Care Quality Commission / Chief Inspector of Hospitals Visit Action Plan	Date Created	12.09.2014

Plan Owner :	Chief Executive, Chief Executive	**Date last updated :** **(and version no)**	V2.9 01.12.14
Core implementation Group :	Executive Directors' Group	**Next review due by - Group / Committee : Date :**	**By Executive Directors' Group on 03.12.2014**

Links to key documents – Care Quality Commission Quality Report for North Devon District Hospital 11Sept14

Link to Corporate Risk Register Risk ID 3139	**Initial Risk Score CxL = 5x4**	**Target Risk Score CxL = 1x3**

Driver Specific Issue / gap / objective requiring action	Monitoring/ Measurable How we know we have succeeded	Ref	Actions Specific, Achievable Stated clearly, communicated widely	Resource demand / constraints	Action owners (Operational / Executive)	Time-Frame To Achieve Timebound	Status
				Realistic			
COMPLIANCE ACTIONS FOR REGULATED ACTIVITY							
Maternity and family planning: Termination of pregnancies The provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of an accurate record regarding each service user. This shall include appropriate information and documents relating to the care and	Guidance for completion of HSA1 and HSA4 documents will be operational and available to all relevant staff.	1.0	Develop guidance for the completion of HSA1 and HSA4 documentation, based on national guidance	None	Clinical Lead, Obstetrics & Gynaecology / Medical Director	30.11.2014	G

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				Realistic			
treatment provided to each service user. Regulation 20 (1)(a), the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – records. Completion of HSA1 and HSA4 were not consistent and there was no guidance, or an identified system in place to ensure records were completed accurately and consistently and, where required, sent to the Department of Health	Audit will demonstrate that 100% of HSA1 and HSA4 documents are completed accurately and consistently, in line with Trust and national and legal guidance.	1.1a	Develop an audit programme to monitor and measure compliance with the completion of HSA1 and HSA4 documentation, including sending of documentation to the DH	None	Clinical Lead, Obstetrics & Gynaecology / Medical Director	31.12.2014	
		1.1b	Utilise expert advice agreed with Royal Devon & Exeter Trust (Nigel Lawrence) to (a) inform implementation of revised procedures and (b) provide external verification of compliance. This will include visits to RDE by NDDH staff and visits by RDE staff to North Devon District Hospital.		Clinical Lead, Obstetrics & Gynaecology / Medical Director	31.12.2014 Complete	G
End of life care Treatment of disease, disorder or injury The registered person did not have suitable arrangements in place to ensure that service	An improvement plan will	2.0	Take expert advice from a CQC expert advisor in relation to TEP and resuscitation decision-making. Specifically • How do the CQC view TEP as an end of life decision making tool and where	CQC (Mary Cridge, Lead Inspector) arranging availability of expert advisor.	Associate Director for Patient Safety / Director of Nursing	31.12.2014	

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				Realistic			
users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information by means of, an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided. • End of life decisions were made without documentation of, or discussion with, patients • The Trust's guidance on the use of TEPs was unclear in relation to responsibilities • TEPs that included 'do not attempt resuscitation'	be developed		does this sit with the consent process • What is the expectation in terms of timeliness of completion and the inclusion of relatives and/or carers. Following these discussions, an improvement plan will be developed.				
	A handover process will be in place to ensure that nursing staff are always aware of resuscitation decisions	2.1	Develop a process of handover between medical and nursing staff to ensure that nursing staff receive accurate information in relation to resuscitation decisions	None	Head of Quality and Safety / Director of Nursing	31.12.2014	
		2.2	Ensure information in relation to end of life decisions / resuscitation is included in nursing safety briefings and handover	None	Head of Quality and Safety / Director of Nursing	01.01.2015	

Driver Specific Issue / gap / objective requiring action	Monitoring/ Measurable How we know we have succeeded	Ref	Actions Specific, Achievable Stated clearly, communicated widely	Resource demand / constraints	Action owners (Operational / Executive)	Time-Frame To Achieve Timebound	Status
				Realistic			
decisions were not consistently being completed appropriately • Mental capacity assessments were not consistently undertaken where capacity had been identified as an issue Decisions about resuscitation were not consistently communicated to nursing staff		2.3	The above actions will be developed to include a Trust-wide review and implementation of an improvement plan of handover processes and procedures at each interface of care, including transfers from • Ward to ward • Acute to community inpatient settings • Acute to community nursing teams • Community inpatients to community nursing teams	None	Head of Quality and Safety / Director of Nursing / Medical Director	30.06.2015	
Surgery Surgical procedures Treatment of disease, disorder or injury The provider did not take proper steps to ensure that each	Clear policies and procedures will be operational and available to staff in relation to transfers and admission of outliers to wards. This relates to both medical and surgical outliers.	3.0a	Continue to action bed reconfiguration, which will improve the ability to place patients in the right ward	None	Head of Quality and Safety, Clinical Director of Medicine and Divisional General Manager, Medicine & Paediatrics / Director of Nursing/ Medical Director	31.12.2014	

Driver Specific Issue / gap / objective requiring action	Monitoring/ Measurable How we know we have succeeded	Ref	Actions Specific, Achievable Stated clearly, communicated widely	Resource demand / constraints	Action owners (Operational / Executive)	Time-Frame To Achieve Timebound	Status
				Realistic			
service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe by the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service users individual needs. • The policies and procedures for patients not being admitted to the most appropriate ward area (outliers) were not consistent or supportive of patients and staff at all times • There is no hospital		3.0b	Develop policies and procedures that support staff in the process of safe selection and transfer of outlying patients.		Head of Quality and Safety, Clinical Director of Medicine and Divisional General Manager, Medicine & Paediatrics / Director of Nursing/ Medical Director	31.12.2014	
		3.0c	These policies will include criteria relating to the most appropriate patients to outlie, and those patients who must remain in areas most appropriate for their care		Head of Quality and Safety, Clinical Director of Medicine and Divisional General Manager, Medicine & Paediatrics / Director of Nursing/ Medical Director	31.12.2014	

Driver Specific Issue / gap / objective requiring action	Monitoring/ Measurable How we know we have succeeded	Ref	Actions Specific, Achievable Stated clearly, communicated widely	Resource demand / constraints	Action owners (Operational / Executive)	Time-Frame To Achieve Timebound	Status
				Realistic			
wide protocol for the safe handover of patients to other wards and how an when this should, or should not, be done	A hospital wide protocol for the safe handover of patients will be operational and available to all staff	3.1	Develop a protocol of the safe handover of patients between wards, including new documentation where appropriate	None	Head of Quality and Safety / Director of Nursing	31.12.2014	
		3.2	The above actions will be developed to include a Trust-wide review and implementation of an improvement plan of handover processes and procedures at each interface of care, including transfers from • Ward to ward • Acute to community inpatient settings • Acute to community nursing teams • Community inpatients to community nursing teams	None	Head of Quality and Safety / Director of Nursing / Medical Director	30.06.2015	

Maternity and family planning Diagnostic screening procedures Treatment of disease, disorder or injury The registered person did not ensure that service users and others had access to premises where a regulated activity was carried out, which were protected against the risks associated with unsafe or unsuitable premises by means of suitable design and layout. • Rooms in which antenatal sonographers carried out their work were not sufficient in size. They did not have curtains or screens	Privacy and dignity of service users will be maintained at all times in sonography rooms	4.0	Review sonography facilities and fit privacy curtains in each room	None	Divisional General Manager, Surgery / Director of Facilities	31.12.2014 Complete	**G**
		4.1	Review physical layout of the two sonography rooms	Capital estimate - £50,000	Divisional General Manager, Surgery / Director of Facilities	28.02.2015	
		4.2	Fit an emergency call bell system in all sonography rooms	None	Head of Midwifery / Director of Facilities	31.12.2014	**G**

to maintain privacy or dignity without the practitioner having to leave the room • There is not system in the rooms for calling for help in emergency situations		4.3	Develop and agree a business case for the refurbishment of the antenatal clinic	Capital cost	Head of Midwifery / Director of Facilities	31.03.2015	
Trust-wide Treatment of disease, disorder or injury The registered person did not ensure that effective operation of systems, designed to assess the risk of, and to prevent, detect and control the spread of, healthcare-associated infection. • Not all staff, in all areas, followed the hospital's 'bare below the elbows' policy.	All staff in all areas will be observed to be compliant	5.0	Communication to be sent Trust-wide advising them of the need to comply, whenever they are in a clinical area, to be 'bare below the elbows' in line with Trust policy	None	Consultant Medical Microbiologist & Director of Infection Prevention & Control / Director of Nursing	31.07.2014	**G**
		5.1a	Conduct random infection control audits to assess compliance with • 'Bare below the elbows'	None	Assistant Director of Nursing (Community) and Interim Assistant Director of Nursing (Acute) / Director of Nursing	31.12.2014	
		5.2a	Conduct random infection control audits to assess compliance with • General environmental cleanliness (including commodes)		Assistant Director of Nursing (Community) and Interim Assistant Director of Nursing (Acute) / Director of Nursing	31.12.2014	

		5.2b	Implement a hand held solution for audits for environmental cleanliness to aid PLACE, Matrons' Walkrounds and Patient Safety Visits	None	Assistant Director of Nursing (Community) and Interim Assistant Director of Nursing (Acute) / Director of Nursing	31.12.2014	
Trust wide Evaluate and improve the effectiveness of the current patient flow and escalation policies. Action must be taken to improve the flow of patients from Accident and Emergency department and across the trust.	Patient flow will be improved and patients will be transferred to the most appropriate ward in a timely manner	6.0a	Workstreams: • Earlier discharge (incorporating overnight transfers)		Divisional General Manager, Medicine & Paediatrics / Director of Operations	31.12.2014	
		6.0b	• Implementation of Ambulatory Care and improved processes on the MAU		Divisional General Manager, Medicine & Paediatrics / Director of Operations	31.01.2015	
		6.0c	• Evaluation, development and roll out of Discharge Co-ordinator role and enhanced recovery in Medicine		Divisional General Manager, Medicine & Paediatrics / Director of Operations	31.03.2015	
		6.0d	• Improve the process for managing medical/surgical expected patients		Divisional General Manager, Medicine & Paediatrics / Director of Operations	31.01.2015	
		6.0e	• 7 day working relevant to patient flow (e.g. weekend ward rounds)		Divisional General Manager, Medicine & Paediatrics / Director of Operations	31.03.2015	

Accident and Emergency Treatment of disease, disorder or injury The registered person did not ensure that effective operation of systems, designed to assess the risk of, and to prevent, detect and control the spread of, healthcare-associated infection. • The availability of hand washing facilities in the major treatment area of A&E was limited • Within A&E, alcohol gel was available for hand cleaning in patient bays, but there was only one dispenser for the rest of the treatment area	Sufficient hand washing facilities will be available in the department	7.0	Six additional hand washing basins will be fitted within patient cubicles.	None – but the work is subject of access in line with the busy day to day activity within the department	Divisional General Manager, Emergency Services, Logistics and Resilience / Director of Facilities	31.10.2014	
	There will be sufficient supplies of alcohol gel in all appropriate treatment areas	7.1	Infection Prevention and Control Team will review availability of alcohol get in treatment areas of A&E	None	Lead Nurse, Infection Prevention & Control / Director of Nursing	30.09.2014	
	A comprehensive infection control audit will be completed in A&E	7.2	Infection Prevention and Control Team and Senior Nurse for Emergency Services will complete a comprehensive infection control audit, and develop an action plan which will be monitored via the Infection Prevention and Control Committee and the monthly divisional performance meeting	None	Lead Nurse, Infection Prevention & Control & Senior Nurse, Emergency Care / Director of Nursing	31.10.2014	

• There had been no comprehensive infection control audits carried out in A&E in the last six months • There were no sluice facilities for non-disposable bedpans in A&E • There was no separate room in A&E for clinical waste, domestic waste or recycling	Sluice facilities in A&E will be fit for purpose and compliant with national guidance	7.3	A review of the provision of sluice facilities in A&E will be undertaken and actions agreed to ensure they are suitable for the department. This will include the agreement of standard bed pan usage **Note –** Non disposable bedpans are not used in this area, therefore this action is not required.	None	Divisional General Manager, Emergency Services, Logistics and Resilience / Director of Facilities	31.12.2014	
	A&E will have suitable waste storage facilities	7.4	A review of waste storage facilities in A&E will be undertaken, and actions agree to ensure that they are suitable for the department` This facility has recently been removed and will now be replaced with a programme, completing by the end of December.	None	Deputy director of Facilities / Director of Facilities	31.12.2014	

ACTIONS THE TRUST SHOULD TAKE TO IMPROVE

TRUST WIDE							
Safety Thermometer Ensure that the Safety Thermometer data be improved to address	The Safety Thermometer data reported will be accurate and reflect the percentage of patient	8.0a	Undertake quarterly cross audits to understand the accuracy of reporting of patient harm using the Safety Thermometer	None	Head of Quality and Safety / Director of Nursing	31.12.2014	

the degree of patient harms from pressure ulcers and infections	harm on the day of data collection	8.0b	Where required, ensure any trends or themes are included in relevant ward, divisional or Trust level action plans	None	Head of Quality and Safety / Director of Nursing	31.12.2014	
Documentation / assessments and care plans Ensure that the documentation audits of patient assessments and care plans are improved to address the degree of patient harms from pressure ulcers and infections	Documentation audits will demonstrate an incremental improvement in the completion of patient assessments and care plans, and by 31.07.2015 will demonstrate 95% compliance	9.0a	Review the work plan of Documentation Review Action and Finish Group to ensure it includes the measurable target of 95% compliance by 31.07.2015	None	Head of Quality and Safety / Director of Nursing	30.11.2014	
		9.0b	Revise and pilot the current audit tool to ensure it captures qualitative, as well as quantitative data.	None	Head of Quality and Safety / Director of Nursing	31.12.2014	
		9.0c	Once implemented, audit results and action plans (as developed by the DRAF Group) will be monitored via the Patient Safety Operational Group	None	Head of Quality and Safety / Director of Nursing	31.03.2015	
Pain management Ensure the implementation of pain assessments.	All patients (including end of life patients) and all patients placed on comfort rounding, will have pain assessments in place	10.1a	Review the current pain assessment tool to ensure it is fit for purpose, and revise if appropriate	None	Senior Nurse, Surgery and Senior Nurse, Medicine / Director of Nursing	31.10.2014	
		10.1b	All wards will ensure they have pain assessment tools available and in use	None	Senior Nurse, Surgery / Senior Nurse, Emergency Care / Senior Nurse, Critical Care / Delivery Suite Manager / Senior Nurse, Medicine /	30.11.2014	

					Director of Nursing		
		10.1c	Audit compliance with use of the pain assessment tool and develop an action plan where appropriate. This will be a quarterly audit; results and an action plan will be presented to the Senior Nurse Forum, Patient Safety Operational Group and Safer Care Delivery Committee	None	Senior Nurse, Surgery / Senior Nurse, Emergency Care / Senior Nurse, Critical Care / Delivery Suite Manager / Senior Nurse, Medicine / Director of Nursing	31.03.2015	
		10.2a	Revise comfort rounding tool to include a pain assessment and test using PDSA methodology	None	Interim Assistant Director of Nursing (Acute) & Head of Quality and Safety / Director of Nursing	30.10.2014	
		10.2b	Implement across the Trust		Interim Assistant Director of Nursing (Acute) & Head of Quality and Safety / Director of Nursing	30.10.2014	
		10.2c	Undertake a quarterly audit of compliance; results and an action plan will be presented to the Senior Nurse Forum, Patient Safety Operational Group and Safer Care Delivery Committee	None	Interim Assistant Director of Nursing (Acute) & Head of Quality and Safety / Director of Nursing	31.12.2014	
Governance In addition to the specific divisional actions detailed below,	Minutes and actions plans will be produced from clinical governance meetings, and minutes	11.0a	Put into place a process for minute taking at clinical governance meetings, ensuring a clear action grid is produced at the	Secretarial resource	Interim Divisional General Manager, Clinical Support Services/ Divisional General Manager,	31.12.2014	

all divisions in the Trust should take accountability for learning and improvement, with minutes and action plans produced from clinical governance meeting	will demonstrate learning		end of each meeting		Emergency Services, Logistics and Resilience / Divisional General Manager, Medicine & Paediatrics / Director of Specialist Services and Special Projects / Divisional General Manager, Surgery / Divisional General Manager, Community Hospitals / Assistant Director of Health and Social Care / Clinical Director for Medicine / Clinical Director for Surgery / Consultant Surgeon / Clinical Director for Community Services / Chief Executive		
		11.0b	Revise the clinical governance meeting agenda includes details of divisional themes of adverse incidents, serious event audits, complaints and PAL feedback and patient experience and details of serious incidents requiring investigation	None	Interim Divisional General Manager, Clinical Support Services/ Divisional General Manager, Emergency Services, Logistics and Resilience / Divisional General Manager, Medicine & Paediatrics / Director of Specialist Services and Special Projects / Divisional General Manager, Surgery / Divisional General	31.12.2014	

					Manager, Community Hospitals / Assistant Director of Health and Social Care / Clinical Director for Medicine / Clinical Director for Surgery / Consultant Surgeon /Clinical Director for Community Services / Chief Executive		
		11.0c	Ensure the chair of the meetings is aware of their accountability in ensuring individuals and teams are held to account for completing action points	None	Interim Divisional General Manager, Clinical Support Services/ Divisional General Manager, Emergency Services, Logistics and Resilience / Divisional General Manager, Medicine & Paediatrics / Director of Specialist Services and Special Projects / Divisional General Manager, Surgery / Divisional General Manager, Community Hospitals / Assistant Director of Health and Social Care / Clinical Director for Medicine / Clinical Director for Surgery / Consultant Surgeon /Clinical Director for Community Services / Chief	31.12.2014	

					Executive		

SURGERY							
Clinical Support Services The Trust should consider improvements to the facilities and environment in the anaesthetic rooms to address infection control risks	The anaesthetic rooms will be fit for purpose and reduce the risk of infections	12.0	Cupboards and worktops in the anaesthetic rooms will be reviewed and replaced where appropriate as part of the department's maintenance programme	None	Interim Divisional General Manager, Clinical Support Services / Director of Facilities	31.05.2015	
Consider how to improve the meeting and admission of patients into Day Surgery. On the day of the inspection, patients had arrived as requested for 07:30, but there were no staff on duty to meet them.	All patients will be asked to arrive at a time in the Day Surgery unit when staff are on duty and available to meet them and book them in.	13.0a	Review staff rotas to ensure that staff are on duty at the time of the patients' arrival	None	Theatres Manager / Director of Nursing	30.11.2014	
		13.0b	Review the time that patients are asked to arrive to ensure it is appropriate	None	Clinical Director for Surgery / Director of Operations	30.11.2014	
Surgical services should take accountability for learning and improvement, with	Minutes and actions plans will be produced from clinical governance meetings, and minutes will demonstrate learning	14.0a	Put into place a process for minute taking at clinical governance meetings, ensuring a clear action grid is produced at the end of each meeting	Secretarial resource	Divisional General Manager, Surgery & Clinical Director for Surgery / Chief Executive	31.12.2014	

minutes and action plans produced from clinical governance meeting		14.0b	Revise the clinical governance meeting agenda includes details of divisional themes of adverse incidents, serious event audits, complaints and PAL feedback and patient experience and details of serious incidents requiring investigation	None	Divisional General Manager, Surgery & Clinical Director for Surgery / Chief Executive	31.12.2014	
		14.0c	Ensure the chair of the meetings is aware of their accountability in ensuring individuals and teams are held to account for completing action points	None	Divisional General Manager, Surgery & Clinical Director for Surgery / Chief Executive	31.12.2014	

MATERNITY AND FAMILY PLANNING SERVICES							
Consider information provided through external reviews and work with medical teams to ensure they are engaged in processes designed to reduce caesarean section and induction rates.	CQUIN plans will clearly indicate where medical teams are involved in reducing caesarean section and induction rates Recommendations and actions will be shared at the appropriate group / committee	15.0a	Existing action plans to be completed ensuring that there is clear medical involvement	None	Clinical Lead, Obstetrics & Gynaecology / Medical Director	31.12.2014	
		15.0b	Medical staff will be asked to input in any future improvement plans or CQUIN proposals		Clinical Lead, Obstetrics & Gynaecology / Medical Director	31.12.2014	
		15.0c	Circulation of action plan to all medical and midwifery staff	None	Clinical Lead, Obstetrics & Gynaecology / Medical Director	31.12.2014	

ACCIDENT AND EMERGENCY							
Accident and Emergency Consider reviewing some areas of the environment, including in A&E with regard to the lack of visibility of patients in the waiting area	Patients in the waiting area of A&E will be more visible	16.0a	Remove the noticeboard at the end of the reception desk for full visibility from the reception area to the waiting room	None	Divisional General Manager, Emergency Services, Logistics and Resilience / Director of Facilities	31.07.2014	
		16.0b	Undertake a feasibility study into changing the current records storage room into a new triage room, to enable the triage nursing to be placed directly in the waiting area.	Alternative storage facilities / sufficiency of space for triage function.	Divisional General Manager, Emergency Services, Logistics and Resilience / Director of Facilities	31.01.2015	
There were poorly implemented early warning scores in A&E	All patients in A&E will have early warning scores calculated and recorded in line with the Patients at Risk of Deterioration (PAR) Policy	17.0a	Undertake a weekly audit of completion and recording of early warning scores and develop an improvement action plan; results and an action plan will be presented to the Patient Safety Operational Group and Prevention and Resuscitation Group	None	Senior Nurse, Emergency Care/ Resuscitation Service Manager / Director of Nursing	30.10.2014	
		17.0b	Continue with audit until 95% compliance complete; reduce to monthly and then quarterly audits	None	Senior Nurse, Emergency Care/ Director of Nursing	31.03.2015	
Consider the management of clinical assessments in the A&E department. There were long waits	All ambulatory patients will have a face to face assessment within 15 minutes of arrival, in line with national Royal	18.0	Undertake a process mapping exercise and review of resource within the department to understand where the ‘blocks’ in the system are. Develop an improvement plan	Current resource and funded establishme	Senior Nurse, Emergency Care /Consultant Emergency Medicine / Director of	31.03.2015	

for clinical assessments of ambulatory patients	College guidance		that will enable the department to move incrementally towards a target of patients receiving a face to face triage within 15 minutes of arrival	nt	Operations		
The flow of ambulance patients is disjointed and there is no monitoring of waiting patients	There will be a clear process for the management of receiving ambulance patients	19.0	Develop a protocol to ensure safe management of the receipt of ambulance patients, including a delegated nurse if appropriate	None	Senior Nurse, Emergency Care/Consultant Emergency Medicine / Divisional General Manager, Emergency Services, Logistics and Resilience / Director of Operations	31.03.2015	
A&E staff should be aware of clinical audits, and how their results compare with national standards	The department's annual audit plan will be shared with the medical staff in the department, including any national comparisons	20.0a	Share details of the departmental annual clinical audit plan, any audit outcomes (including national comparisons) with the medical staff in the department (via email, at regular staff meetings, etc.)	None	Consultant Emergency Medicine / Medical Director	30.11.2014	
		20.0b	Include the clinical audit programme, including an exception report, at the divisional monthly performance meeting	None	Head of Quality and Safety / Director of Nursing	30.11.2014	
The Trust should consider the deployment of senior	The A&E department will have visible senior medical and nursing	21.0a	Consultants will be involved in hand-over	None	Consultant Emergency Medicine / Medical Director	17.10.2014	

staff in the A&E department. At the time of the visit, there was a lack of visibility of senior medical and nursing staff, and nursing leadership was shared with other departments in the Trust	leadership	21.0b	The roles and responsibilities of the senior nurse for emergency medicine will be reviewed, in order to provide more visible leadership in the department	Ensuring appropriate nursing clinical leadership for the Clinical Site Management Team	Divisional General Manager, Emergency Services, Logistics and Resilience / Director of Nursing	17.10.2014	
Security staff should have suitable training in order to manage violence and aggressive behaviour in A&E	Security staff will be suitably trained to manage violence and aggression in A&E and across the acute site	22.0a	Through the work of the Restraint Group (a task and finish group), identify suitable training for security staff in order for them to be able to apply control and restraint techniques.	Cost of initial and ongoing training	Assistant Director of Nursing (Community)	31.03.2015	
		22.0b	Business case to Executive Directors in respect of resource required for security staff		Assistant Director of Nursing (Community)/ Director of Finance	30.11.2014	

CRITICAL CARE							
Critical Care The Trust should consider plans to improve the facilities and environment in the Intensive Care Unit, in order to achieve best practice standards	The Intensive Care Unit facilities will be reviewed and, if appropriate, an action / business plan developed to address the environment	23.0	Undertake a review of the environment and facilities in the Intensive Care Unit, and develop business and action plans, where appropriate to improve. Consider plans for improving the environment condition, particularly in relation to clutter and storage of equipment.	Limitations of current footprint and lack of opportunity to expand or relocate	Interim Divisional General Manager, Clinical Support Services/Director of Facilities	28.02.2015	

Review medicines storage security arrangements in the Intensive Care Unit to achieve best practice standards	Medicines storage in the Intensive Care Unit will be compliant with best practice standards	24.0	Review and update medicines storage facilities in the Unit to ensure medicines are secured and stored in locked cupboards where appropriate, and in line with the Medicines Policy.	None	Senior Nurse, Critical Care & Director of Pharmaceutical Services / Medical Director	31.12.2014	
The Trust should ensure there is a clear protocol for doctors to follow when caring for a deteriorating patient in the Intensive Care Unit	A protocol will be available and operational that supports staff when caring for a deteriorating patient	25.0	Review current policies and protocols and either (i) revise current protocols to ensure they are fit for purpose, or (ii) develop a new protocol that addresses the procedure for caring for a deteriorating patient	None	Lead Intensivist / Medical Director	01.01.2015	
Critical care services should take accountability for learning and improvement, with minutes and action plans produced from clinical governance meeting	Minutes and actions plans will be produced from clinical governance meetings, and minutes will demonstrate learning	26.0a	Put into place a process for minute taking at clinical governance meetings, ensuring a clear action grid is produced at the end of each meeting	None	Interim Divisional General Manager, Clinical Support Services/ Chief Executive	31.12.2014	
		26.0b	Revise the clinical governance meeting agenda includes details of divisional themes of adverse incidents, serious event audits, complaints and PALs feedback and patient experience and details of serious incidents requiring investigation	None	Interim Divisional General Manager, Clinical Support Services/ Chief Executive	31.12.2014	
		26.0c	Ensure the chair of the meetings is aware of their accountability in ensuring individuals and teams are held to account for completing	None	Interim Divisional General Manager, Clinical Support Services/ Chief	31.12.2014	

			action points		Executive		
Ensure that management of discharge of patients from the Intensive Care Unit is in line with national guidance	Local policies relating to discharge from the Intensive Care Unit will be reflect national guidance	27.0	Review local policies to ensure they are in line with national guidance and best practice	None	Senior Nurse, Critical Care & Lead Intensivist / Medical Director	31.12.2014	

SERVICES FOR CHILDREN AND YOUNG PEOPLE							
The Trust should also consider improving the environment if children's services, as the environment of the ward made it challenging to meet the differing needs of patients and parents, and to provide single – sex accommodation when required	The facilities and environment in Caroline Thorpe Ward will be reviewed and, if appropriate, an action / business plan developed to address the environment	28.0a	A review of the environment and facilities in Caroline Thorpe Ward will be undertaken and, where possible and practicable, facilities changed to provide same sex bays. The environment will also be reviewed to ensure that breast-feeding mothers are provided with privacy and the space to do this	Limitations of current footprint	Lead Nurse, Neonatal & Paediatric Services / Director of Facilities	31.12.2014	
		28.0b	Review opportunities for providing at least some parental overnight accommodation within the ward.	Limitations of current footprint	Lead Nurse, Neonatal & Paediatric Services / Director of Facilities	30.11.2014	
Consider the risks associated with the admission of young people requiring	An urgent assessment protocol will be agreed and operational	29.0a	Develop an urgent assessment protocol for young patients with mental health needs	None	Paediatric Consultant / Medical Director	31.12.2014	

intensive mental health support. The CQC are aware that, at the time of the visit, there were plans in place for an urgent assessment protocol		29.0b	Ensure there are clear protocols / guidance in place for staff in order to facilitate referral to CAHMS when appropriate, and clear escalation processes when required	None	Paediatric Consultant / Director of Operations	30.11.2014	
		29.0c	Continue to work closely with the Devon Safeguarding Children Board and its sub-committees; ensure the Trust escalates concerns via this route and contributes to, implements solutions.	Capacity to ensure representation at DSCB	Director of Nursing	30.11.2014	
Ensure there is nutritious food available to parents and breastfeeding mothers	Parents and breastfeeding mothers will have access to nutritional food	30.0	Review current processes and identify the options for providing this. A business case may be required where there is a cost implication	None	Lead Nurse, Neonatal & Paediatric Services / Director of Facilities	31.12.2014	
		30.1	Improve staff awareness of the availability and process of offering snack boxes, toast etc.	None	Lead Nurse, Neonatal & Paediatric Services / Director of Facilities	30.09.2014	

COMMUNITY HEALTH INPATIENT SERVICES

The Trust should review the security of resuscitation trolleys in all community hospitals to ensure they are tamper proof	All hospital trolleys will be secure and tamper proof	31.0a	Undertake a risk assessment of all resuscitation trolleys in community hospitals	None	Resuscitation Service Manager / Director of Nursing	30.11.2014	
		31.0b	Present an option paper to the Executive Directors outlining the various ways the Trust can become compliant with this action	None	Resuscitation Service Manager / Director of Nursing	31.12.2014	
		31.0c	Implement chosen option	Resource to finance option	Resuscitation Service Manager / Director of Nursing	31.01.2015	
		31.0d	Audit compliance	None	Resuscitation Service Manager / Director of Nursing	30.06.2015	
The Trust should develop processes to monitor and analyse patient outcomes in order to review the effectiveness of the services	The Trust will have a fully developed set of metrics to measure patient outcomes in community inpatient services	32.0a	Review current metrics and agree new metrics (ideally these will be from data currently collected)	None	Divisional General Manager, Community Hospitals / Director of Operations	31.03.2015	
		32.0b	Agree reporting schedules and assurance processes	None	Divisional General Manager, Community Hospitals / Director of Operations	30.06.2015	
The Trust should review the discharge processes for patients, to ensure they are commenced as early as possible following	Discharge planning for patients will commence as soon as possible, and patients will have robust discharge plans in place during their stay.	33.0a	Develop a standard operating procedure for community hospital discharges and test	None	Assistant Director of Nursing (Community) & Divisional General Manager, Community Hospitals / Director of Nursing	30.11.2014	

admission		33.0b	Once agreed, implement the SOP	None	Assistant Director of Nursing (Community) & Divisional General Manager, Community Hospitals / Director of Nursing	31.03.2015	
		33.0c	Monitor compliance with the SOP through quarterly audit; results will be shared at the Matrons' Meeting and monitored through the Patient Safety Operational Group	None	Assistant Director of Nursing (Community) & Divisional General Manager, Community Hospitals / Director of Nursing	30.06.2015	
The Trust should establish a system to identify, assess and manage risks via a risk register at community hospital level to ensure the health, safety and welfare of patients, staff and others	Risks will be reviewed and update at community hospital level, and this process will be monitored via the Risk Management Committee	34.0a	Produce monthly risk reports for each community hospital	None	Senior Governance Manager (Risk and Incidents) / Commercial Director	31.12.2014	
		34.0b	Add open risks as a standing agenda item at the Matrons' Meeting and ensure updates are provided to the Risk Management Team	None	Divisional General Manager, Community Hospitals / Commercial Director	01.01.2015	
		34.0c	Monitor compliance with completion of actions via the Risk Management Committee	None	Senior Governance Manager (Risk and Incidents) / Commercial Director	31.03.2015	
		34.0d	Identify an additional community hospital representative for the Risk Management Committee to ensure consistent representation	None	Divisional General Manager, Community Hospitals / Commercial Director	31.12.2014	

COMMUNITY HEALTH SERVICES FOR ADULTS							
The Trust should ensure that the infection control policy and procedure provide specific information and guidance for staff working within patients' own homes	Infection control policy and procedure for community staff will contain specific information and guidance for those working within patients' own homes	35.0a	Review current policy and procedure to ensure they reflect the needs to community staff and share these widely for comment	None	Lead Nurse, Infection Prevention and Control / Director of Nursing	31.12.2014	
		35.0b	Once agreed, implement new policy and procedure	None	Lead Nurse, Infection Prevention and Control / Director of Nursing	31.12.2014	
The Trust should ensure that infection-control training for staff working in patients' own homes related to the community setting, rather than a hospital setting	Provision of infection control training for community staff will reflect the needs of those working within patients' own homes	36.0a	Review current training to ensure it reflects the needs to community staff and revise where necessary	None	Lead Nurse, Infection Prevention and Control / Director of Nursing	31.12.2014	
		36.0b	Implement new training	None	Lead Nurse, Infection Prevention and Control / Director of Nursing	31.12.2014	

CARE QUALITY COMMISSION CHIEF INSPECTOR OF HOSPITALS INSPECTION VISIT 1-4 JULY 2014 ACTIONS MENTIONED IN THE REPORT WHERE REQUESTED FACTUAL ACCURACY CHANGES WERE NOT ACCEPTED							
Accident and Emergency							
None of the staff spoken to could recall receiving feedback from any of the incidents that had been reported.	Staff are aware of the Incident management process and how they can receive feedback.	37.0a	Communicate the requirement for all responsible managers to feedback incident reporting information to their teams .	None	Consultant Emergency Medicine and Senior Nurse, Emergency Care / Director of Nursing	30.11.2014	

		37.0b	Review Datix system to make feedback question mandatory and explore the possibility and possible confidentiality issues around enabling reporters to login and access incidents they report on DATIX.	None	DATIX & Incident Manager / Commercial Director	30.11.2014	
The staff thought they would report 'near misses' if the reporting process was easier.	Staff reporting all incidents including near misses	38.0	Awareness campaign for staff on incident reporting	None	Consultant Emergency Medicine and Senior Nurse, Emergency Care / Director of Nursing	31.12.2014	
Nurse staffing levels were based on historical establishments, which had been reviewed over time to take account of changing demand. A specific staffing tool was not used.	Use of a nurse staffing tool	39.0	Review the Nurse Staffing Tools the CQC have suggested. RCN Emergency Care Association tool (ECA). Faculty of Emergency Nursing tool (FEN). BEST tool updated in 2013 (Recommended)	None	Interim Assistant Director of Nursing (Acute) and Senior Nurse, Emergency Care / Interim Director of Workforce & Organisational Development	31.12.2014	
Concerns raised around Band 6 nurses in charge of A&E and that Band 7 nurses did not work at night, posing a safety risk as activity at night can involve greater risk in emergency departments	Review of safe levels of staffing in A&E over 24 hour period, seven days a week.	40.0	Staffing level review of A&E staffing with recommended staffing levels for 24/7 working, formally presented to Execs/Board with clear responsibilities for each role.	None	Senior Nurse, Emergency Care / Interim Director of Workforce & Organisational Development and Director of Nursing	31.12.2014	

Junior Doctors stated they were not encouraged to ask for help when a medical or management dilemmas occurred.	Clear protocols and induction advice on when junior doctors should seek advice	41.0	Produce protocols detailing when junior doctors should seek support or advice from the Consultants and clear instruction on how the advice is given. Also to be included in all induction booklets for junior doctors	None	Paediatric Consultant/Clinical Director for Surgery /Clinical Director for Medicine/ Consultant Surgeon/Clinical Director for Community Services/Medical Director	31.03.2015	
Not all members of staff were able to find their appraisal paperwork.	Copies of the appraisal documentation filed in the personnel files.	42.0a	An audit of personal files to ensure the Appraisal and Development Review Guidance and Forms for Managers is being adhered to.	None	Senior Nurse, Emergency Care / Interim Director of Workforce & Organisational Development	31.03.2015	
		42.0b	All personal files for ED nursing staff will be securely stored in ED.				
None of the staff had a development plan that identified learning needs for the forthcoming year.	A personal development plan is available for all members of staff	43.0	An audit of personal files to include whether each file has a personal development plan	None	Senior Nurse, Emergency Care / Interim Director of Workforce & Organisational Development	31.03.2015	
No personal files that were looked at contained job description or person specifications.	All personal files containing job description and person specifications of the current role the staff member has	44.0	An audit on personnel files to include whether each file has the staff members current Job Description and Person specification included.	None	Senior Nurse, Emergency Care / Interim Director of Workforce & Organisational Development	31.03.2015	

The inspection team looked at records on MAU and found that very few patients had been transferred out to other wards in preparation for the evening and night shifts, despite a steady stream of referrals to the medical team from GPs and A&E	Clear protocol on the timely transfer of patients from MAU	45.0a	Audit of current practice and improvements made to ensure timely transfers are made	None	Divisional General Manager, Emergency Services, Logistics and Resilience / Director of Operations	31.03.2015	
		45.0b	Development and operational implementation of a protocol for the transfer of patients from MAU to other wards	None	Divisional General Manager, Emergency Services, Logistics and Resilience / Director of Operations	31.03.2015	
There was no information given to patients in the waiting room about waiting times	Waiting times for treatment clearly shown in the A&E waiting room at all times	46.0	Identify and implement another reliable method of displaying waiting times, other than the television which is not always switched on.	None	Divisional General Manager, Emergency Services, Logistics and Resilience / Director of Operations	31.12.2014	
The inspection team noted that the only nurse present at the divisional governance meetings was the A&E Manager, and although it was explained that the minutes were available for all staff on the notice board, none were visible	Increased nursing presence at the divisional governance meetings and departmental wide availability of minutes	47.0a	Review nurse attendance at divisional governance meetings to increase numbers attending	None	Divisional General Manager, Emergency Services, Logistics and Resilience / Director of Operations	31.03.2015	
		47.0b	Clear cascade process of the minutes of Governance meetings to all staff.	None	Divisional General Manager, Emergency Services, Logistics and Resilience / Director of Operations	31.03.2015	

The Corporate Risk Register was being used to report incidents and not as a register of other known or potential risks	The Risk register will reflect all known risks	48.0	Review the current process for risk inclusion on the register; propose and implement revised process.	Manageable and relevant risk registers.	Senior Nurse, Emergency Care and Consultant Emergency Medicine / Commercial Director	31.03.2015	
Critical Care							
Limited availability of ventilators in ICU making the ability to ventilate six patients not available in an emergency	Sufficient ventilators available in ICU for any emergencies	49.0	Risk assess the availability of ventilators available and develop a business case, if appropriate, to increase numbers available	None	Senior Nurse, Critical Care/ Head of Procurement	31.03.2015	
There was a fairly high level of sickness compared with the NHS England average	Escalation plan in place when shortfall in nursing staff is experienced	50.0	Review to identify when to implement escalation plan for extra nursing staff	None	Senior Nurse, Critical Care / Interim Director of Workforce & Organisational Development	31.03.2015	
There was no evidence or comments from staff to show patients were followed-up in the first 24 hours despite discharge to ward arrangements being discussed at length	Comprehensive record of follow-up of patient within 24 hours of discharge from ICU	51.0	Review current follow up procedures and, where necessary, implement a robust process to ensure there is a consistent approach	None	Director of Nursing/ Medical Director	31.12.2014	
Some patients were discharged from the unit too early	Patients being discharged in a timely manner	52.0	Audit the discharge of patients over the past 6 months and identify optimal discharge criteria.	None	Senior Nurse, Critical Care / Medical Director	31.12.2014	

The Corporate Risk Register was being used to report incidents and not as a register of other known or potential risks	The Risk register will reflect all known risks	53.0	Review the current process for risk inclusion on the register; propose and implement revised process.	Manageable and relevant risk registers.	Senior Nurse, Critical Care / Commercial Director	31.03.2015	
A feedback form for comments on care from patients and their relatives had been designed and was collated by a volunteer member of staff but there was no analysis of the reports or any trend analysis to drive practice improvements	Analysis reports from the feedback provided by patients and their relatives from which actions can be identified that would make improvements to the service.	54.0	Ensure analysis of feedback forms is made as with any other department, implementing any actions made as a result of the forms.	None	Head of Communications / Director of Nursing	31.03.2015	
End of Life Care							
Staff were not aware of a system or policy in place that required staff to have regular formal supervision meetings with their line manager	All staff receiving formal supervision meetings with their line managers	55.0a	Promotion and awareness of the Staff Supervision policy.	None	Interim Assistant Director of Nursing (Acute) / Interim Director of Workforce & Organisational Development	31.03.2015	
		55.0b	Audit of frequency and quality of supervision	None	Interim Assistant Director of Nursing (Acute) / Interim Director of Workforce & Organisational Development	30.04.2015	
Community Adults							

Not all teams visited were conducting a patient safety handover	Handovers will be in place in all community nursing teams	56.0	Continue with planned roll out of handover implementation in community nursing teams	None	Head of Quality and Safety / Director of Nursing	30.03.2015	
Community Inpatients							
GP and therapist notes in community hospitals were not locked	All notes stored in a secure location.	57.0	Audit the storage of all notes in the community hospitals and implement actions to ensure safe storage at all times.	None	Divisional General Manager, Community Hospitals / Director of Operations	31.12.2014	

Job Title	Initials	Actions
Chief Executive	AD	11.0, 14.0, 26.0
DATIX and Incidents Manager	AW	37.0
Senior Nurse, Surgery	AB	10.1, 28.0
Divisional General Manager, Medicine and Paediatrics	Abu	3.0, 6.0, 11.0
Clinical Director for Medicine	Ada	3.0, 11.0, 41.0
Commercial Director	AI	34.0, 37.0, 48.0, 53.0
Financial Director	AR	22.0
Lead Intensivist	Awa	25.0, 27.0
Risk Manager	BH	34.0
Clinical Director for Surgery	CB	11.0, 13.0, 14.0, 41.0
Clinical Director for Community Services	CBo	11.0, 41.0
Head of Procurement	DP	49.0
Interim Director of Workforce & Organisational Development	DA	39.0, 40.0, 42.0, 43.0, 44.0, 50.0, 55.0
Consultant Medical Microbiologist & Director of Infection Prevention & Control	DR	5.0
Interim Assistant Director of Nursing (Acute)	DB	5.1, 5.2, 10.2, 39.0, 55.0
Senior Nurse, Critical Care	DK	10.1, 24.0, 27.0, 49.0, 50.0, 52.0, 53.0
Lead Nurse Infection Prevention and Control	FB	7.1, 7.2
Medical Director	GT	1.0, 1.1, 2.3, 3.0, 3.2, 15.0, 20.0, 21.0, 24.0, 25.0, 27.0, 29.0, 41.0, 51.0, 52.0

Status tracking		
Complete	Green	G
Risks slippage	Amber	A
Barriers – not achieved	Red	R

Divisional General Manager, Surgery	HB	4.0, 4.1, 11.0, 14.0
Director of Facilities	IR	4.0, 4.1, 4.2, 4.3, 7.0, 7.3, 7.4, 12.0, 16.0, 23.0, 28.0, 30.0, 30.1
Lead Nurse Infection Prevention and Control	JW	35.0, 36.0
Senior Nurse, Emergency Care	JH	7.2, 10.1, 17.0, 18.0, 19.0, 37.0, 38.0, 39.0, 40.0, 42.0, 43.0, 44.0, 48.00
Interim Divisional General Manager, Clinical Support Services	JG	11.0, 12.0, 23.0, 26.0
Paediatric Consultant	JC	29.0, 41.0
Associate Director for Patient Safety	KR	2.0
Consultant Surgeon	KC	11.0, 41.0
Head of Communications	KA	54.0
Assistant Director Health & Social Care	KS	11.0
Director of Nursing	KM	2.0, 2.1, 2.2, 2.3, 3.0, 3.1, 3.2, 5.0, 5.1, 5.2, 7.1, 7.2, 8.0, 9.0, 10.1, 10.2, 13.0, 17.0, 20.0, 21.0, 29.0, 31.0, 33.0, 35.0, 36.0, 37.0, 38.0, 40.0, 51.0, 54.0, 56.0
Consultant Emergency Medicine	LK	17.0, 18.0, 19.0, 20.0, 21.0, 37.0, 38.0, 48.0
Lead Nurse, Neonatal & Paediatric Services	LM	
Theatres Manager	MG	13.0
Resuscitation Service Manager	MC	17.0, 31.0
Director of Pharmaceutical Services	NF	24.0
Director of Specialist Services & Special Projects	NMcN	11.0
Director of Operations	RS	6.0, 13.0, 18.0, 19.0, 29.0, 32.0, 45.0, 46.0, 47.0, 57.0
Delivery Suite Manager	SS	10.1
Head of Quality and Safety	SJ	2.1, 2.2, 2.3, 3.0, 3.1, 3.2, 8.0, 9.0, 10.2, 20.0, 56.0
Divisional General Manager, Emergency Services, Logistics and Resilience	SH	7.0, 7.3, 11.0, 16.0, 19.0, 21.0, 45.0, 46.0, 47.0
Clinical Lead, Obstetrics and Gynaecology	SB	1.0, 1.1, 15.0
Divisional General Manager, Community Hospitals	Shu	11.0, 32.0, 33.0, 34.0, 57.0
Senior Nurse, Medicine	SP	10.1
Assistant Director of Nursing (Community)	TN	5.1, 5.2, 22.0, 33.0
Head of Midwifery	TC	4.2, 4.3, 30.0, 30.1
Deputy Director of Facilities	TH	7.4