Appendix C: Action Plan from the CQC unannounced inspection of the RUH (February 2013)

Key findings	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
Inpatients accommodated on the day surgery unit at the time of the inspection visit were not having their privacy and dignity maintained. ***(Outcome 1 – Minor impact)***	Review DSU admission criteria.	March 2013	Suzanne Wills, Divisional Manager		**Action complete**
	Develop DSU admission criteria for red / black escalation status.	April 2013	Suzanne Wills		
The CQC notes, "the day surgery unit was being used as a facility to care for inpatients who would normally be accommodated elsewhere in the hospital. The environment and the care arrangements on this unit were not suited to ensuring inpatients privacy, dignity, health and welfare needs were met."	Review of DSU patients by duty matron / site manager is documented daily.	March 2013	Sharon Bonson, Assistant Director of Nursing, Surgery		
	Site management team to hold a log of patient safety issues raised and actions taken. Develop process for addressing where patient safety concerns have been raised but not resolved.	April 2013	Janet Wright, Clinical Site Manager		
	DSU staff / clinical site team / on call managers / on call directors to be made clear of DSU function when trust is in red / black escalation (circulate DSU admission criteria and process for addressing patient safety concerns).	April 2013	Suzanne Wills		
	Investigate option of providing an additional shower.	April 2013	Julia Papps, Matron Howard Jones, Director of Facilities		
	Air flow for DSU has been reviewed and found to be fully functional.	March 2013	Howard Jones		**Action complete**

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Patients being cared for and treated on the day surgery unit (DSU) were not having their care needs adequately assessed, planned and delivered. The care and treatment arrangements on the unit were not organised around the range of care needs of the patients accommodated there. ***(Outcome 4 – Moderate impact)*** Concerns raised in DSU included: • No comfort rounds carried out • Risks assessments for pressure ulcers not completed in line with NICE guidance • No access to turn charts • Care plans for prevention of pressure ulceration not in place • Risk assessments / care plan for falls not completed • Mobility assessment and communication assessment not completed Concerns raised in OPU included: • Patients not able to understand CQC questions were not having all their care needs met • No other mental cognitive tests had been completed for patients with abbreviated mental test (AMT) scores of less than eight. This meant no further assessment or care planning had been developed for the risks associated with their confusion.	Review availability of documentation within DSU. Nursing documentation to be held in folders at the end of the patient's bed to allow easy access for staff (yellow clip boards to indicate if comfort rounds required) Appoint ward clerk for DSU who will be responsible for maintaining a supply of relevant documentation. Develop an overview of documentation that should be completed for inpatients – core and care need specific, in line with record keeping standards. DSU staff to be trained on inpatient millennium record keeping and patient documentation. Shift coordinator to ensure that all patients have had appropriate nursing documentation commenced, including initial and on-going risk assessments. Develop a guideline for AMT (to include requirements for further assessment and care planning)	March 2013 March 2013 April 2013 April 2013 April 2013 April 2013 May 2013	Julia Papps Julia Papps Sarah Fletcher, DSU Senior Sister Anne Plaskitt Jessica Flower, Millennium Change Lead Anne Plaskitt Sarah Fletcher Dr Chris Dyer, Consultant Geriatrician		Completed. DSU have been provided with relevant documentation for inpatients. Interviews to be planned for April 2013. Training log to be maintained. Sue Leathers (Matron) to discuss with Chris Dyer.

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Patients discharged from the hospital cannot be confident that the hospital will communicate necessary information about their care and treatment to ensure continuity of care and minimise risks arising from the transfer of care. ***(Outcome 6 – Moderate impact)*** Concerns identified included: • Nursing and care information to external providers was not consistently documented in the discharge planning form (e.g. continence status, support with medications) • Essential medications not always sent to the nursing home • Unlabelled medicines, or medicines not prescribed for the patient supplied inappropriately	Roll out the use of the transfer of care power form on Millennium to all wards Nursing documentation standards for discharge will be promoted on each ward through: • Poster of discharge documentation standards • Awareness sessions with each ward and sisters meetings • Prompt cards with step by step information for completion of the transfer of care form on Millennium Audit of completion of discharge checklist – to include checking on what information was given to the patient and external providers. This will be carried out by ward staff (5 records per week). Audit on the transfer of care form to be carried out monthly (data can be exported from Millennium). Sections 10 & 11 of Discharge Medicines Policy to be promoted on each ward through: • Poster and prompt cards for key actions • Awareness sessions with each ward and sisters meetings Audit of Discharge Medicines Policy standards Green Review meetings with external providers are held 3 times a week. Ensure that issues around discharges are a standing agenda item and a log kept of identified concerns to raise at site / bed management meetings.	March 2013 April 2013 May 2013 May 2013 May 2013 May 2013 April 2013	Anne Plaskitt Anne Plaskitt, Senior Nurse, Quality Improvement Anne Plaskitt Rob Eliot, Lead for Quality Assurance Ward Sisters Business Intelligence Unit Regina Brophy, Chief Pharmacist Rob Eliot Clare O'Farrell, Divisional Manager		Refer to Transfer of care roll out plan. First awareness sessions are to be held week commencing 11 March 2013. Add audit of the discharge checklist to the monthly global trigger tool harm review (from April 2013, in addition to the weekly ward audits). The results from completed audits will be reviewed at Quality Board. Only in exceptional circumstances should patients be discharged home without their medicines, e.g.OOH discharge of local patient who can collect medicines the following morning.

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People were not protected from the risks of unsafe or inappropriate care and treatment by means of accurate and up to date records. ***(Outcome 21 – Moderate impact)*** Health Records Management Policy states, "any information that is stored, produced or recorded for patients must be printed and added to the paper record". Concerns identified included record keeping not being consistently completed for: • Patients' fluid intake and output / fluid balance charts • Discharge planning & checklist • Falls care plan • Pressure Ulceration prevention and turn charts • Malnutrition • Continence • Comfort rounds (completed on some shifts but not others)	Revise Health Records Management Policy to more accurately reflect where documentation should be recorded / filed. Whiteboards are used as a tool for viewing patient status at a glance. Develop a revised comfort and pressure care record. This combines information from the comfort round record, repositioning charts, daily skin check and pressure ulcer care plan. A new hydration record chart is being tested on Parry Ward. This will then be rolled out for use across the Trust. Further promotion on use of the fluid intake and output / fluid balance charts through awareness sessions with each ward and sisters meetings. Review Patient Assessment Record to consider recording whether a fluid balance chart and comfort round is required for each patient Comfort Round compliance is audited through the IHI General Ward Work stream (to include Day Surgery) Audit form to be designed to allow a full patient case note review (this will be undertaken across the Trust on a monthly basis)	April 2013 May 2013 May 2013 May 2013 April 2013 May 2013	Mark Hawkins, Medial Records Manager Anne Plaskitt Anne Plaskitt Natasha Howard, Sister, Parry Ward Anne Plaskitt Nutrition and Hydration Steering Group Anne Plaskitt Anne Plaskitt Rob Eliot Bernie Marden, Chair of Medical Records User Group		Agree changes to policy at next Medical Records User Group / NHSLA documentation steering group. The results from completed audits will be reviewed at Quality Board.

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Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress

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