2014, key working and a family nurse role were introduced. In November 2014, therapeutic groups for young people who self-harm were commenced. The SPC charts presents the current shift in mean number of self-harm incidents requiring physical intervention since the team commenced their safer care work.

The OSCA team have developed a project with Safer care to support seriously unwell patients with the aim would to provide clearer cover to those at high risk of serious self-harm, and a smoother transition from Tier 3 to OSCA or T4 to avoid crisis referrals. The project is working towards the 'watchlist'[[1]](#footnote-1) ceasing to exist from the 1st June 2015 and there is a project plan and steering group to ensure that the correct actions have happened to safely support this transition.

Cotswold House Oxon is working on Admission Pathways as a result of some potentially serious near misses, a serious incident as well as patient feedback. A Standard Operating Procedure has been implemented which includes an admission pack, a checklist of tasks for Doctors and Nurses, new & updated core and medical risk assessments (appropriate to Emergency departments), triage of other needs including children, pets, accommodation etc, capacity and consent assessment, code of conduct for patients, carers and staff and finally outcome measures as a baseline (EDEQ, CIA, CORE)

To date the outcomes that are reported to have been achieved are:

* Significant reduction in incidents and near misses
* Safer admission pathway with robust systems and processes
* Increase in patient satisfaction
* Increase in staff satisfaction

1. The watch list was seen as the high risk, contains names of potentially around 50 patients who may be deemed to be at high risk and so need 'watching'. [↑](#footnote-ref-1)