NHS
Greater Glasgow and Clyde

NHS GREATER GLASGOW AND CLYDE

NHS Board Meeting
16th December 2014 **Paper No 14/64**

Chief Executive

RESPONSE TO THE VALE OF LEVEN HOSPITAL INQUIRY REPORT IMPLEMENTATION OF RECOMMEDATIONS

RECOMMENDATION

The NHS Board is asked to approve the process to submit to the Scottish Government Health Directorate by 19th January 2015 the progress made in implementing the 65 NHS Board recommendations from the Vale of Leven Hospital Inquiry Report.

1. BACKGROUND

1.1 The Vale of Leven Hospital Inquiry was set up by Scottish Ministers to investigate the occurrence of C. Difficille infection at the Vale of Leven Hospital and the Inquiry was tasked with investigating the deaths associated with C. Difficille which occurred between 1st December 2007 and 1st June 2008. The Inquiry was set up under the Inquiries Act 2005 and the Inquiries (Scotland) Rules 2007 and the Right Honourable Lord MacLean commenced Chairmanship of the Inquiry from 1st October 2009.

1.2 Following a preliminary hearing on 1st February 2010, oral hearings took place over 126 working days from 7th June 2010 until 28th June 2012. Over 10,000 documents were recovered by the Inquiry of which 5,000 documents were considered to be relevant to the Terms of Reference. 214 witnesses gave either written or oral evidence to the Inquiry and 27 expert witnesses were instructed by the Inquiry leading to a total of 268 Expert Reports being produced.

2. PUBLICATION OF REPORT

2.1 Lord MacLean published the Vale of Leven Hospital Inquiry Report on 24th November 2014 and made 75 recommendations; 9 for the Scottish Government, 1 for the Crown Office and 65 for NHS Boards in Scotland. He commented that he believed the adoption of the recommendations would result in a significantly improved focus on patient care and in particular on the care of patients who had contracted an infection such as C. Difficille. The recommendations were designed to encapsulate a concept of patient care that included skilled and considerate medical and nursing care, transparency, candour, effective systems of infection prevention and control, and strong and dedicated leadership.

2.2 The report highlighted findings of significant failures from which important lessons must be learned; it identified failings by individuals, supervisory and managerial arrangements and systems failures which should have been expected to identify the occurrence of C. Difficille at the appropriate levels of staff/managers in order

that action could have been taken to deal with it at the time.

2.3 Lord MacLean identified deficiencies in nursing care and medical care, governance and management failures which resulted in an environment in which patient care was compromised and in which infection prevention and control was inadequate and therefore had a profound impact in the care provided to patients in the hospital. In addition Lord MacLean commented that the prolonged uncertainty over the future of the Vale of Leven Hospital also had a damaging effect on recruitment, staff morale and the physical environment of the hospital, which was not conducive to good patient care.

3. NHS GREATER GLASGOW AND CLYDE RESPONSE

3.1 The Chairman and Chief Executive of the NHS Board immediately on the publication of the report made a public apology to the patients affected and to the families of those who had died as a result of the occurrence of the C Difficille infection in 2007 and 2008. It was acknowledged that this had been a failure which was profoundly regretted and assurances were given that as the result of the lessons which had been learned over the earlier investigations, that this could not happen again.

3.2 In addition to issuing a Press Release which contained the apology from the Chairman and Chief Executive as well as statements from the Medical Director and Nurse Director in relation to the improvements that had been made since 2007/2008, a letter was also sent to the patients and families affected and an open letter of apology was sent to the two local papers expressing the NHS Board's deep regret and full and unreserved apology for these failures and impact it had on the families.

3.3 The culture of antibiotic prescribing by GP's and hospital doctors was changed in the summer of 2008 resulting in the use of antibiotics which target specific germs and where more powerful antibiotics required to be prescribed their use was now strictly monitored by a specialist team of doctors and pharmacists. There has been significant investment in the Vale of Leven Hospital in order to deliver a wide range of improvements aimed at preventing the spread of bacteria, including better bed spacing and improved hand washing facilities. There has been an 80% reduction in cases of C. Difficille in both the Vale of Leven Hospital and in NHS Greater Glasgow and Clyde and the NHS Board now has one of the lowest rates of C. Difficille infection in Scotland. There has been significant strengthening of the system of monitoring and surveillance which has resulted in the monitoring being visible at ward level and at Board level and all stages in between.

3.4 The NHS Board approached the families who had submitted legal claims and has made a formal offer to settle the outstanding claims and negotiations with the families' solicitors are ongoing.

3.5 The Chairman of the NHS Board has asked the Directors to review the statements made by Lord MacLean in relation to individual members of staff and to also consider all subsequent steps taken since 2008 in relation to the actions of staff at that time. This review is now currently under way and will have Non-Executive Director involvement in the process and outcome.

4. IMPLEMENTATION OF RECOMMENDATIONS

4.1 The Scottish Government Health Directorate has set up a process to monitor each NHS Boards' assessment and implementation against the 65 recommendations identified for NHS Boards. A guidance note and template has been provided (attached) and the NHS Board will be required to describe the current position/progress towards implementing the recommendations and where relevant provide supporting evidence and examples of good practice.

4.2 The Chief Executive is required to sign and return NHS Greater Glasgow and Clyde's template to Scottish Government Health Directorate by 19th January 2015 and it is recommended that a final draft be submitted to NHS Board Members by email on 13th January 2015 for comment. Once completed it will be submitted to the Scottish Government Health Directorate by 19th January 2015 and the finalised template will be submitted to the Quality & Performance Committee at its meeting on 20th January 2015 for endorsement.

4.3 The NHS Board is asked to consider and approve the process described above for handling the return of the completed template to Scottish Government Health Directorate in relation to the implementation of the recommendations from the Vale of Leven Hospital Inquiry Report.

John C Hamilton
Head of Board Administration
0141 201 4608

5th December 2014

Attachment: SGHD Guidance & Template

RESPONSE TO VALE OF LEVEN HOSPITAL INQUIRY REPORT

GUIDANCE FOR COMPLETING TEMPLATE

PLEASE READ THIS BEFORE COMPLETING THE TEMPLATE

1. RECOMMENDATIONS

Lord Maclean's inquiry report made 75 recommendations, 9 for Scottish Government, 1 for Crown Office and 65 for Health Boards. The Cabinet Secretary for Health, Wellbeing and Sport, Shona Robison has accepted all 75 recommendations. Health Boards are asked to make an assessment of progress using the template attached.

The template has been pre-populated with the 65 Health Board recommendations by chapter and signposts you to the relevant pages in Lord MacLean's main report. This will enable you to refer to additional information, see the recommendation in context and gain a better understanding of what it means in practice before you start your assessment.

2. CURRENT POSITION

In this section you should describe where you are now/progress with the recommendation. Please answer as succinctly as possible and if the recommendation has already been delivered or is ongoing please provide supporting evidence. If you can identify examples of good practice which could be shared with others please highlight these. We may showcase innovative working practices in our final response to Lord Maclean's report.

3. WHAT MORE NEEDS TO BE DONE?

If more needs to be done and you are currently not on track please set out the reason why and the planned key steps to be taken which will influence delivery of the recommendation.

Your response should take account of the following factors:

- Are you delivering 'in the spirit' of the recommendation rather than to the letter?
- Is the work being reviewed and under development?
- Are you considering/testing out new ways of doing things?
- Has the work started but still to be evidenced?

3. TIMESCALES FOR IMPLEMENTATION OF RECOMMENDATIONS

Having considered what more needs to be done please provide your best estimate of when you expect the recommendation to be fully implemented. If full implementation is likely to take a phased approach please provide timescales for this and the interim key milestones.

4. DELIVERY STATUS

Using the descriptors below what is your overall assessment of the current delivery status for each recommendation? . Your overall analysis of the information presented in the other parts of the template should inform your decision. It is important that this assessment accurately describes the current situation to enable an open and transparent response to Lord MacLean's report.

DESCRIPTORS

Fully Implemented (F)	➢ Policy in place ➢ Health Board taking action ➢ Being monitored/evidenced
Mostly Implemented (M)	➢ Policy in place ➢ Health Board taking action ➢ Not yet fully evidenced ➢ Close but not 'perfect fit' ➢ More can be done
Partially Implemented (P)	➢ Policy/discussions started ➢ Different ways of doing things/testing ➢ More can be done ➢ No evidence yet
Not Started (NS)	➢ Yet to begin

5. SIGN OFF

Completed templates should be signed off by Board Chief Executives and returned to volhir@scotland.gsi.gov.uk mailbox by Monday 19th January 2015.

RESPONSE TO VALE OF LEVEN HOSPITAL INQUIRY REPORT
65 HEALTH BOARD RECOMMENDATIONS – ASSESSMENT OF PROGRESS TEMPLATE

NAME OF HEALTH BOARD……………………………………………………………………………………..

Please send completed return, signed off by Chief Executive, to Inquiries mailbox volhir@scotland.gsi.gov.uk **by Monday 19th January 2015**

Telephone Enquiries to: Irene Bruce 0131 244 2328

CHAPTER 7 – NATIONAL POLICIES AND GUIDANCE – PAGES 95-107

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
3. Health Boards should ensure that infection prevention and control policies are reviewed promptly in response to any new policies or guidance issued by or on behalf of the Scottish Government, and in any event at specific review dates no more than two years apart.				

CHAPTER 9 – THE CREATION, LEADERSHIP AND MANAGEMENT OF THE CLYDE DIRECTORATE – PAGES 117-130

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
7. In any major structural reorganisation in the NHS in Scotland a due diligence process including risk assessment should be undertaken by the Board or Boards responsible for all patient services before the reorganisation takes place. Subsequent to that reorganisation regular reviews of the process should be conducted to assess its impact upon patient services, up to the point at which the new structure is fully operational. The review process should include an independent audit.				
8. In any major structural reorganisation in the NHS in Scotland the Board or Boards responsible should ensure that an effective and stable management structure is in place for the success of the project and the maintenance of patient safety throughout the process.				

CHAPTER 10 – CLINICAL GOVERNANCE – PAGES 131-152

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
9. Health Boards should ensure that infection prevention and control is explicitly considered at all clinical governance committee meetings from local level to Board level.				

CHAPTER 11 – THE EXPERIENCES OF PATIENTS AND RELATIVES – PAGES 153-168

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
10. Health Boards should ensure that patients diagnosed with CDI are given information by medical and nursing staff about their condition and prognosis. Patients should be told when there is a suspicion they have CDI, and when there is a definitive diagnosis. Where appropriate, relatives should also be involved.				
11. Health Boards should ensure that patients, and relatives where appropriate, are made aware that CDI is a condition that can be life-threatening, particularly in the elderly. The consultant in charge of a patient's care should ensure that the patient and, where appropriate, relatives have reasonable access to fully informed medical staff.				

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
12. Health Boards should ensure that when a patient has CDI patients and relatives are given clear and proper advice on the necessary infection control precautions, particularly hand washing and laundry. Should it be necessary to request relatives to take soiled laundry home, the laundry should be bagged appropriately and clear instructions about washing should be given. Leaflets containing guidance should be provided, and these should be supplemented by discussion with patients and relatives.				

CHAPTER 12 - NURSING CARE – PAGES 169-214

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
13. Health Boards should ensure that there is a clear and effective line of professional responsibility between the ward and the Board				
14. Health Boards should ensure that the nurse in charge of each ward audits compliance with the duty to keep clear and contemporaneous patient records, and that there is effective scrutiny of audits by the Board				
15. Health Boards should ensure that nursing staff caring for a patient with CDI keep accurate records of patient observations including temperature, pulse, respiration, oxygen saturation and blood pressure.				
16. Health Boards should ensure that the nurse in charge of each ward reports suspected outbreaks of CDI (as defined in local guidance) to the Infection Control Team				

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
17. Health Boards should ensure that where there is risk of cross infection, the nurse in charge of a ward has ultimate responsibility for admission of patients to the ward or bay. Any such decision should be based on a full report of the patient's status and full discussion with site management, the bed manager, and a member of the Infection Control Team. The decision and the advice upon which the decision is based should be fully recorded contemporaneously.				
18. Health Boards should ensure that there is an agreed system of care planning in use in every ward with the appropriate documentation available to nursing staff. Where appropriate they should introduce pro forma care plans to assist nurses with care planning. Health Boards should ensure that there is a system of audit of care planning in place.				

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
19. Health Boards should ensure that where Infection Control Nurses provide instructions on the management of patients those instructions are recorded in patient notes and are included in care planning for the patient.				
20. Health Boards should ensure that where a patient has, or is suspected of having, *C.difficile* diarrhoea a proper record of the patient's stools is kept. Health Boards should ensure that there is an appropriate form of charting of stools available to enable nursing staff to provide the date, time, size and nature of the stool. Stool charts should be continued after a patient has become asymptomatic of diarrhoea in order to reduce the risk of cross infection. Health Boards should ensure that all nursing staff are properly trained in the completion of these charts, and that the nurse in charge of the ward audits compliance.				
21. Health Boards should ensure that a member of nursing staff is available to deal with questions from relatives during visiting periods				

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
22. Health Boards should ensure that any discussion between a member of nursing staff and a relative about a patient which is relevant to the patient's continuing care is recorded in the patient's notes to ensure that those caring for the patient are aware of the information given.				
23. Health Boards should ensure that a nurse appointed as Tissue Viability Nurse (TVN) is appropriately trained and possesses, or is working towards, a recognised specialist post-registration qualification. Health Boards should ensure that a trainee TVN is supervised by a qualified TVN.				
24. Health Boards should ensure that where a TVN is involved in caring for a patient there is a clear record in the patient notes and care plan of the instructions given for management of the patient				

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
25. Health Boards should ensure that every patient is assessed for risk of pressure damage on admission to hospital using a recognised tool such as the Waterlow Score in accordance with best practice guidance. Where patients are identified as at risk they must be reassessed at the frequency identified by the risk scoring system employed. Compliance should be monitored by a system of audit.				
26. Health Boards should ensure that where a patient has a wound or pressure damage there is clear documentation of the nature of the wound or damage in accordance with best practice guidance, including the cause, grade, size and colour of the wound or damage. The pressure damage or wound should be reassessed regularly according to the patient's condition. Compliance should be monitored by a system of audit.				
27. Health Boards should ensure that where a patient requires positional changes nursing staff clearly record this on a turning chart or equivalent. Compliance should be monitored by a system of audit.				
RECOMMENDATION	**CURRENT POSITION**	**WHAT MORE NEEDS TO BE DONE**	**TIMESCALE FOR COMPLETION**	**DELIVERY STATUS (F,M,P,NS)**

28. Health Boards should ensure that all patients have their nutritional status screened on admission to a ward using a recognised nutritional screening tool. Where nutritional problems are identified further assessment should be undertaken to determine an individual care plan. Appropriate and timely referrals should be made to dieticians for patients identified as being in need of specialist nutritional support.				
29. Health Boards should ensure that there is appropriate equipment in each ward to weigh all patients. Patients should be weighed on admission and at least weekly thereafter and weights recorded. Faulty equipment should be repaired or replaced timeously and a contingency plan should be in place in the event of delays.				
30. Health Boards should ensure that where patients require fluid monitoring as part of their critical care, nursing staff complete fluid balance charts as accurately as possible and sign them off at the end of each 24-hour period.				

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
31. Health Boards should ensure that the staffing and skills mix is appropriate for each ward, and that it is reviewed in response to increases in the level of activity/patient acuity and dependency in the ward. Where the clinical profile of a group or ward of patients changes, (due to acuity and/or dependency) an agreed review framework and process should be in place to ensure that the appropriate skills base and resource requirements are easily provided.				
32. Health Boards should ensure that there is straightforward and timely escalation process for nurses to report concerns about staffing numbers/skill mix.				
33. Health Boards should ensure that where a complaint is made nursing practice on a ward this complaint is investigated by an independent senior member of Nursing Management				

CHAPTER 13 - ANTIBIOTIC PRESCRIBING – PAGES 217-227

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
34. Health Boards should ensure that changes in policy and/or guidance on antimicrobial practice issued by or on behalf of Scottish Government are implemented without delay.				

CHAPTER 14 - MEDICAL CARE – PAGES 229-262

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
36. Health Boards should ensure that the level of medical staffing planned and provided is sufficient to provide safe high quality care.				
37. Health Boards should ensure that any patient with suspected CDI receives full clinical assessment by senior medical staff, that specific antibiotic therapy for CDI is commenced timeously and that the response to antibiotics is monitored on at least a daily basis.				
38. Health Boards should ensure that clear, accurate and legible patient records are kept by doctors, that records are seen as integral to good patient care, and that they are routinely audited by senior medical staff.				

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
39. Health Boards should ensure that medical and nursing staff are aware that a DNAR decision is an important aspect of care. The decision should involve the patient where possible, nursing staff, the consultant in charge and, where appropriate, relatives. The decision should be fully documented, regularly reviewed and there should be regular auditing of compliance with the DNAR policy.				
40. Health Boards should ensure that the key principles of prudent antibiotic prescribing are adhered to and that implementation of policy is rigorously monitored by management.				
41. Health Boards should ensure that there is no unnecessary delay in processing laboratory specimens, in reporting positive results and in commencing specific antibiotic treatment. Infection control staff should carry out regular audits to ensure that there are no unnecessary delays in the management of infected patients once the diagnosis is confirmed.				

CHAPTER 15 - INFECTION PREVENTION CONTROL – PAGES 263-368

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
42. Health Boards should ensure that all those working in a healthcare setting have mandatory infection prevention control training that includes CDI on appointment and regularly thereafter . Staff records should be audited to ensure that such training has taken place.				
43. Health Boards should ensure that Infection Control Nurses and Infection Control Doctors have regular training in infection prevention and control of which a record should be kept				
44. Health Boards should ensure that performance appraisals of infection prevention and control staff take place at least annually. The appraisals of Infection Control Doctors who have other responsibilities should include specific reference to their Infection Control Doctor roles.				

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
45. Health Boards should ensure that where a manager has responsibility for oversight of infection prevention control, this is specified in the job description.				
46. Health Boards should ensure that the Infection Control Manager (ICM) has direct responsibility for the infection prevention control service and its staff				
47. Health Boards should ensure that the ICM reports direct to the Chief Executive or, at least, to an executive board member.				
48. Health Boards should ensure that the ICM is responsible for reporting to the Board on the state of HAI in the organisation.				
50. Health Boards should ensure that there is 24-hour cover for infection prevention and control seven days a week, and that contingency plans for leave and sickness absence are in place.				
51. Health Boards should ensure that any Infection Control Team functions as a team, with clear lines of communication and regular meetings				

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
52. Health Boards should ensure that adherence to infection prevention and control polices, for example C. difficile and				

Loose Stools Policies, is audited at least annually, and that serious non-adherence is reported to the Board.				
53. Health Boards should ensure that surveillance systems are fit for purpose, are simple to use and monitor, and provide information on potential outbreaks in real time				
54. Health Boards should ensure that the users of surveillance systems are properly trained in their use and fully aware of how to use and respond to the data available.				
55. Health Boards should ensure that numbers and rates of CDI are reported through each level of the organisation up to the Chief Executive and the Board. Reporting should include positive reporting in addition to any exception reporting. The Chief Executive should sign off the figures to confirm that there is oversight of infection prevention and control at that level.				

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
56. Health Boards should ensure that infection prevention and control groups meet at regular intervals and that there is appropriate reporting upwards through the management structure.				
57. Health Boards should ensure that the minutes of all meetings and reports from each infection prevention and control committee are reported to the level above in the hierarchy and include the numbers and rates of CDI, audit reports and training reports.				
58. Health Boards should ensure that there is lay representation at Board infection prevention and control committee level in keeping with local policy on public involvement.				

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
59. Health Boards should ensure that attendance by members of committees in the infection prevention and control structure is treated as a priority. Non-attendance should only be justified by illness or leave or if there is a risk of compromise to other clinical duties in which event deputies should attend where practicable.				
60. Health Boards should ensure that programmes designed to improve staff knowledge of good infection prevention and control practice,such as Cleanliness Champions Programme, are implemented without undue delay. Staff should be given protected time by managers to complete such programmes.				
61. Health Boards should ensure that unannounced inspections of clinical areas are conducted by senior infection prevention and control staff accompanied by lay representation to examine IPC arrangements including policy implementation and cleanliness.				

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
62. Health Boards should ensure that senior managers accompanied by IPC staff visit clinical areas at least weekly to verify that proper attention is being paid to infection prevention and control				
63. Health Boards should ensure that there is effective isolation of any patient who is suspected of suffering from CDI, and that failure to isolate is reported to senior management.				
64. Health Boards should ensure that cohorting is not used as a substitute for single room isolation and is only resorted to in exceptional circumstances and under strict conditions of dedicated nursing with infected patients nursed in cohort bays with en-suite facilities.				

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
65. Health Boards should ensure that appropriate steps are taken to isolate patients with potentially infectious diarrhoea.				
66. Health Boards should ensure that the healthcare environment does not compromise effective IPC, and that poor maintenance practices, such as the acceptance of non-intact surfaces that could compromise effective IPC practice, are not tolerated.				
67. Health Boards should ensure that, where a local Link Nurse system is in place as part of the IPS system, the Link Nurses have specific training for that role. The role should be written into job descriptions and job plans. They should have clear objectives set annually and have protected time for Link Nurse duties.				

CHAPTER 16 - DEATH CERTIFICATION – PAGES 371-379

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
68. Health Boards should ensure that where a death occurs in hospital the consultant in charge of the patients care is involved in completion of the death certificate wherever practicable, and that such involvement is clearly recorded in patient records. Regular auditing of this process should take place.				
69. Health Boards should ensure that if a patient dies with CDI either as a cause of death or as a condition contributing to the death, relatives are provided with a clear explanation of the role played by CDI in the patient's death.				

CHAPTER 17 - INVESTIGATIONS FROM MAY 2008 - PAGES 381-391

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
72. Health Boards should ensure that a non – executive Board Member or a representative from internal audit takes part in an Internal Investigation of the kind instigated by NHSGGC				
73. Health Boards should ensure that OCT reports provide sufficient details of the key factors in the spread of infection to allow a proper audit to be carried out, as recommended in the Watt Group Report.				

CHAPTER 18 - EXPERIENCES OF C.DIFFICILE INFECTION WITHIN AND BEYOND SCOTLAND – PAGES 393-410

RECOMMENDATION	CURRENT POSITION	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F,M,P,NS)
75. Health Boards should review such reports to determine what lessons can be learned and what reviews, audits or other measures (interim or otherwise) should be put in place in the light of these lessons.				

BEST PRACTICE EXAMPLES/ADDITIONAL INFORMATION

Please use this space to tell us about **best practice examples** linked to any of the 65 recommendations which you would be willing to share with others and possibly have published as part of the response to Lord Maclean's report. At this stage you are only required to highlight the example(s) rather than go into detail. We will contact you at a later date if further information is needed.
Please also use this space to provide **additional information** you would like to share which is not covered in the template.

BEST PRACTICE EXAMPLE(S)	**ADDITIONAL INFORMATION**
CHAPTER/RECOMMENDATION NUMBER:	

THANK YOU FOR TAKING THE TIME TO COMPLETE THE TEMPLATE

Please send completed return, signed off by Chief Executive, to Inquiries mailbox volhir@scotland.gsi.gov.uk **by Monday 19th January 2015**

Sign off – Name of Chief Executive…………………………………………………………..

Date ………………………………………………………………..