Care Quality Commission

Good feedback from trainee doctors about working here.

Mortality & Morbidity meetings - 5 last year, planned 4 this year. - CS

Neonatal depend on number of cases to be discussed.

In Childrens Services not cases were teenage suicides (These have been Serious case reviews)

Perinatal + neonatal meetings are done Separately to ensure all cases given enough time.

Governance board meets on a monthly basis

Recently started a Complaints Peer Reviewed meeting, usually 6 monthly.

Minutes from both Governance + Complaints meetings are emailed out individuals involved spoken to and feed back to routinely.

Pertinent issues are put on the safety bulletin + incident meetings.

Staff involved in incidents do reflective practice.

Care Quality Commission

17/2/16 5 IV ... on unit
x5 upstairs.
not know.
doses delayed previously but now ... being down
more on time

staffing RR since 2010.

Transition cots on risk register

criteria for transition changed - 36/40+ ↑ TC
due to.
?1/10/14 crying less on the unit
thought prem than safe.

go to NNU, are assessed,
can use space on NNU for transition

? use transition care if midwives are busy - ? not breastfeeding

mat - planned care
NNU - urgent care
Equipment /
ordering consumables. budget implications.
... in 1 bay ...

Build relationship with consultants.

NNU all ... centre
resuscitation
training

MAV / NNU closed
not

management
discussion

working relationship ... mat ...

NLS

All ... 3 NLS trained - all reg staff min 3.

QIS 80% of reg staff.

rolling programme ... new staff - part of action plan ... kit
replace ... - all going to be QIS
... for safety.

Transfers maybe delayed to ensure competency
...
get 50% competency then work on rest.

TNA report.

Preceptorship new staff allocated mentor / local induction / inc. ... competencies

Agency staff have orientation.

Fire / ...
Emergency
procedure

INQ0017339_0200

8 managers
1 staff = 9

Note taking template for acute hospital inspection

Name of location:	Countess of Chester.
Date:	17/2/16
Time (if applicable):	2pm
Method: *(cross through/circle as appropriate):*	(Interview circled) Interview Focus group Observation Listening event Other (write in here): ....
Name of recorder:	Helen Cain
CQC Inspection Team attendees:	Ben Odeka SPA Mary Potter SPA Helen Cain Inspector. Ann Moran Peads ward Nurse Y NNU
Attendees:	Steve Brearey Peads neonatal lead. 1 service leads meeting Ravi Jayaram Consultant Paediatrician. Ann Murphy Lead nurse for childrens services. Sarah Jackson manager for CYP complex care Team Cath Moat Divisional support manager urgent care Matron manager Peads.
Summary *Please summarise key points from your notes below.*	Karen Townsend Matron Director for Urgent care. Karen Reece Divisional nurse for Urgent care. Eirian Powell neonatal unit manager. Hospital @ Home Integrated care Morbidity & mortality meetings Governance Safeguarding / Child deaths review On call rota NED representative Transition / competency Conflict resolution Patient engagement Electronic prescriptions.
In the Key question score column enter the codes S, E, C, R or W with the KLOE number to map key messages to one of the five domains with "+" for a positive comment, or a "-" for a negative comment.	**Key question score**

NNU - staffing
appraisal
mandatory training
major incident policy

staffing for today NNU / Peads ward

Gen
Paeds: looked @ how delivered inpatient service

RCH work ïc Primary Care

reduce no who are presented / treated appropriately

reduce length of stay / reduce rates of readmission

Paed H@ Home service ↓ length stay / readmissions.

Potential for GP to access H@H service direct.

criteria / eligibility

GP's clinical responsibility / own consultants.

comm Paeds
pilot - ANP work ïc GP in community.

Paed outpatients - specialist interests

links ïc tertiary services ïc Alderhey

reduce follow ups / RTT

AM

integrated service

H@H / integrated care packages / comm Paeds. nurs service.

NNU
COCH
wider Cheshire neonatal partnership

raised success pulse oximetry pilot.

only DGH in region that cools babies prior to transfer.

Positive feedback from Deanery trainees / learning.

mortality + morbidity Meetings

perinatal
x8 from NNU last year x4 this year. - ïc obs / midwives

neonatal mortality x2 last year. (deep in cases to be discussed).

x2 Paed mortality meetings. ∴ n^os fairly small.

majority teenage suicides last meeting.

awaiting action plan from SCR.

Cheshire & Merseyside
Cases reviewed neonatal network. / peer review

monthly
Governance meeting - Paed / neonates / obs / gyn governance board

Set agenda trend / guidelines / NICE guidance

Complaints
peer review
meeting
day 6/12
consultants
increase
+ present
case
+ learning. 6 in 6/12.

not reported
as freq
as liked
but backed
on track.