Kingston Hospital NHS Foundation Trust

CQC INSPECTION – 'MUST DO' ACTIONS UPDATE JANUARY 2017

	MUST DO ACTION
1.	Ensure that the Duty of Candour is adhered to by including a formal apology within correspondence to relevant persons and that records are kept.
2.	Ensure that individuals who lack capacity are subjected to a mental capacity assessment and best interest decisions where they require restraint and that this information is recorded in the patient record.
3.	Make improvements to ensure medicines are not accessible to unauthorised persons; are stored safely, and in accordance with recommended temperatures
4.	Make improvements to the systems for monitoring of equipment maintenance and safety checks in order to assure a responsive service.
5.	Ensure the management, governance and culture in A&E, supports the delivery of high quality care.
6.	Improve the quality and accuracy of performance data in A&E, and increase its use to identify poor performance and areas for improvement.
7.	Ensure all identified risks are reflected on the A&E risk register and timely action is taken to manage risks.

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Regulation 20 (1) (2) (d) & (e)HSCA (RA) Regulations 2014 Duty of candour. **How the regulation was not being met:** A formal apology was not always included in all letters written to relevant persons during and following the safety incident review process.	**MUST DO ACTION 1** **Ensure that the Duty of Candour is adhered to by including a formal apology within correspondence to relevant persons and that records are kept.**

Action	**Progress**
1) The duty of Candour (DOC) requirement has been communicated to staff via team and trust wide communications to raise awareness of this requirement	This action is complete. Extensive CQC briefings on areas for improvement have been given to all staff and there have been Trust wide communications to staff and managers on Duty of Candour
2) Template letters for patients have been developed & rolled out across the Trust	This action is complete. Report and letter templates are in place and being used by staff. These are sent out to each incident manager as part of incident investigation and management process. The letter template was reviewed to ensure it is user friendly and contains a clear apology.
3) The Duty of Candour was subject to internal audit and the actions from this are being tracked through the Trusts Audit Committee	This action is completed. The actions are tracked as part of the Audit Committee agenda/workplan.
4) Additional Duty of Candour training for senior managers & clinicians has been commissioned and is taking place in quarter 3 2016/17.	This action is complete. Intensive training was completed by a cohort of senior managers and senior clinicians in Oct 16 and feedback was very positive. A second training session has been arranged for Jan 17. Awareness training is also available for all staff. This training is part of London wide DOC training package developed by the Health Innovation Network. Session dates for 2017 have been widely publicised to staff, and were included in pay slips. Attendance is reviewed on an ongoing basis.
5) A Moderate Incident tracker has been put in place to supplement the existing Serious Incident Tracker	This action is complete and a moderate incident tracker is in place. The tracker is now reviewed by Serious Incident Group on a monthly basis.
6) A Duty of Candour audit has been designed with audits planned for quarter 3 of 2016/17	There is a mandatory DOC reporting field on Ulysses (Trust incident reporting system) and an initial audit of recording of DOC on Ulysses was carried out in Oct 16. This showed that some improvement was still necessary in recording on Ulysses that each stage of DOC had been completed. Services have been encouraged to record the DOC process in Ulysses through awareness raising with incident managers, sharing the moderate incident tracker and updating the policy and procedure. The second audit of recording DOC in Ulysses is currently underway. If this demonstrates any remaining gaps in recording DOC on Ulysses, a notes audit will be carried out in Jan 17 to provide assurance. The

	appointment of a band 7 to the patient safety team in Q4 16/17 will support the ongoing monitoring of the DOC process.
7) Revision of Duty of Candour elements of the Trusts Incident Reporting Policy taking place in September 2016; for launch with trust wide awareness raising in October 2016	This action is complete. The Policy was reviewed and shared with staff. This includes the requirement to record on Ulysses a rationale for not applying DOC where appropriate.
8) Progress with Duty of Candour requirements will be tracked through the Trusts weekly Serious Incident Group (SIG), and the Clinical Quality Improvement Committee (CQIC), Chaired by the Medical Director	The moderate incident tracker is now part of the monthly SIG work plan. When the moderate incident Tracker is discussed at CQIC in January this action will be complete.

Regulation 13 (1) (2), (4) (b), (5) & (7) (b) HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met**: Individuals who lacked capacity were not always subject to a mental capacity assessment. Individuals were being restrained without evidence of mental capacity assessment or best interest decisions having been formally made and recorded. Systems and processes were not sufficiently established around training of staff with regard to the Mental Capacity Act (2005) and Deprivation of Liberties Safeguarding.	**MUST DO ACTION 2** **Ensure that individuals who lack capacity are subjected to a mental capacity assessment and best interest decisions where they require restraint and that this information is recorded in the patient record.**
Action reported to CQC	**Progress**
1) Remind all staff of the requirements through Trust wide CQC briefings	This action is complete. Extensive CQC briefings on areas for improvement have been given to all staff and there has been Trust wide communications and briefings for staff and managers on Mental Capacity.
2) Critical Care to identify the place in clinical documentation to record capacity assessments	This action is complete. There is a CRS Mental Capacity template in use by all ITU staff.
3) Undertake 'Grand Round' session for medical & nursing staff on the Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLs)	This action is complete. A Grand Round session to discuss the Mental Capacity Act & Deprivation of Liberty Safeguards took place in Sep 16. Another Grand Round session on this topic will be held in 2017.
4) Matron led checks established for supply of 'mittens' to confirm appropriate documentation of Mental Capacity Act and best interests decision	Matrons carry out regular checks. An audit was carried out in Q3 to assess whether staff are recording correctly and in a timely manner. The audit results show improvements but there are some areas of variation and action plans have been developed to address these. To monitor improvements more closely audits have now moved from quarterly to monthly. To sustain improvements the Trust is also recruiting a nutrition nurse with responsibility for overseeing DoLS and Mittens in relation to NG tubes. A full organisational audit is planned in Feb 17 to provide assurance of improvements.
5) Ensure compliance with adult safeguarding training (which includes Mental Capacity Act & Deprivation of Liberty Safeguarding awareness) meets required minimum compliance across all clinical areas	This action is complete. Matrons are providing all staff with a certificate once their mandatory training handbook has been completed. Trust training figures are currently above 85%.
6) Provide additional Mental Capacity & Deprivation of Liberty Safeguards Training sessions targeted to medical service areas	This action is complete. MCA training and teaching sessions have commenced with medical staff. To date medical teams in the following areas have received bespoke training; Surgery and Orthopaedics, REU, Sexual Health Clinic, Dieticians, Junior doctor training (Elderly care teaching sessions). More training is planned in 2017. Bespoke training sessions for specific departments and professional groups is done throughout the year.
7) Review and amend safety checklist for 'mitten' use with the addition of a section to confirm that a patient's capacity has been assessed prior to their use in accordance with the policy	This action is complete and the checklist has been revised.

8) Add 'mittens' safety check list as an appendix to restraint policy	This action is complete. The restraint policy was updated in Jan 2016 with the safety checklist as an appendix.
9) Create plan to transfer 'mitten' safety checking documentation to electronic records by end of financial year 2016/17	Planning has commenced. The build will take some months to design, test and implement. It is planned to agree the design and implementation timeline at the end of Jan 2017.
10) Establish Safeguarding/Mental Capacity Act and DoLs link nurses in each ward	This action is complete. Link nurses are in place. Formal link nurse training by the Social Care Institute for Excellence has been arranged for Feb 17.
11) Improve quality of and accessibility of Mental Capacity Act and DoLs information for staff on the Trust intranet.	This action is complete. The Trust Intranet has been updated with clear guidance and supporting information. There is a new quick read flowchart now available on the intranet as part of a suite of information resources for all staff. MCA information and training guidance is now also on the same dedicated intranet site. All referral paperwork is collated aside guidance. A new poster has been developed for each department to display.

Regulation 12 HSCA (RA) 12 (2) (e) & (g) **How the regulation was not being met:** Systems and processes were not established or operated effectively to ensure the safety of service users. This was because; • Equipment in use by patients had not always been serviced and safety checked. • Resuscitation trolleys were not always checked to ensure they were fit for use. • Medicines were not always stored safely and could be accessed by unauthorised individuals. • Temperature checks on storage units were not always carried out.	**MUST DO ACTION 3 Make improvements to ensure medicines are not accessible to unauthorised persons; are stored safely, and in accordance with recommended temperatures.** **MUST DO ACTION 4 Make improvements to the systems for monitoring of equipment maintenance and safety checks in order to assure a responsive service.**
Action reported to CQC	**Progress**
Medication Safety 1) Remind all staff of the requirements through Trust wide CQC briefings	This action is complete. Trust wide briefings on areas for improvement have taken place including medicines and equipment. Key staff have been briefed through introduction of drug safety audits. A Monthly medicines safety newsletter is now circulated and a Medicines Safety Awareness week took place during Dec 16.
2) Create Quality Improvement Project for medication safety	This action is complete. The Medicines Storage and Security Quality Improvement Project has been established, with progress being monitored by the Clinical Quality Improvement Committee, chaired by the Medical Director .
3) Secure all drug trolleys and make any changes to medication storage as identified in the report	This action is complete. Drug trollies are now secured by chains in all areas.
4) Ensure medication room thermometers are in place, with checking process	This action is complete. There are thermometers in medication rooms and a process in place to ensure temperatures are recorded daily which is audited.
5) Review mitigation requirements for deviation of room temperatures from normal range, including any infrastructure requirements, such as cooling mechanisms,	A review of best practice elsewhere has been completed; However, this has revealed that there is no consensus. There has been investment in cooling systems in a few places but this is expensive and likely to cost c£200k-£300k to implement at KHFT. A London wide review is taking place on behalf of London Chief Pharmacists and is expected to report Spring 2017. It is proposed to await the outcome of this review before making a decision on the way forward
6) Increase medication audit frequencies to monthly across all areas of Trust, this is to include fridge and medication storage room temperatures	This action is complete. Regular and comprehensive audits now take place monthly.
7) Test compliance has been sustained through audit process	There are monthly audits in place. Results are fed back to the Medicines Storage and Security Quality Improvement Project Task & Finish Group and the Matrons group. At these groups non-compliant areas are identified and action plans agreed. Results are showing improvement overall. Further focus is required in a few areas. In particular, the consistency

	of recording temperatures at weekends when the housekeeper is not present requires improvement and plans are being developed.
Medical equipment 1) Remind all staff of the requirements through Trust wide CQC briefings, including need to ensure release of equipment at local level to allow maintenance to be carried out	This action is complete. There were Trust wide briefings on areas for improvement including medicines and equipment. Equipment is also discussed at handovers.
2) Review the staffing resource within the medical physics team to ensure delivery of timely medical equipment checks	This action is complete. A review was completed, requirements identified and additional resources approved.
3) Recruit to new posts within the medical physics team	This action is complete. Additional resources have been provided to the medical equipment team as below: • Additional engineer posts x3 recruited to (in post by end Feb 17) with gap plugged by overtime in existing team and bank admin support in the short term • Head of EBME role approved and interim in place
4) Undertake complete review of the medical equipment asset register and all other equipment (high and low risk items) by end of Dec 2016	A review of all equipment was undertaken. All items have now been given a risk level rating: • Risk level 4/5 items have all been identified and reviewed • Risk level 1/2/3 items are currently being reviewed and are part of a rolling programme Progress is being reported to the Medical Devices Group, chaired by the Director of Nursing.
5) Complete maintenance check of all OPD trolleys and ensure ongoing mechanism in place for regular checks	This action is complete. All the trolleys in OPD have now been checked. Ongoing checks will be done as part of the Planned and Preventative Maintenance schedule.
6) Implement revised reporting arrangements to the Medical Device Committee to track ongoing compliance with medical equipment checking processes	This action is complete. New style comprehensive reports and a tracking process are in place. Reports are provided to the Medical Devices Group, chaired by the Director of Nursing.
Resuscitation Trolleys 1) Remind all staff of the requirements through Trust wide CQC briefings	This action is complete. Extensive CQC briefings on areas for improvement have been given to all staff including resuscitation trolleys.
2) Increase random spot checks on resuscitation trolleys by Matrons and resuscitation officers	Spot checks are in place and these have indicated improvements. Further action is being undertaken to formalise the recording of the spot checks by matrons.

Regulation 17 HSCA (RA) Regulations 2014 Good Governance Regulation 17 (1) (2) (a) & (b) **How the regulation was not being met:** Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the services provided in ED because; • The quality and accuracy of performance data and its use in identifying poor performance and areas for improvement was not adequate. • The management, governance and culture in ED, did not support the delivery of high quality care. • Risks in the ED service were not always identified, analysed and managed.	**MUST DO ACTION 5. Ensure the management, governance and culture in A&E, supports the delivery of high quality care.** **MUST DO ACTION 6. Improve the quality and accuracy of performance data in A&E, and increase its use to identify poor performance and areas for improvement.** **MUST DO ACTION 7 Ensure all identified risks are reflected on the A&E risk register and timely action is taken to manage risks.** **EXECUTIVE LEAD: RACHEL WILLIAMS**
Action reported to CQC	**Progress**
1) Creation of an Emergency Care Programme Board (ECPB), Chaired by the Chief Operating Officer, with a number of improvement work streams.	This action is complete. An Emergency Care Programme Board (ECPB) was established July 2016 and has a work programme in place to support the improvement and sustainability of emergency care. The ECPB meets regularly and is attended by key staff internally and externally.
2) A&E workforce stream focused on addressing recruitment to middle grade roles and development and recruitment to alternative roles.	This workstream has been established, reporting to the Emergency Care Programme Board. It remains difficult to recruit middle grades but a number of alternatives have been put in place or are being explored: • Physicians associates appointed • Extended Scope Practitioner (ESP) pilot in place • A review of the consultant establishment is underway with a view to agreeing the way forward at investment Committee Jan 17 • A recruitment strategy is being developed with the Director of HR
3) Team development sessions for nursing & medical staff commissioned aimed at improving team working and engagement	This action is complete. There is a department training plan in place and a communications and engagement workstream has been established of the Emergency Care Programme Board. Clinical workshops have taken place and consultant and nursing away days completed. An action plan has been developed in relation to the staff survey results. Provisional feedback from the Internal Audit of A&E conducted in Dec 16 was that staff morale and engagement had improved.
4) Increase leadership provision in department through consultant recruitment and additional Matron	This action is complete. A Clinical lead has been appointed in ED (in addition to Clinical Director for A&E and AAU). An additional part time matron has been appointed. Additional consultants have been recruited. To support leadership a number of mechanisms have been put in place • Handover format in place with big 4 to identify priorities and areas of focus • Action card for Consultant and Nurse in Charge are displayed in department

	• Allocation of doctor roles (Lead Reg and Consultant in Charge and RAP) is shown on the rota
5) Undertake a review of progress in quarter 3 of 2016/17 by Internal Audit focused on 'must do' and 'should do' actions.	This action is complete. The internal audit review has been completed and the final report is due in Jan 17. Provisional feedback from the audit identified a number of areas of good practice alongside areas for improvement. An action plan will be finalised in response to the results upon receipt of the final report.
6) Review risk register and mitigating actions	This action is complete. The risk register has been reviewed and now reflects the relevant risks for the department at this current time. All the mitigating actions have also been reviewed. The risk register is regularly reviewed, updated and risks discussed in the governance meetings. We therefore consider this action complete.
7) Improve Friends & Family (FFT) response rates	Requirements have been reinforced with matrons and actions developed to improve performance including: • Additional IPADs have been provided to the department • Band 6/7 team are receiving a daily email with the response rate • Volunteers have been assigned to support data capture and data entry • An alternative approach to data collection (texting after the attendance) is being explored The response rate for Dec 16 was 5%
8) Utilise daily 'Kingston Day' Performance Pack for improvement and weekly review at the Emergency Care Programme Board	This action is complete. As part of the ECPB a performance data work stream has been set up. A daily and weekly performance pack has been developed and is now in use, enabling a clear understanding of the issues and areas of focus for improvement. The data packs are reviewed at ECPB weekly to inform improvement initiatives.
9) Complete technical changes within CRS to deliver full set of required metrics	The Business Intelligence team have worked with A&E to implement a number of local improvements in the system to produce more reliable metrics. A workaround solution has been developed for recording initial time to assessment pending a permanent fix by Cerner. Staff training took place in Nov 16 on how to discharge a patient correctly on the Patient Administration System.
10) Increase capacity and performance through creation of Clinical Decisions Unit	The CDU was opened 23 Nov 2016. At this early stage it not possible to reliably evaluate the impact on performance. An evaluation will be done at the end of Mar 17.
11) Review and implement changes to governance meetings and processes in Emergency Department	This action is complete. Monthly governance meetings are in place with a revamped format, full agenda and good attendance. There is a Risk lead in place to support governance and safety. Governance updates are shared with staff in a monthly newsletter.
12) Enhance learning from complaints and clinical audit including outcome measures	There are monthly governance meetings in place with a set agenda including a complaints tracker, incidents trends and themes, audits, guidance/best practice and risks. There is a scorecard in place with outcome measures. There is an audit schedule for 16-17 with action plans and a process for reviewing progress with actions from previous and forthcoming audits.
13) Improve delayed transfer of care (DTOC) meetings	This action is complete. Weekly and daily delays meetings are now embedded. There are Monthly DTOC reports and a scorecard to provide information to inform decision making. The validation and escalation process has improved and a PTL developed to track delays electronically.

14) Undertake more risk and incident reporting training with staff key staff within the Emergency Department	Incident training is in the mandatory training booklet, completion of this was at 83% for Dec 16. Staff have been reminded of the importance of reporting incidents and face to face incident training for key staff is planned for Q4 16/17.The A&E is the largest incident reporting area in the Trust.
15) Deliver compliance with hand hygiene requirements, resuscitation equipment checks and medication safety requirements	There have been a number of measures put in place to improve hand hygiene. All staff were sent a letter to remind them of their individual responsibilities. The Matron is overseeing the hand hygiene audits, and the audits have increased to a weekly frequency. Additional Infection Control training has been given to staff. The most recent performance for Dec 16 was 100% in the hand hygiene audit. Spot checks are in place to ensure there is regular checking of equipment and improvements have been found during these. Further action is being undertaken to formalise the recording of the spot checks by matrons. There are monthly medication safety audits in place. Results are fed back to the Medicines Storage and Security Quality Improvement Project Task & Finish Group and the Matrons group. At these groups non-compliant areas are identified and action plans agreed. Results are showing improvement overall.