Dorset County Hospital NHS
NHS Foundation Trust

Care Quality Commission

Action Plan following unannounced inspection

June 26th/27th, July 1st/2nd 2013

This action plan has been developed to capture and monitor the improvements required to ensure that the Trust is compliant with the CQC essential standards. The plan was developed following the unannounced inspection that took place on the June 26th/27th and July 1st/2nd 2013. The inspection reviewed eight of the essential standards and identified two standards as being compliant and moderate failings in five of the standards inspected and included a warning notice being issued against one standard.

Individual actions are owned by members of Trust staff, who have specific responsibilities as part of their role or have been allocated responsibility for tasks due to their particular field of expertise. The leads are responsible for progressing and reporting against the required actions and for testing their compliance.

Progress will be monitored by the Senior Management Team on a monthly basis and on a bi monthly basis scrutinised by the quality committee and progress towards compliance reported to the Trust Board quarterly and by exception via the Quality Committee.

An Executive Director is responsible for each standard.

If there is a request for the alteration of any Expected Completion Date, this must be agreed by the Executive Director responsible for that Standard and submitted for approval to the Quality Committee.

Timescale Progress Updated 20th January 2014

Outcome 4 – Alison Tong, Director of Nursing and Quality

Regulation 9 HSCA 2008 (Regulated activities) Regulations 2010 - Care and Welfare of people who use services

CQC Findings - Some patients did not experience care, treatments and support that met their needs and protected their rights. Patients were at risk of inappropriate and unsafe care. Regulation 9 (1) (a) (b) (i) (ii).

Issue	Resulting Action	Lead	Planned timescale Progress	Outcome	Evidence	Expected Completion date of all Actions
Increased prevalence of Pressure Ulcers identified through Safety Thermometer Data in June/July	To monitor data and analyse for trends. Reporting to the Trust board on a monthly scorecard of incident and prevalence (via Safety thermometer) in place and quarterly detailed review of pressure ulcer management.	Director of Nursing (Alison Tong)	Monthly monitoring. Information now being captured daily by IP+C team, cross referenced to Datix and reported to matrons for investigation.	Zero tolerance to preventable pressure ulcers. Improve and sustain cross learning in ward areas.	Audit compliance against RCA action plan findings.	Continuous – will be via monthly monitoring
	Any area(s) identifying more than one new pressure ulcer reported by the Safety Thermometer and/or incident reporting will be subject to a root cause analysis investigation undertaken by the Matron for that speciality.	Matrons (Simeon Edwards, Miles Tompkins, Tess Drabble, Michelle Smith, Abigail Orchard) report to Deputy Director of Nursing (Neal Cleaver)	Monthly review. New Datix form developed to include mini RCA completion, to be implemented February.	Learning from RCA's to be disseminated with a reduction in avoidable pressure ulcers	Audit compliance against RCA action plan findings.	Continuous. Root Cause Analysis to be undertaken on any Grade III or above and learning disseminated within 1 month of completion
	Improve education to areas where an increased incidence is noted. To include the principles of pressure ulcer prevention, assessment of patients at risk and appropriate use of mattresses/pressure relieving aids.	Matron with responsibility for Tissue Viability (Emma Hoyle) in collaboration with Head of Education, Learning and Development (Tina Jackson).	Commenced 19/08/13 Audit of policy March 2014 Tissue Viability week undertaken on w/c 19th August	Reduction in preventable pressure ulcer rate measured via incidents and safety thermometer.	Audit against Pressure ulcer prevention policy in March 2014.	March 2014 - Audit against Policy to gain understanding of any further training needs

			TVN absent from post. Alternatives being reviewed to ensure adequate cover arrangements.			
	Development and launch of Pressure Ulcer Guidelines/ Policy.	Matron with responsibility for Tissue Viability Emma Hoyle)	30/09/13 policy ratified by Clinical Governance Committee Audit of policy March 2014	Reduction in preventable pressure ulcer rate measured via incidents and safety thermometer.	Audit against Pressure ulcer prevention policy in March 2014. Decrease in prevalence of avoidable pressure ulcers	March 2014 - Audit against Policy to gain understanding of any further training needs
Incomplete documented assessments of patients' needs and medical conditions	Develop and implement a policy for documentation/ record keeping standards in line with national and professional bodies.	Deputy Director of Nursing (Neal Cleaver)	Documentation group established. Reviewing documentation to understand what should be included within policy	All patients to have a contemporaneous record of care that is used to support practice.	Audit of patient records against the criteria detailed in the policy to demonstrate improvements.	April 2014 (will be dependent on pilots of documentation, but draft copy available)
	Review and audit of practice to ensure that assessments of patients' needs and medical conditions are undertaken and recorded in a timely fashion.	Director of Nursing (Alison Tong)	Inpatient Record audit completed October 2013. Results feedback to documentation group to inform changes to paperwork.	All patients to have initial assessments of needs and medical conditions documented within 12 hours of admission to hospital in line with Trust documentation standards.	Audit following implementation of new documentation to demonstrate improvement in compliance	April 2014 (will be dependent on pilots and launch of new documentation)
Poor documented	To review the documentation of	Deputy Director of Nursing (Neal	Documentation group	All patients will be	Audit of patient records	April 2014 (dependent on

compliance of patients assessed for risk factors in accordance with Trust Guidance (e.g. Falls, Pressure Area damage, Malnutrition, Wound healing, Moving and Handling)	patients assessments within the Trust and revise in line with best practice.	Cleaver)	established to ascertain information to be included for pilot. Pilot documentation currently underway on POW. Awaiting feedback.	assessed for risk factors in line with Trust Guidance and the assessments recorded in the patient documentation.	following implementation of new documentation will demonstrate improvements.	pilot and launch)
	Learn from other organisations by scoping their documentation and adopting best practice.	Deputy Director of Nursing (Neal Cleaver)	Documentation form other Trusts received for review (including other Trusts utilising VitalPac system) - 31/10/13	Evidence of best practice from other organisations used to support new documentation.	Evidence of modification of current documentation and improvements in compliance following launch.	April 2014 (dependent on pilot and launch)
	To liaise with 'VitalPac' regarding updates and available modules.	Deputy Director of Nursing (Neal Cleaver)and ICT Lead (Ann Little)	30/11/13. Roadmap of modules available and timescales. Development of 'VitalPac Users Group' within Trust. Inaugural meeting January 31st 2014.	To ensure that assessments are standardised across the Trust and defined as either paper or electronic in all areas and made explicit in documentation policy.	Audit to provide assurance that documentation meets the Trust Documentation policy standards. Road Map available.	VitalPac to produce roadmap by 31st January 2014. Users group to be established by 31st January 2014
	Pilot revised documentation.	Deputy Director of Nursing (Neal	Pilot commenced.	Test suitability of	Continual cycle of audits to test	April 2014 (dependent on

		Cleaver)	Awaiting feedback.	revised documentation.	documentation in pilot phase.	outcome of pilots and changes required)
	Roll out of pilot across the trust alongside a package of training materials to support best practice of documentation standards.	Deputy Director of Nursing (Neal Cleaver)	Group established. Training materials to be determined post trial of documentation .	Documentation fit for purpose.	Audit of patient records monitoring to demonstrate improvement in compliance against Trust standard.	Roll out plan to be completed by March 2014 (dependent on pilots and changes required)
	Audit revised documentation to ensure compliance.	Deputy Director of Nursing (Neal Cleaver)	01/06/14	Evidence to support that documentation is fit for purpose.	Audit results will highlight best practice and areas for improvement.	June 2014 (dependent on successful roll out in April 2014)
Poor documentation and knowledge regarding the care of patients with an indwelling Urinary catheters	To educate staff in the care of patients with an indwelling Urinary Catheter and ensure that a standard and consistent approach is applied across the organisation by introducing a catheter care bundle.	Infection Prevention and Control Matron (Emma Hoyle)	Care bundle introduced in August 2013 and Audit undertaken 31st October 2013. Re- audit to take place in Jan/February 2014	The Catheter Care bundle will be in use in all clinical areas of the Trust to ensure best practice is applied and reduce the risk to patients of acquiring a Catheter associated Urinary Tract Infection.	Audit of practice to demonstrate improved compliance with the catheter care bundle and reduce the risk of harm to patients, evidenced by sustained/reduction in CAUTI's	Re-audit to be completed by February 2014.

Regulation 13 HSCA 2008 (Regulated activities) Regulations 2010 – Management of Medicines
Outcome 9 – Patricia Miller, Director of Operations
CQC Findings - Patients were not protected against the risks associated with medicines because arrangements in place for the safe keeping of some medicines were not always followed.

Issue	Action	Lead	Planned Timescale Progress	Outcome	Evidence	Expected Completion date of all Actions
Unsecure storage arrangements for Intravenous fluids found in one clinical area.	Ensure that Intravenous fluids are kept securely in a locked cupboard. Spot Check of wards to be undertaken on a weekly basis by matrons and ward based pharmacist until sustained improvement is achieved. Action to be taken against the managers of areas failing to comply with the storage requirements on more than two consecutive occasions.	Chief Pharmacist (Steve West)	Actions completed. Storage areas identified and key codes now in place. Audits reported at the Medicines Management Committee and escalated to the senior management team if concerns are noted.	Storage areas are identified, are kept closed and are only accessible by staff.	Audit/spot check of compliance by Matrons and ward based pharmacists.	Completed. Spot checks to continue.
Recording of minimum and maximum temperature of cold storage facilities for medicines inconsistently undertaken	Implement electronic cold storage probes linked to Wi-Fi in all clinical medicines fridges. Central alerts and monitoring capability to be electronically undertaken and replace paper based system except in areas where there is no Wi-Fi. Temperature fluctuation alerts and reports are managed, monitored and	Chief Pharmacist (Steve West)	Actions Completed Wi-fi probe system procured and implemented to all ward areas.	Cold Medications will be stored in facilities that are fit for purpose and monitored in line with Trust policy.	Reports of cold storage facilities will be managed by the pharmacy team and reviewed at the Medicines Management	Completed 11/09/13.

and action following incorrect temperatures not consistently taken.	reported by the pharmacy team.				Committee and escalated to the Senior Management Team if concerns are noted.	
	Revise the cold storage of medicines policy in line with the sustainable monitoring solution.	Chief Pharmacist (Steve West)	Complete	Medications will be safely stored in a facility that is fit for purpose.	Revised policy developed and published on the trust intranet	Completed 11/09/13

Outcome 13 – Mark Power, Director of HR and Workforce
Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 – Staffing
CQC Findings - There were not always sufficient numbers of qualified, skilled and experienced staff to meet patient's needs. Regulation 22.

Issue	Action	Lead	Planned Timescale Progress	Outcome	Evidence	Expected Completion date of all Actions
Staffing levels on occasions fall below the identified staffing establishments	Staffing levels are reviewed on a daily/shift basis to ensure directing of resources is effective. Shortfalls are escalated to the Director of Nursing /Deputy Director of Nursing in 'real time'. Safety issues escalated to Director of Nursing/ Deputy Director of Nursing	Matrons (Miles Tompkins, Simeon Edwards, Tess Drabble, Michelle Smith)/ Divisional managers (Laurie Scott, Jayne Oliver, Catherine Abery Williams, Catherine Aiken	Daily staffing reviews undertaken by Matrons to identify shortfalls and escalation to Divisional manager in place. Daily/monthly reporting template to be developed and reported to Trust Board.	To ensure the safety of patients within the hospital.	Duty rosters in line with agreed establishments and based on patient dependency.	Continuous. Systems in place immediately.
	Development of criteria to identify the need for additional staff.	Deputy Director of Nursing (Neal Cleaver)	'Specials Criteria' developed and implemented in ward areas.	Criteria to identify the need for additional staff in place to ensure patient safety.	Additional staff requirements identified appropriately.	January 2014
	Escalation to the clinical commissioning group to be invoked if staffing levels reach critical levels and compromise patient safety.	Director of Nursing (Alison Tong)/ Director of Operations (Patricia Miller)	Director of Nursing/ Director of Operations to escalate to the commissioners if staffing concerns cannot be resolved and compromise the ability to	To ensure the safety of patients within the hospital.	Escalated if internal major incident plan invoked	As required.

			deliver safe services.			
	Business continuity plan to support continuation of safe services in the event of staffing shortages to be developed as part of Major Incident plan.	Director of Workforce and HR (Mark Power)	Safe staffing Escalation Process policy developed. To be ratified January 2014.	Ensure continuation of safe services in the event of staffing shortages.	Internal audit of business continuity plans.	30/11/2013 (Delayed completion as agreement of content sought)
Staffing of escalation area (Annex) by Bank and Agency staff.	Identify substantive staff to resource escalation areas to ensure that bank and agency staff are supported and patients receive best possible care. Staffing skill mix signed off by the Director of Nursing	Matron for Medicine (Simeon Edwards) reporting to the Deputy Director of Nursing (Neal Cleaver)	Winter plan in place, staffing rotas using substantive seconded members of staff in place.	Safe staffing levels in place in all escalation areas and in line with the winter plan and agreed skill mix.	Duty rosters in line with agreed establishments and based on patient dependency.	Continuously reviewed.
Inadequate arrangements in place to ensure that temporary staff recruited have the right skills and experience to meet patients' needs.	Annually review agency Service Level Agreements to ensure mandatory training requirements are explicit.	Director of Workforce and Human Resources (Mark Power)	Review of Service Level Agreements on-going	Trust is confident that agency staff receive agreed levels of training prior to being employed by the organisation.	Confirmation from Agencies regarding training provided.	30/11/2013 (Delayed as negotiation required in SLA's)
	Conduct annual checks on all agency staff employed to ensure they have completed all mandatory training requirements.	Director of Workforce and Human Resources (Mark Power)	Schedule for undertaking agency staff annual checks	Trust is confident that checks on agency staff are completed prior to being employed by the organisation.	Outcomes of audit of agency staff checklists in clinical areas to demonstrate training compliance	30/11/2013 (Delayed as negotiation required within SLA's)

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 – Supporting Workers
Outcome 14 – Mark Power, Director of HR and Workforce
CQC Findings - Patients were cared for by some staff who were not up to date with relevant training and did not always receive supervision. Therefore they were not always supported to deliver care and treatment safely and to an appropriate standard. Regulation 23 (1) (a) (b).

Issue	Action	Lead	Planned Timescale Progress	Outcome	Evidence	Expected Completion date of all Actions
Inadequate uptake for some elements of mandatory training (specifically conflict resolution, safeguarding adults and safeguarding children) in all divisions.	Further review the periodicity requirements for all elements of core and non-core mandatory training and revise where possible. Continue to extend the range of delivery options available for mandatory training. Mandate all line managers and supervisors to ensure staff for whom they are responsible receive all elements of their mandatory training. Continue to provide monthly performance information to divisions and reports to Trust Board.	Head of Education, Learning and Development (Tina Jackson)	Extra mandatory training sessions now in place. Identification of areas for improvement.	Compliance with Trust Policy regarding mandatory training.	Training records; revised appraisal documentation ; Trust Board performance reports.	Trust compliance target achieved for all elements of mandatory training by 30/04/14
Inadequate training in Dementia awareness in clinical areas.	Awareness Training Plan, which includes dementia training at four levels (dementia aware; dementia aware-clinical; dementia skilled; dementia specialised). To be overseen by the Dementia Steering Group. Establish Dementia Champions in all key clinical areas.	Divisional Manager for Medicine (Jayne Oliver, Dementia Lead)	Training Plan has been established and is being implemented (training will be continuous). Dementia Champions to be established by April 2014.	Dementia training (at the appropriate level) is provided to all staff identified as requiring it. Dementia Champions established and supporting staff in all key clinical areas.	Audit to demonstrate increased awareness of dementia care in clinical areas	Dementia Champions in place by April 2014. Audit of staff knowledge by June 2014.

Clinical Supervision not evidenced robustly in all clinical settings.	Clinical supervision policy to be revised to reflect the needs for supervision and identify methods for delivery and ensuring this is achieved.	Deputy Director of Nursing (Neal Cleaver) and Head of Education, Learning and Development (Tina Jackson)	Policy being revised to incorporate additional opportunities. To be presented to Education Committee (Last meeting cancelled)	Clinical supervision will be available to support staff in their effective delivery of care if requested.	Revised policy in place. Appraisal records will include discussion regarding supervision arrangements if requested by staff member.	Policy to be in place by February 2014 (dependent on approval and ratification at committees)
	Development of a mentor/ coaching/ supervisor registers in place for staff to access.	Head of Education, Learning and Development (Tina Jackson)	Identification of current mentors, coaches and supervisors	Register of staff that are trained to provide mentoring/ coaching and/or clinical supervision accessible for staff.	Staff records of uptake of mentorship/ coaching and /or clinical supervision.	Register to be available for staff by April 2014
	Programmes to support individuals becoming a mentor/coach and/or clinical supervisor to be sourced and available to support clinical practice.	Head of Education, Learning and Development (Tina Jackson)	Identification of programmes and courses available by different providers	A portfolio of programmes to support individuals developing the skills required to provide mentorship/ coaching and /or clinical supervision will be available to staff.	Staff training records of uptake of mentorship/ coaching and /or clinical supervision.	Programmes to be publicised and available by April 2014

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 - Assessing and monitoring the quality of service provision
Outcome 16 – Alison Tong, Director of Nursing and Quality
CQC Findings - The trust had systems in place to regularly monitor and manage some risks however the risk register was not up to date and audits may not have been effective. Regulation 10 (1) (a) (b).

Issue	Action	Lead	Planned Timescale Progress	Outcome	Evidence	Expected Completion date of all Actions
Inability to identify progress against the Trust wide Audit Plan and track changes required in practice.	To record audits that are taking place, their progress, results and any outstanding actions required (excluding proposed/ not commenced audits) on the clinical audit database.	Deputy Director of Nursing (Neal Cleaver)/ Clinical Audit Team (Carrie Ward, Liz Hemsley)	Completed and now in place	The clinical audit database clearly identifies progress against individual audits and action plans that demonstrate how audit findings will be used/have been used to affect changes in practice.	Results produced in GAANT chart to demonstrate timescales and progress. Demonstration that actions have occurred as result of audit.	GAANT Chart Completed. Recommendations for further action to be monitored by April 2014.
Inconsistency in how the risk registers are used, reviewed and updated across the Trust, and presented to Trust Board	Produce a forward planner with timescales for completion of the risk register and approval mechanisms.	Head Of Risk Management (Jonathan Webb)	New format for the risk register introduced in May 2013. Forward Planner to be available 01/12/13	Risk Register reviewed quarterly by the Trust Board.	Trust Board meeting minutes.	01/12/13

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 – Records
Outcome 21 – Libby Walters, Director of Finance
CQC Findings - Patients were not protected from the risks of unsafe or inappropriate care and treatment because records were not always complete or accurate. Regulation 20 (1) (a).

Issue	Resulting Action	Lead	Planned timescale Progress	Outcome	Evidence	Expected Completion date of all Actions
Incomplete documented assessments of patients' needs and medical conditions	Develop and implement a policy for documentation/ record keeping standards in line with national and professional bodies.	Deputy Director of Nursing (Neal Cleaver)	Documentation group established. Reviewing documentation to understand what should be included within policy	All patients to have a contemporaneous record of care that is used to support practice.	Audit of patient records against the criteria detailed in the policy to demonstrate improvements.	April 2014 (will be dependent on pilots of documentation, but draft copy available)
	Review and audit of practice to ensure that assessments of patients' needs and medical conditions are undertaken and recorded in a timely fashion.	Director of Nursing (Alison Tong)	Inpatient Record audit completed October 2013. Results feedback to documentation group to inform changes to paperwork.	All patients to have initial assessments of needs and medical conditions documented within 12 hours of admission to hospital in line with Trust documentation standards.	Audit following implementation of new documentation to demonstrate improvement in compliance	April 2014 (will be dependent on pilots and launch of new documentation)
Poor documented compliance of patients assessed for risk factors in accordance with Trust Guidance (e.g. Falls, Pressure Area damage,	To review the documentation of patients assessments within the Trust and revise in line with best practice.	Deputy Director of Nursing (Neal Cleaver)	Documentation group established to ascertain information to be included for pilot. Pilot documentation currently	All patients will be assessed for risk factors in line with Trust Guidance and the assessments recorded in the patient documentation.	Audit of patient records following implementation of new documentation will demonstrate improvements.	April 2014 (dependent on pilot and launch)

Malnutrition, Wound healing, Moving and Handling)			underway on POW. Awaiting feedback.			
	Learn from other organisations by scoping their documentation and adopting best practice.	Deputy Director of Nursing (Neal Cleaver)	Documentation form other Trusts received for review (including other Trusts utilising VitalPac system) - 31/10/13	Evidence of best practice from other organisations used to support new documentation.	Evidence of modification of current documentation and improvements in compliance following launch.	April 2014 (dependent on pilot and launch)
	To liaise with 'VitalPac' regarding updates and available modules.	Deputy Director of Nursing (Neal Cleaver)and ICT Lead (Ann Little)	30/11/13. Roadmap of modules available and timescales. Development of 'VitalPac Users Group' within Trusts. Inaugural meeting January 31st 2014.	To ensure that assessments are standardised across the Trust and defined as either paper or electronic in all areas and made explicit in documentation policy.	Audit to provide assurance that documentation meets the Trust Documentation policy standards. Road Map available.	VitalPac to produce roadmap by 31st January 2014. Users group to be established by 31st January 2014
	Roll out of pilot across the trust alongside a package of training materials to support best practice of documentation standards.	Deputy Director of Nursing (Neal Cleaver)	Group established. Training materials to be determined post trial of documentation .	Documentation fit for purpose.	Audit of patient records monitoring to demonstrate improvement in compliance against Trust standard.	Roll out plan to be completed by March 2014 (dependent on pilots and changes required)

	Audit revised documentation to ensure compliance.	Deputy Director of Nursing (Neal Cleaver)	Audit to take place following roll out of documentation	Evidence to support that documentation is fit for purpose.	Audit results will highlight best practice and areas for improvement.	June 2014 (dependent on successful roll out in April 2014)
Inadequate documentation regarding patients capacity to consent	To ensure that there is assessment by a trained and competent individual of patients abilities to make decisions and influence their own care recorded accurately in the records	Medical Director (Paul Lear)	Awareness to be cascaded to staff by December 2013. Mental Capacity training available	Patients capacity to consent will be robustly assessed and accurately recorded within the patient records	Compliance with Mental Capacity Act training. Accurate patient records evidenced through the annual consent audit	Training publicised by December 2013. Ongoing actions to be identified through the annual consent audit.