

**Item 2.4a
CQC Post Inspection Action Plan**

September 2016 - Updated March 2017

Topic	Division/ Corporate Area	Issue/concern	Action to date	Time frame for review/ delivery	Executive Lead
Delirium Policy	Critical Care	The management team should ensure that the policy for managing delirium is updated	The Delirium policy will be revised and ratified by Clinical Services Divisional Governance by March 2017. March 17 Policy completed and due for ratification by QPFEC on 26 th March 2017. Supporting EPR documentation completed. Information leaflets developed to support patients and families. Pharmacological management pathways developed.	September 2017	Director of Nursing & Quality
End of Life Care	Medicine/ End of Life Team	The Trust should ensure that plans in place are implemented to ensure all staff have access to specific training needs in end of life to deliver effective and high quality care to all	March 2017 End of Life Strategy awaiting ratification by QPFEC on 24 th March 2017. New work plan and TOR being developed for EOL Steering Group Further refinement required for EOL training strategy. Training is taking place but is not being captured accurately due to how it is coded. This is being addressed currently.	September 2017	Director of Nursing & Quality

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End of Life Care (cont)	Medicine /End of Life Team (cont)		<p>Five priority training areas now agreed. Working with L&D and EOL leads to develop blended learning approaches which include face to face ward based training and exposure to core programmes such as preceptorship, junior doctor training and HCA pathway. Sessions focused on end of life care and syringe driver training.</p> <p>March 2017 Agreed Consultant in Palliative Care time increased at LHCH under SLA arrangement to 0.4 shared through the relevant governance committees.</p>	September 2017	Director of Nursing & Quality
		The Trust should ensure that there are specific medication guidelines in place for patients at the end of their lives who are being cared for in the intensive care environment	The policy was reviewed by a Lead Intensivist and End of Life Leads in Critical Care. Amendments to guidelines (e.g. justifiable change of administration route from subcutaneous to intravenous) are included in EoL training.	September 2017	Director of Nursing & Quality
		Not all staff were aware of the end of life strategy	The strategy is due to be approved at the Quality and PFEC meeting on 24 TH March 2017 and will then be shared trustwide	September 2017	Director of Nursing & Quality

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End of Life Care (cont)	Medicine /End of Life Team (cont)	The end of life dashboard was not always updated and therefore could be inaccurate	following approval it will be shared across the organisation and shared through the relevant governance committees The EoL specialist nurses are working with the information team to review the dashboard and agree robust timeframes for updating	September 2017	Director of Nursing & Quality
Mandatory and Safe- guarding training	Learning and Development	The Trust should ensure that staff attendance at mandatory and safeguarding training is improved. The Trust should ensure that medical staff attendance at safeguarding training sessions is documented to determine compliance.	Trust mandatory Training compliance is above target. The area for improvement is with other essential training. The learning and development team are reviewing the training plan currently. The trust is currently at 94.7% for both mandatory training and safeguarding training trust wide.	September 2017	Director of Nursing & Quality
Human factors training	Learning and development	The Trust should ensure that medical trainees can access human factors training, simulation training and formalise cardiac training opportunities.	The Trust has a strategy for developing awareness and building capability trust wide for human factors. This encompasses offering awareness training to all groups of staff which is in place currently. Human factors awareness is available for medical trainees and has been embedded onto the trust induction, preceptorship and the care certificate training.	Completed	Director of Nursing & Quality

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WHO checklist	Medicine and Surgical Divisions	The Trust should continue to improve the WHO checklist completion by staff	<p>Good progress has been made across both divisions with completion of the WHO checklist. Both the surgery and medicine divisions are working with the EPR Team to ensure the checklist information is robust and is written correctly for the purposes of audit. The Trusts focus in on the qualitative aspects of the checklist. This is monitored through the Quality committee.</p> <p>March 2017 LHCH monitor the WHO safe surgery checklist on a monthly basis. The WHO checklist is carried out for all patients and is therefore at 100%. The assurance target for the WHO checklist is set at 90% within theatres (quality of each element being completed). In January 2017 compliance was at 92.1% and February 92%. The compliance rate for Cath Labs for February 2017 was 98.13%.</p>	September 2017	Medical Director
Resuscitation Equipment	Outpatients and Diagnostics	The Trust should take steps to ensure that resuscitation equipment is checked in line with trust policy, expiration dates are monitored and all emergency equipment is available for use	<p>All Resuscitation Trolleys are checked daily. The Leads in Outpatients and Diagnostics need to ensure this is carried out thoroughly.</p> <p>March 2017 A Trustwide monitoring audit on resuscitation checklists was carried out in February 2017. The audit showed that all the resuscitation trolleys were</p>	September 2017	Director of Nursing & Quality

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Resuscitation Equipment (cont)	Outpatients and Diagnostics(cont)		sealed and there was clear documentary evidence that the contents were checked weekly. The main deficiencies found were overstocking of equipment on some trolleys and in one area an old check-list was in use. A report will be presented at Quality and Patient and Family Experience Committee in March 2017		
Mixed sex breaches critical care	Critical care	The management team had struggled to manage mixed sex breaches in the POCCU areas of the unit in accordance with the Department of Health standard	March 2017 Up until Feb 2017, there had been a marked improvement in the MSA breaches within Critical Care. Unfortunately during February there have been some MSA breaches. Each breach has been due to ward bed capacity or the unavailability of enhanced levels of care provision in the ward environment. Each case was escalated to a Head of Nursing and a risk assessment on an individual basis and when deemed in the patient's best interest with regard to safety, patients remained on critical care. Where possible, patients were moved to a side room on ITU to eliminate further breaches. To aid further delayed discharges, patient flow and MSA breaches, extra ward bed capacity has been achieved, with Cedar ward opening an extra 4 beds. There is a patient low working group, led by the Deputy Director of Nursing to provide solutions and an action.	September 2017	Chief Operating Officer

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MSA (cont)			plan which will enable further improvements		
Delayed discharges critical care	Critical care	Approximately 35% of all discharges from the unit had been delayed by over 4 hours between April 2015 and May 2016. This was higher than similar units nationwide	Significant improvements have been made to delayed discharges and this is work on- going There has been an increase in our discharges within 4 hours of patients being medically discharged, a decrease in the number of patients being discharged between 4 – 24 hours and the Trust has practically eliminated delayed discharges over 24 hours. This information is for Q1-Q3 (i.e. up until the end of January 2017)	September 2017	Director of Nursing and Quality
Risk register	Medicine	There were governance structures in place which included a risk register but some actions on the risk register had not been recorded in the correct section	This has been addressed.	Completed	Director of Research and Informatics
Hand washing	Critical care	We observed some occasions where staff did not wash their hands in between treating patients which meant that there was a risk of infection being transmitted between patients.	March 2017 Increased Surveillance in critical care and this will be monitored through the infection prevention committee. Adhoc checks continue to be made, ITU action team in place, February hand hygiene audits show 100% compliance for ITU/POCCU.	Completed	Medical Director
Storage of cleaning chemicals	Medicine	Cleaning chemicals had been left out in an unlocked room on Maple Suite and the dirty utility room was left unlocked which presented a risk to people	This has been addressed	Completed	Director of Nursing & Quality

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Leadership in medical areas	Medicine	It was identified that improvements could be made in the leadership/culture in couple of isolated areas in medical services	<p>The trust has undertaken a trust wide culture survey in 2014, and each individual area has an action plan. The plan is in place to repeat this survey in spring 2017. The medical areas have action plans and are involved in Listening into action Workshops</p> <p>The Head of Nursing is working with the managers in medical services to further develop an open and transparent culture</p>	September 2017	Director of Nursing & Quality
Store room unlocked	Medicine	There was a store room unlocked. This posed a risk as it contained essential fluids and equipment and there was direct access to an area where procedures were being undertaken.	This has been addressed	Completed	Director of Nursing & Quality
Incident reporting	Outpatients and diagnostics	Staff knew how to report incidents and received feedback but there was inconsistency in the types of incidents reported.	<p>Information has been circulated trust wide regarding examples of types of incidents that staff should report</p> <p>March 2017</p> <p>Incident reporting awareness raising continues. Training continues on induction and ad hoc on request. The laminated copy of definitions of incidents was recirculated in February 2017 to wards and department areas incident reporting is underway</p>	Completed	Director of Research and Informatics

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DNA rates	Outpatients and diagnostics	The Trust had a number of patients who failed to attend for their appointments and the did not attend (DNA) rate was higher than the England average. A DNA policy was in place however this had been scheduled for review in March 2016. 44% of clinics started late and 41% of patients waited over 30 minutes to see a clinician	<p>March 17 – The SMS Text Project has been placed on hold whilst a full Trust wide admin review takes place. It is planned that this will be completed by October 17.</p> <p>A trial on undertaking reminder phone calls was completed but was found to demonstrate no benefit in reducing DNAS</p> <p>The second phase will involve an Initial trial being conducted on a selection of specific clinics, with higher than average DNA rates.</p> <p>A review of administration functions within the Trust is currently underway. All administrative policies and processes are being reviewed with an expected completion date for March 2017. The draft Access and administration Policy has been submitted to NHS Improvement. Further review is required by CCGs and Trust Divisions</p>	September 2017	Tony Wilding
Late Starts in OPD			<p>March 17 – Changes to the previous data collection have been made to collate more meaningful information. The information is currently being collated and will be shared with the Divisions for action by the end of April 2017.</p>	September 2017	Tony Wilding

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Late Starts in OPD (cont)			<p>March 17 - Self-Check-In Kiosks were introduced within Outpatients in November 2016 to help support the Patient journey through the Department, which will enhance the Patient's experience</p> <p>A clinic room booking system has been designed and introduced within Outpatients in September 2016. It is hoped that this will ensure occupancy of clinic rooms are fully utilised.</p> <p>The service lines will continue to review their Outpatient processes to enhance the outpatient experience throughout 2017</p>		
Waiting times	Surgery	<p>The national referral to treatment data target fell below both the England average and referral to treatment standard. The 18 week RTT times for elective cardiac surgery were an issue as demand outstripped supply. The Trust had focused on improving the delivery of RTT 18 week waiting times during 2016/16. The backlog of patients waiting over 18 weeks had significantly reduced</p>	<p>On-going monitoring in place to ensure the Trust meets the 18 week RTT standard.</p> <p>March 2017 The trust has been compliant with RTT. A robust action is in place to ensure continuous improvement.</p>	September 2017	Chief operating Officer

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Waiting Times (cont)	Surgery (cont)	<p>and plans were in place for 2016/17 to reduce the backlog further. Service developments had also improved patients access to treatment</p> <p>A revised action plan is in place to reduce the backlog by 50% to 70 at the end of 2016/17 and a plan to become service line compliant at the end of November 2017. Substantive consultant to be appointed in January and an additional locum to be recruited for a February 2017 start. Additional urgent capacity implemented so the impact on the elective service should be minimal</p>			