The Leeds Teaching Hospitals NHS Trust

ACTION PLAN - CQC INSPECTION (March 2014) V1.5 22 9 14

Recommendation	Committee			Lead Director	Management Lead	Position at March 2014	Action Agreed	Date for Completion	Progress
	QC	WC	RC						
Actions that SHOULD be taken to improve quality and safety									
1. Staffing									
1.1 Ensure that there is medical ownership of patients in the emergency department, regardless of which speciality they have been referred to and accepted on.				**Chief Medical Officer**	**Steve Bush**	Process in place for medical review	Review process for medical review and communicate this to clinical leads	31 October 2014	To be discussed further at Clinical Director's forum to ensure medical ownership of patients in ED are clearly understood and communicated to clinical teams in CSUs.
1.2 Implement a 24 hour, seven day a week critical care outreach team.				**Chief Nurse**	**Lorna Johnson**	Outreach service provided 7 days a week	Complete review of critical care outreach support in line with quality improvement programme (deteriorating patient)	31 March 2015	Lead Nurse (deteriorating patient) post established; pilot wards and leads for QI programme established.
2. Training									
2.1 Ensure that all staff involved in patient care are aware of the needs of people living with dementia and that the documentation used reflects these needs.				**Chief Nurse**	**Oliver Corrado**	Improvement programme in place in line with national CQUIN, quality and safety briefing issued. Documentation reviewed and in place for dementia assessment		Completed	Completed
2.2 Review the implementation of the guidance for the use of locum medical staff to ensure the effective induction and support of doctors.				**Director of HR**	**Graham Johnson**	Locum induction process in place	Review effectiveness of locum induction	31 October 2014	
3. Risk and Safety									
3.1 Ensure that confidential patient information stored on computers in the minor injuries area is not accessible to unauthorised personnel.				**Director of Informatics**	**Johnny Chagger**	Policy in place for patient information	Review access to patient information stored on computers in the minor injuries area	30 September 2014	Completed: review undertaken
3.2 Ensure that the provision of oxygen is appropriately prescribed.				**Chief Medical Officer**	**Liz kay**	Plan agreed for rolling out new prescription booklet with integrated oxygen prescription	Implement plan and include in staff training and induction; add to e-learning mandatory training update on prescribing standards	31 October 2014	Completed: Included in Induction E-prescribing tool replaced; oxygen prescribing now included in current prescriber induction/updates. Additional implementation actions and assurance audit to be overseen through the Trust Medicines Risk Management and Medical Gases Groups
3.2 Ensure that all early warning score documentation is fully completed on each occasion used.				**Chief Medical Officer**	**Jackie Whittle**	Early warning score subject to audit to check compliance (healthcheck)	Review outcomes of healthcheck and take action where required to improve practice (compliance)	Completed	Completed
3.3 Review the use of the World Health Organisation safety checklist for theatres to ensure that it includes all elements such as the team debrief.				**Chief Medical Officer**	**Joan Ingram**	WHO checklist in place in all theatres, team brief included	Monitor compliance and integrate into performance review process	31 October 2014	Completed: World Health Organisation safety checklist for theatres discussed at Risk and Safety Sub-Committee; includes requirement to do a team brief in all areas
3.4 Review the bathing arrangements on Wards L24 and L50 to ensure that they meet health and safety standards and that there is accessible facilities for people with mobility problems.				**Director of Estates and facilities**	**Nigel Lumb**	Standards in place for the assessment of ward-based facilities in line with health and safety regulations	Undertake review of bathing arrangements on Wards L24 and L50 to ensure that they meet health and safety standards and that there is accessible facilities for people with mobility problems	30 September 2014	Completed. L24 requires minor improvement works to bathing arrangements in October 2014. Expected completion 31 October 2014. L50, assessment by Matron has identified extensive improvements may be needed. These have been passed to Estates for further consideration and development.
3.5 Introduce a robust patient tracking system for surgical patients so that there is continuity of care at all times.				**Director of IT**	**Balbir Bhogal**	Electronic system in place for patients, including daily outlier report	Review tracking process for identifying patients	31 December 2014	
3.6 Review the security of the hospital in general, but specifically with regard to access to theatre departments.				**Director of Estates and Facilities**	**Craige Richardson**	Hospital security systems in place, communications sent out to staff re visitors to clinical areas	Review access to theatre departments	31 October 2014	A review of security regarding theatre access has commenced and an action plan in place to address the issues identified.
3.7 Ensure that risk registers are of a consistent quality and contain the appropriate details regarding actions taken or in progress.				**Chief Medical Officer**	**Craig Brigg**	Risk improvement plan in place, supported by Risk Consultant; all CSU and corporate risk registers	Complete implementation of plan; review all CSU risk registers and corporate teams	31 March 2015	All CSU and corporate department risk registers scheduled for review at RMC

Recommendation	Committee			Lead Director	Management Lead	Position at March 2014	Action Agreed	Date for Completion	Progress
	QC	WC	RC						
Actions that SHOULD be taken to improve quality and safety									
						revised and updated			
3.8 Review the use of personal protective equipment on the critical care units to ensure consistent practice.				**Chief Nurse**	**Lorna Johnson**	Personal protective equipment available for staff to use on critical care units	Review use (compliance) and provide training and advise to staff	31 October 2014	
3.9 Review the arrangements for surgery on the Clarendon Wing regarding their suitability and how performance, oversight and reporting were effective.				**Chief Medical Officer**	**David Berridge**	There was a range of observations from the CQC relating to Clarendon Wing surgery	Review of Clarendon Wing Surgery in light of CQC observations and develop action plan	31 October 2014	
3.10 Ensure that the World Health Organisation safety check is consistently applied in the operating theatres. **(Chapel Allerton)**				**Chief Medical Officer**	**Joan Ingram**	WHO checklist in place	Review performance (compliance) at Chapel Allerton and provide advice and training to staff where required	30 September 2014	Completed: Compliance (performance) reviewed at theatres & anaesthetics meeting (September 2014); staff aware of requirement to complete team debrief and this will continue to be monitored
3.11 Ensure that 'do not attempt cardiopulmonary resuscitation' decisions follow best practice, and are appropriately recorded in patient records. **(LGI)**				**Chief Medical Officer**	**Adam Hurlow/Simon Whiteley**	Procedure in place for DNACPR, included in annual audit programme	Review findings of next audit to get assurance on recording decisions in medical records	31 January 2015	Quality & Safety briefing issued September 2014
3.12 Review and improve staff access to patients' notes in the outpatients department. **(Wharfedale)**				**Director of Informatics**	**Balbir Bhogal**	Medical records availability co-ordinated through the patient administration team	Review access to records in the outpatients department at Wharfedale and agree action where required	31 October 2014	Completed: Electronic method of reviewing casenotes available across all services including Wharfedale outpatients. For Services at Wharfedale, the average availability from internal reports since Aug 14 - Sept 14 approx. 86%.
4. Governance									
4.1 Consider displaying trend data over a period of time as part of the ward dashboards and that information is disseminated to staff.				**Chief Nurse**	**Jackie Whittle**	Ward healthcheck information displayed in all ward areas	Review information display and agree how trends can be communicated and displayed	30 November 2014	Information reviewed; process to be established to show trends.
4.2 Review the consent process to ensure that where appropriate the child or young person is involved in decisions and signatures are obtained.				**Chief Medical Officer**	**Ian Wilson**	Consent process (policy) reviewed in 2013	Review guidance on the involvement of children and young people in decisions about treatment, in conjunction with children's CSU	31 December 2014	Guidance on young people included in consent policy; further review to be undertaken in conjunction with children's CSU.
4.3 Appoint an executive lead for children's services to ensure that there is consistent oversight and shared learning across clinical areas.				**Chief Executive**	**Yvette Oade**	Clinical leadership provided by Clinical Director (CD), oversight provided by CMO and Chief Nurse	Executive lead agreed (Chief Medical Officer)	Completed	Completed
4.4 Review the frequency and effectiveness of the surgical morbidity and mortality meetings so that there is a more effective use of lessons learnt to improve patient outcomes.				**Chief Medical Officer**	**Bryan Gill**	Mortality and morbidity process in place, guidance provided to clinical teams	Review surgical mortality and morbidity meeting arrangements and their effectiveness	30 November 2014	Trust wide mortality group established. Visit to surgical mortality and morbidity meeting to be undertaken in November 2014.
4.5 Review the support and provision of the medical elderly care services with consideration of providing a seven day service and contribution to the monthly clinical service unit governance meetings.				**Chief Medical Officer**	**Mike Mansfield**	7 day service available in acute wards and governance forum in place.	Review services available to older people and integration of older people and medicine governance meetings	30 November 2014	
5. Communication									
5.1 Ensure that information about the Patient Advice and Liaison Service (PALS) and how to make a complaint is visible in patient areas.				**Chief Nurse**	**Krystina Kozlowska**	PALS information available to wards and departments	Check availability of PALS information in ward areas; issue communication through Heads of Nursing and Matrons	31 October 2014	Audit to be re-commenced by Sept 30th 2014 to provide assurance of availability of information on wards and to feedback findings to Heads of Nursing and Matrons.
5.2 Review the information available for people who have English as a second language and make written information more accessible including clinical decisions and end of life care.				**Chief Nurse**	**Krystina Kozlowska**	Information available to people who have English as second language	Review information available and agree actions where improvements are required	31 December 2014	Head of Patient Experience appointed September 2014; to review availability of information for people who have English as a second language.
5.3 Review the use of the Family and Friends Test results to improve consistency across departments.				**Chief Nurse**	**Krystina Kozlowska**	F&FT implemented in line with national guidance and CQUIN requirements. Reporting arrangements in place, included in ward healthcheck.	Sign up to research study undertaken by Bradford Institute of Health Research - improving the use of patient experience information	30 September 2014	Completed
5.4 Review the performance outcomes to ward safety thermometer dashboard results to ensure effective action planning to drive improvement.				**Chief Nurse**	**Jackie Whittle**	Safety thermometer reporting arrangements in place with improvement programmes for the 4 harms; reviewed at Quality	Report on progress to Trust Board and review with commissioners at NHS West Leeds CCG.	Completed	Completed

Recommendation	Committee			Lead Director	Management Lead	Position at March 2014	Action Agreed	Date for Completion	Progress
	QC	WC	RC						
Actions that SHOULD be taken to improve quality and safety									
						Committee and with commissioners (CCG); included as a KPI on ward healthcheck			
5.5 Review the effectiveness and care of patients following surgery in Bexley Wing in relation to the transfer post operation to Geoffrey Giles (Lincoln) Wing, and potential multiple moves to fit in with service operating times.				**Chief Medical Officer**	**David Berridge**	Surgical transfer and handover arrangements in place	Review arrangements for transferring patients from Bexley Wing to Lincoln Wing theatres	31 December 2014	Audit of patient transfers to be undertaken in Q4 2014/15.
5.6 Consistently apply patient feedback processes across clinical support services.				**Chief Nurse**	**Krystina Kozlowska**	Patient feedback generated through local processes, including complaints and PALS across clinical support services	Work with leads for clinical support services to implement processes for capturing patient feedback to make improvements	31 December 2014	Summary of progress on patient feedback reported to Quality Committee (September 2014).
5.7 Review the waiting times in the outpatient clinics and information given to patients to ensure these are kept to a minimum length and patients understand what to expect.				**Director of Finance**	**Helen Gilbert**	Information on waiting times for patients in outpatient clinics provided; reviewed during outpatient visits by CSU and executive team	Review information provided to patients re waiting times for all clinics, to ensure consistency and that patient are kept informed	30 November 2014	
6. Human Resources									
6.1 Review the effectiveness of the recruitment of staff processes to ensure delays to recruitment are kept to a minimum.				**Director of HR**	**Chris Carvey**	Recruitment processes revised and in place with minimum standards agreed	Review effectiveness of recruitment processes to ensure that avoidable delays are eliminated	31 December 2014	Summary of progress reported to Workforce Committee (September 2014).
8. Equipment									
8.1 Ensure that the windows on L26 are repaired and that the ventilation of the ward is appropriate to need.				**Director of Estates and Facilities**	**Craige Richardson**	Programme of review and inspection in place (estates)	Review windows and ventilation on ward L26 and undertake repairs as required	30 September 2014	Completed - The windows are checked under a ppm there is assurance that there are no problems with the windows at present. With regard to ventilation this is achieved by an air conditioning system providing both supply and extract to the ward.
8.2 Ensure that labelling is clear on equipment that has been cleaned and is ready for use. **(Wharfedale)**				**Chief Nurse**	**Zoe Kirk**	Equipment labelling process following cleaning in place	Review compliance with labelling of equipment following cleaning at Wharfedale hospital and communicate this to staff	30 September 2014	Completed; review undertaken by Head of Nursing at Wharfedale hospital
8.3 Review the sterile supplies provision for sterile instruments and equipment in theatres to be assured that they deliver good quality in a timely manner.				**Chief Medical Officer**	**Joan Ingram**	Service agreement in place with provider (B-Braun), including process for reporting incidents where sterile equipment is below agreed (safe) standard)	Review quality of service through existing arrangements and agree further improvement with B-Braun where required	30 November 2014	Joint group established (quality review) - theatres CSU and B-Braun and improvement plan agreed. Business Manager from Trust theatres CSU taken up post with B-Braun; effective working relationship established from this.
9. Information Technology									
9.1 Review the IT system to ensure that all necessary information such as that identifying if a social worker is involved when 'Looked After Children' arrive in the hospital.				**Director of Informatics**	**Balbir Bhogal**	Electronic Patient Administration process in place in all clinical areas	Review electronic information that is available relating to "looked after children" in conjunction with safeguarding team	31 January 2015	
10. Facilities									
10.1 Review the condition of the facilities in the mortuary to ensure all areas are fit for purpose.				**Director of Estates and Facilities**	**Craige Richardson**	Mortuary facilities overseen by pathology CSU	Undertake a review of mortuary facilities in conjunction with pathology CSU	31 December 2014	
10.2 Ensure that clinical waste is disposed of in accordance with legislative and best practice guidance. **(Chapel Allerton)**				**Director of Estates and Facilities**	**Craige Richardson**	Policy for the disposal of clinical waste in place across the Trust in line with national guidance	Undertake a review of disposal of clinical waste at Chapel Allerton and agree actions, including communication to staff, where required	31 December 2014	
11. Children's									
11.1 Develop facilities and recreational activities for older children and young adolescents in children's services.				**Chief Medical Officer**	**Ian Crabtree**	Recreational facilities available to older children and young adolescents	Review the recreational facilities that are available, including seeking views from patients on what they would like to have access to during their hospital stay	31 January 2015	

Recommendation	Committee			Lead Director	Management Lead	Position at March 2014	Action Agreed	Date for Completion	Progress
	QC	WC	RC						
Actions that SHOULD be taken to improve quality and safety									
12. Care									
12.1 Review the arrangements for male and female patients dressed only in theatre gowns sitting in the pre-operative area to ensure their privacy and dignity is safeguarded. **(Chapel Allerton)**				**Chief Nurse**	**Zoe Kirk**	Pre-operative waiting area overseen by Chapel Allerton hospital CSU	Review the arrangements for male and female patients at Chapel Allerton hospital in pre-operative waiting area and agree actions to ensure privacy and dignity is maintained, if required	31 October 2014	Completed: Arrangements reviewed by Head of Nursing (Chapel Allerton). Additional blankets made available in waiting area to maintain patient dignity.
13. Clinical Support									
13.1 Ensure that specimens are handled, stored and disposed of in accordance with legislative and best practice guidance. **(Chapel Allerton)**				**Chief Medical Officer**	**Zoe Kirk**	Process in place for the handling of specimens	Review compliance with handling of specimens at Chapel Allerton hospital in conjunction with pathology CSU	31 October 2014	Head of Nursing (Chapel Allerton) reviewed recommendation with Head of Nursing (Theatre and Anaesthetics); compliance in theatres to be assessed.