Action Plan from the CQC unannounced inspection of the RUH (June 2013)

The CQC assessed 6 outcomes of the essential standards of quality and safety

Outcome	Judgement	How the regulation was not met
Outcome 1: Respecting and involving people who use services	Standard not met – Minor impact	Generally patient's privacy and dignity were respected. However, on two of the four older people's wards, at the time of the inspection visit, we saw instances where patients were not having their privacy and dignity maintained.
Outcome 4: Care and welfare of people who use services	Standard not met – Moderate impact	Care delivery by staff generally was managed to meet patients' care and treatment needs, but risks remained of inappropriate or unsafe care. This was because systems were not used in a co-ordinated and consistent way. At times there were delays in the assessment of patient's mental health needs in the emergency department.
Outcome 6: Cooperating with other providers	Standard met	N/A
Outcome 7: Safeguarding people who use services from abuse	Standard not met – Moderate impact	There were not suitable arrangements in place to protect people against the risk of excessive control.
Outcome 16: Assessing and monitoring the quality of service provision	Standard not met – Moderate impact	The provider had a system in place to regularly assess and monitor the quality of service that people receive and to identify, assess and manage risks to the health, safety and welfare of people using the service and others. The internal quality assurance mechanisms were not effective in ensuring the action plan from our last inspection had been implemented.
Outcome 21: Records	Warning Notice issued Standard not met – Moderate impact	People were not protected from the risks of unsafe or inappropriate care and treatment by means of the maintenance of accurate and up to date records.

Author: Rob Eliot, Lead for Quality Assurance
Version 13
Date: 4 November 2013

Action Plan from the CQC unannounced inspection of the RUH (June 2013)

Privacy and Dignity

The following issues were raised under outcome 1.

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)*
• Patient waited 10 minutes in an odorous, soiled bed before staff came to help • Call bell not accessible but patient called for help • Personal care inadequate: dirty finger nails and brown food supplement staining round the patient's mouth • Toilet door wide open on 2 occasions. One patient that had difficulty standing was not assisted despite having a Zimmer frame and visibly struggling in clear view of staff. This was brought to the attention of the nurse in charge	Amend the comfort round form to have a separate statement to record the nurse has checked call bells are in reach.	31 October 2013	Senior Nurse, Quality Improvement	Green	**Action complete (reported to Quality Board in October 2013)** Comfort round form amended.
	Check call bells are accessible as part of CQC mock inspection.	12 September 2013	Lead for Quality Assurance	Green	**Action complete (reported to Quality Board in October 2013)**
	Plan a dignity day. Also consider showing a privacy and dignity DVD at induction / open staff meeting.	31 October 2013	Associate Director of Nursing, Quality and Patient Safety Matron	Green	**Action complete (reported to Quality Board in October 2013)** Use of Dignity DVD has been used with ward teams and played at the Senior Nurse Meeting. Dignity issues have been raised during Winter Ever Green week and a Pledges to Patients campaign launched. This has included cards of 5 key dignity pledges for staff and posters being distributed to all areas and staff groups.
	Review the work plan of the Privacy and Dignity Group to ensure it reflects findings from the CQC report	30 September 2013	Matron	Green	**Action complete (reported to Quality Board in October 2013)** Findings discussed at the Privacy and Dignity meeting on 18 September 2013. Work plan revised.

Author: Rob Eliot, Lead for Quality Assurance

Action Plan from the CQC unannounced inspection of the RUH (June 2013)

Supervision / Monitoring of patients

The following issues were raised under outcomes 1 and 16.

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)*
• Monitoring of patient care including challenging poor care: Ward sisters should be supernumerary but this was not always possible meaning it was difficult for qualified staff to know about (supervise) care delivered by unqualified staff • Nurse in charge was unable to tell the CQC about patients where they were not undertaking clinical work on other parts of the ward. The only information available to them was in shift handover notes • Regular supervision did not take place	Message to staff about safety briefings to increase their awareness / understanding	31 October 2013	Senior Nurse, Quality Improvement	Green	**Action complete (reported to Quality Board in November 2013)** The wards already undertake safety briefings. An explanation of safety briefings has been included in the overview of nursing documentation standards and this was disseminated by the Assistant Directors of Nursing week commencing 28 October 2013.
	Nursing Workforce Planning Group to lead the work on the supervisory ward sister role pilot	31 October 2013	Assistant Director of Nursing – Workforce Development Assistant Director of Nursing – Surgery	Green	**Action complete (reported to Quality Board in November 2013)** Funding released for October 2013 for ward sisters to be supervisory.
	Revised Job Description being developed for Ward Senior Sisters and Charge Nurses clearly stating their responsibility and accountability for standards of nursing care and leading on quality improvement.	30 November 2013	Associate Director Nursing, Quality and Patient Safety	Green	**NEW ACTION (added 25 October 2013)** Success measures (Key Performance Indicators) identified from the Ward level scorecard will form part of this Job Description outlining expectations of role and enabling performance to be measured.
	Development of ward scorecards which will help to measure the difference in relation to improvements with patient care when ward managers have additional supervisory time	9 December 2013	Business Analyst Associate Director of Nursing, Quality and Patient Safety	Green	The ward scorecard is being developed; to be presented to Management Board on 20th November. A testing, implementation and training plan will then be put in place with system roll out to be launched in December 2013..

Author: Rob Eliot, Lead for Quality Assurance
Version 13
Date: 4 November 2013

Action Plan from the CQC unannounced inspection of the RUH (June 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)*
	Matrons and Assistant Director of Nursing will closely monitor ward level scorecards. Matrons will meet with Senior Sisters/Charge Nurses monthly to identify issues and where improvements need to be made and this will form part of their 'Ward to Board' quarterly reports.	31 January 2014	Associate Director Nursing, Quality and Patient Safety	Green	**NEW ACTION (added 25 October 2013)**
	Quality indicators from the ward scorecard will be monitored and discussed at the Trust's Senior Nurses Forum chaired by the Director of Nursing.	31 January 2014	Director of Nursing	Green	**NEW ACTION (added 25 October 2013)**
	Senior Nurse unannounced visits (out of hours) to take place on all wards as a minimum quarterly	30 November 2013	Director of Nursing	Green	**NEW ACTION (added 25 October 2013)** Issues of concern and poor performance will be discussed promptly and directly with the Director of Nursing.

Action Plan from the CQC unannounced inspection of the RUH (June 2013)

Documentation

The following issues were raised under outcomes 4 and 21.

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)*
Overall: Shortfalls in assessment, care planning and delivery of care in the areas of nutrition and hydration, pain management and pressure area care: • The electronic record keeping system was not used on a shift by shift basis • Nursing staff did not write in the multidisciplinary records every day	Highlight issues of poor documentation at senior sisters, matrons, Assistant Directors of Nurse's meeting – 5th September 2013	5 September 2013	Director of Nursing Associate Director of Nursing, Quality and Patient Safety Senior Nurse, Quality Improvement	Green	**Action complete (reported to Quality Board in October 2013)** Staff were reminded of their renewed commitment for completion and monitoring of records in their areas. Assurance received from ward teams that they are reconfirming documentation requirements with ward staff. Further meeting held with senior nurses on 17 October 2013.
	Hold hourly briefing sessions for a senior sister responsible for each ward regarding the use of Millennium for recording patient assessments and as a management tool for overseeing compliance with key assessments	15 November 2013	Senior Nurse, Quality Improvement	Green	**NEW ACTION (added 23 October 2013)** Planned visits underway – visits due to be completed by week ending 22nd November 2013
	Provide information to staff on how they can access Millennium	16 September 2013	Senior Nurse, Quality Improvement Associate Director of Nursing, Quality and Patient Safety	Green	**Action complete (reported to Quality Board in October 2013)** Information on accessing Millennium has been refreshed and distributed to the wards.
	Completion of key documentation, MUST, nutrition support record (includes food chart), fluid balance charts, hydration charts and comfort rounds to be monitored through ward documentation audits (weekly)	10 September 2013 (ongoing)	Lead for Quality Assurance	Green	**Action complete (reported to Quality Board in October 2013)** Revised documentation audits commenced 10 September 2013. Trust audit results are reviewed at every CQC Steering Group and forums of senior nursing staff with the Director of Nursing and matrons' meetings. Peer audits to commence week commencing 4 November 2013.

Action Plan from the CQC unannounced inspection of the RUH (June 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)*
	Nursing shift summary guidance and philosophy to be developed to include a list of key information to be recorded on the multidisciplinary / evaluation sheets	30 September 2013	Ward Sister Midford Ward Ward Sister, Helena Ward Senior Nurse, Quality Improvement	Green	**Action complete (reported to Quality Board in October 2013)** Guidance has been produced and tested on the Older People's Unit wards.
Nutrition: • Nutritional (electronic) risk assessments not always completely in a timely manner (at least monthly). Weight was not consistently recorded and this could delay completion of the risk assessment • Patients requiring assistance did not always have a record that they had difficulty drinking / eating and a plan of care about how they would be supported to drink or eat • Food charts: Not completed for all meals	Agree work plan and membership of the Nutrition and Hydration Steering Group. This will include a review of training (including MUST) and standards / performance data around nutritional assessments and meal times. Meal time observations to also be carried out.	20 October 2013 **Revised date: 18th November 2013**	Associate Director of Nursing, Quality and Patient Safety Matron	Green	Issues raised at the CQC inspection were discussed at the Nutrition and Hydration Steering Group in October 2013. The Nutrition Group work plan has been revised to reflect the priorities. Link workers for all ward areas have been identified and are working with the steering group to progress the work programme
	Nutrition week / fundamentals of care week to be arranged	30 November 2013	Associate Director of Nursing, Quality and Patient Safety	Green	Celebrating the 6 C's Event to be held on 12th November 2013 as a world café style event to re-launch mealtime standards and provide key messages about all aspects of nutrition to many groups of staff.
	Monitor compliance with the Nutrition Support Record through the Nutrition and Hydration Steering Group	20 October 2013 **Revised date: 18th November 2013**	Matron	Amber	This has been included in the revised work plan of the Nutrition and Hydration Steering Group.
Hydration: • Fluid balance charts were not completed fully including the patient's total fluid intake and output or there was inaccurate fluid intake recorded (e.g. 'sips' written as a measure of intake)	Refinement to fluid balance chart (last updated 2008) and hydration chart to add in guidance about its use	26 September 2013	Senior Nurse, Quality Improvement Nurse Consultant	Green	**Action complete (reported to Quality Board in October 2013)** The fluid balance charts and hydration charts have both been revised and agreed. New forms are available and will replace the old forms week commencing 4 November 2013.

Action Plan from the CQC unannounced inspection of the RUH (June 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)*
• Fluid charts did not have entries recorded for intravenous fluids that were administered • Hydration charts not completed fully including totalling the amount of fluids drunk • Staff were not aware of their own compliance rates for completion of fluid balance and hydration charts for audits that were undertaken	Compliance with ensuring every patient has a fluid or hydration chart and comfort round forms to be monitored by Senior Nurse for Quality Improvement on a **2 weekly basis** (to be agreed at Steering Group)	26 September 2013	Senior Nurse, Quality Improvement	Green	**Action complete (reported to Quality Board in October 2013)** The first set of results were presented at the CQC Steering Group on 26 September 2013.
	Method for reporting of audit results to be agreed. It is proposed that audit findings are presented at the CQC Steering Group and on the ward scorecards	26 September 2013	Lead for Quality Assurance	Green	**Action complete (reported to Quality Board in October 2013)** Trust audit results are reviewed at every CQC Steering Group and at forums of senior nursing staff with the Director of Nursing and matrons' meetings. The Assistant Directors of Nursing are e-mailed audit results on a fortnightly basis, to disseminate to the matrons and ward sisters, with a summary of key findings, areas for improvements.
Pressure Ulcer Care: • Comfort and Pressure Care Records not completed daily including the re-positioning record • Care plans not in place for patients at risk of pressure ulceration	Care plan to be developed for patients at risk of pressure ulceration.	31 October 2013	Clinical Nurse Specialist Senior Nurse, Quality Improvement	Green	A nutritional needs leaflet for patients with pressure ulcers has been developed and with a revised care plan will be launched week commencing 4 November 2013.
Pain Management: • Pain management care plan not in place	Pain management care plan to be reviewed and revised. Guidance will also be reviewed to support its use	31 October 2013	Senior Nurses, Quality Improvement Charge Nurse, Acute Pain Service	Amber	Revised care plan developed and implementation being drawn up
Documentation processes and standardisation: • The main nursing handover took place using handover sheets (with limited space). There was a delay in the electronic recording system being up to date because it was updated by adding the information from the	Produce a high level overview of nursing documentation requirements, including timescales for assessments	31 October 2013	Senior Nurse, Quality Improvement	Green	**Action complete (reported to Quality Board in November 2013)** Overview of nursing documentation developed. This was disseminated to the matrons by the Assistant Directors of Nursing week commencing 28th October 2013

Action Plan from the CQC unannounced inspection of the RUH (June 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)*
handover sheet only once a day, by the night staff • Four information recording systems (electronic record keeping, handover sheets, patient notes and white boards). Staff did not use these systems equally and chose the system they found the quickest. This meant information was not always up to date and increased the risk of inaccuracies • Staff did not always have access to the electronic recording system as it was often in use by other staff	Standardise content for nursing folders and storage of documentation on all wards	30 November 2013	Senior Nurse, Quality Improvement	Green	Files to be launched Trust-wide week commencing 4 November 2013. This will include a standardised index of documentation (
	Obtain funding for new bed boards on all wards that highlight key patient requirements, e.g. hydration, fluid balance charts, assist to eat, pressure ulcer prevention, falls etc	30 November 2013	Senior Nurse, Quality Improvement	Green	New bed boards purchased and being installed across wards in week commencing 4 November 2013 with roll out plan.
	Ensure that staff are aware of requirements for ensuring that all relevant patient information from handover sheets and white boards are recorded within the patient record (Millennium / patient notes)	30 September 2013	Associate Director of Nursing, Quality and Patient Safety	Green	**Action complete (reported to Quality Board in October 2013)** Routine checks to be carried out by the wards and matrons to ensure relevant information is recorded in the patient record.

Action Plan from the CQC unannounced inspection of the RUH (June 2013)

Discharge Planning

The following issues were raised under outcomes 6 and 21.

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)*
Discharge plans (checklist) not consistently completed and where in place this was often only completed on the day of discharge. There were references to medical fitness for discharge but this approach was not used consistently (differences between doctors on duty and individual wards) *These issues were also raised under Outcome 21: Records*	Discharge checklist to be audited as part of weekly ward documentation audits	10 September 2013 (ongoing)	Lead for Quality Assurance	Green	**Action complete (reported to Quality Board in October 2013)** Revised documentation audits commenced 10 September 2013 and presented at fortnightly CQC Steering Group meetings and forums with Senior nurses and ward sisters with Director of Nursing Improved completion of the discharge checklist was noted at the CQC Steering Group on 25 October 2013.
Information from white boards (including medical fitness for discharge and relevant assessments by therapists) were not documented in all the patients' notes	Investigate recording of discharge plans on Millennium	30 September 2013	Senior Nurse, Quality Improvement Associate Director of Nursing, Quality and Patient Safety	Green	**Action complete (reported to Quality Board in October 2013)** A message was sent to all ward managers and matrons by the Associate Director of Nursing, Quality and Patient Safety detailing the requirements that all relevant patient information from handover sheets and white boards are recorded within the patient record.
Information about people's mental cognition or mobility was mostly "one word", e.g. dementia was often recorded. There was no more detailed information about the nature, impact or support needed	Raise with Clinical Lead for Older People & Dementia Strategy Group and strengthen understanding through the fundamentals of care awareness week	30 November 2013	Associate Director of Nursing, Quality and Patient Safety	Green	Celebrating the 6C's - fundamentals of care day to take place on 12 November 2013 as a world café style event. This will include Privacy & Dignity, Pressure Ulcers, Nutrition & Hydration and Safeguarding.

Action Plan from the CQC unannounced inspection of the RUH (June 2013)

Mental Health: Emergency Department

The following issues were raised under outcome 1.

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)*
Emergency Department (ED): Delays in the assessment of people's mental health needs	Meet with the Director of Nursing of Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) to discuss the issues raised in the CQC report	31 October 2013	Director of Nursing Associate Director of Nursing, Quality and Patient Safety	Amber	Meeting arranged with the Director of Nursing for AWP on 7 November 2013.
	Escalate to the Commissioning College the level of service provision commissioned in relation to Mental health service provision to the RUH Trust	31 October 2013	Head of Business Development	Green	Completed. Discussions held with Commissioners, further meetings to be held.
	Work with AWP to develop 7 day Mental Health Liaison services supporting adults of working age and older adults.	30 November 2013	Specialty Manager Liaison Team leader – AWP	Green	**NEW ACTION (added 25 October 2013)** Additional mental health liaison services funded as part of RUH Dementia Challenge bid. Recruitment in progress.
	Pilot extension to Mental health liaison services to 8am-8pm and additional resource to support Intensive services overnight.	1 November 2013	Specialty Manager Liaison Team leader – AWP	Amber	**NEW ACTION (added 25 October 2013)** Winter funding money agreed to extend liaison hours 7 days a week to 8am – 8pm. Intensive team to recruit an additional resource focused directly on RUH ED overnight. Recruitment in progress
	Information for patients who wait in the RUH ED greater than 4 hours to be shared with AWP for joint pathway analysis.	4 November 2013	Specialty Manager Liaison Team leader – AWP)	Amber	**NEW ACTION (added 25 October 2013)**
	Internal Mental Health Forum for departments and wards to discuss Mental Health process and raise issues	18 September 2013	Specialty Manager	Green	**NEW ACTION (added 25 October 2013)** **Action complete** Meetings started. First meeting held on 18 September 2013. Meetings to be held quarterly.
	Develop Standard Operating Procedures (SOP) with AWP	31 October 2013 **Revised date of 30 November 2013**	Specialty Manager	Amber	Standard Operating procedures drafted and to be finalised following meeting with AWP Director of Nursing on 7th November 2013

Action Plan from the CQC unannounced inspection of the RUH (June 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)*
	Following development of the Standard Operating Procedures, produce a gap analysis and develop a new service model to take to the commissioners for review and potential funding	31 October 2013	Specialty Manager	Red	

Action Plan from the CQC unannounced inspection of the RUH (June 2013)

Mental Health: DoLS and Assistive Technology

The following issues were raised under outcome 7.

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)*
Issues related to the use of 'Assistive Technology': • Documentation to support the use of electronic tagging devices was incomplete. The checklist for the 'Risk Assessment and Care Plan – Patients at risk of leaving the ward unattended' had not been used correctly. The section on potential and available options for the choice of the least restrictive measure for restraint was not completed. In one instance this care plan was completed 4 days after the tag was applied • Capacity assessments not carried out. Checklists for carrying out mental capacity assessments and making best interest decisions (referenced in the RUH policy) were not completed. Staff relied on agreement of patients' relatives for the use of 'tags' instead of carrying out the process for best interest decision making • Staff were not aware of the policy for the use of electronic tags (draft policy) • Adequate consideration was not given to alternative interventions, other than tagging • The ward log for the use of tags was inconsistently completed with no entries after March 2013. The register did not always identify when tags were removed, even on discharge • The risk assessment action plan summary regarding 'the assessment relating to wandering / absconsions older people's unit' was last reviewed on 21 January 2010 and Trust policy for the use of electronic tagging	Draft policy on the use of 'Assistive Technology' to be ratified taking into account comments from the CQC report including the requirement to clearly document best interest decision making and consideration of safety without restraint	31 October 2013	Matron	Green	**Action complete (reported to Quality Board in November 2013)** The policy has been reviewed and is called the 'Safe Wandering Technology Policy'.
	Inform Clinical Site Manager of all patients where 'Safe Wandering Technology' used	9 September 2013	Matron Older Persons Unit (OPU) Consultant and Clinical Lead OPU Consultant	Green	**Action complete (reported to Quality Board in October 2013)** The Trust Clinical Site Team is routinely informed of any patients where 'Assistive Technology' is being used.
	Develop an information leaflet for families on 'Safe Wandering Technology'	31 October 2013	Senior Nurse for Quality Improvement & Adults at Risk	Green	**Action complete (reported to Quality Board in November 2013)** Information leaflet available on the RUH Intranet.
	Include information on 'Safe Wandering Technology' in the local induction for OPU	31 October 2013	Matron	Green	**Action complete (reported to Quality Board in November 2013)**
	Commence routine checking of paperwork for patients where 'Safe Wandering Technology' has been used. A column will be added to the ward log to record if the paperwork has been checked	31 October 2013	Matron	Green	**Action complete (reported to Quality Board in November 2013)** Paperwork updated and in place; log and documentation being routinely checked by matron and Assistant Director of Nursing (Medicine)
	Investigate whether it is possible for a nominated individual to carry the alert system for 'Safe Wandering Technology' rather than using the current loudspeaker system on the ward	31 October 2013	Matron	Amber	Awaiting new pager system installation Trust-wide to test new system can work with the wandering technology so that an alarm will sound carrying information as to which door a patient is nearing.

Action Plan from the CQC unannounced inspection of the RUH (June 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)*
devices was not followed	Increase staff awareness of Deprivation of Liberty Safeguards (DoLs) & Mental Capacity Act (MCA): • Extend the Adults Safeguarding refresher training to all clinical staff • Provide further enhanced DoLS training for senior nurses and OPU consultants • Rolling programme of ward visits, for brief interventions about MCA & DoLS	30 November 2013	Senior Nurse for Quality Improvement & Adults at Risk Senior Nurse, Adult Safeguarding Sister in Quality Improvement for Learning Disabilities and Mental Health	Green	**NEW ACTION (added 23 October 2013)** Refresher training has been opened up to all clinical staff. Enhanced training to be commenced November 2013 and key staff identified to attend. First date booked for 6 November 2013. Rolling programme is being carried out during handover time. This is commencing 28 October 2013. The Clinical Reference Group meetings in November will be dedicated to a café style approach with medical staff and include information about DoLS and MCA.

Action Plan from the CQC unannounced inspection of the RUH (June 2013)

Governance

The following issues were raised under outcome 16.

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)*
Divisional Clinical Governance Meeting: No minuted discussion in regards to a number of agenda items (e.g. the review of red incidents, external regulatory issues; business from corporate leads for clinical governance; issues for operational governance committee; and finalise action plan/risk for management board)	Develop a formal template for governance meetings.	30 November 2013	Assistant Director of Nursing – Medicine Assistant Director of Nursing – Surgery	Green	Template agreed. Rolled out at a specialty, ward and departmental level from 28 October 2013 by the Heads of Divisions.
Matrons meetings did not contain information on clinical incidents or lessons learnt (e.g. low fluid intake or dietary intake)	Review agenda to ensure lessons learnt and clinical incidents are a standing agenda item	2 September 2013	Director of Nursing	Green	**Action complete (reported to Quality Board in November 2013)**
On some wards regular governance meetings did not take place and were not minuted	Ward Governance meetings to be minuted. Matrons to agree with ward sisters	30 November 2013	Assistant Director of Nursing – Medicine Assistant Director of Nursing – Surgery	Green	**Action complete (reported to Quality Board in November 2013)**
Staff on some wards were aware of new documentation but not the action plan or compliance actions from the last inspection	The full action plan will be distributed to all wards following receipt of the final CQC inspection report and also published on the RUH Intranet	31 October 2013	Director of Nursing Lead for Quality Assurance	Green	**Action complete (reported to Quality Board in November 2013)**

Action Plan from the CQC unannounced inspection of the RUH (June 2013)

How are you going to ensure that improvements have been made? What measures are going to be put in place and who will do it?
Progress in completing this action plan will be monitored at the Trust's CQC Steering Group and reported to Quality Board on a monthly basis. This will also be reported to Trust Board through the monthly Quality Report.
Describe the resources needed to implement the changes and whether or not they are in place:
Funding to be agreed for documentation folders and bed boards for all wards
Provide an appropriate date by which the improvements will be made:
See action plan timescales
Describe the impact the improvements will have on people who use the service:
Improved outcomes and experience for service users
How we will monitor to check that the action plan is working?
Through audit work and mock inspections. The Matrons will also carry out unannounced visits out of hours, commencing November 2013, to check that nursing standards are being met and findings fed back to the Director of Nursing. Success measures (Key Performance Indicators) identified from the Ward level scorecard will form part of the job description for ward senior sisters and charge nurses, outlining expectations of the role and enabling performance to be measured. The Matrons and Assistant Director of Nursing will closely monitor ward level scorecards. Matrons will meet with Senior Sisters/Charge Nurses monthly to identify issues and where improvements need to be made and this will form part of their 'Ward to Board' quarterly reports and will also be monitored and discussed at the Trust's Senior Nurses Forum chaired by the Director of Nursing.

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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