2019 CQC Core and Well Led Quality Improvement Plan - COMPLIANCE ACTIONS

Provider: Nottinghamshire Healthcare NHS Foundation Trust

Service: Adult Mental Health In-Patient Wards

G — Positive impact of improvement found. It is embedded into practice and has been signed off by the appropriate forum.
I — Improvement considered complete by action plan lead. Evidence of compliance and embeddedness is available.
P — Progressing to time, evidence of progress.
A — Delayed, with evidence of improvement and agreed actions to get back on track.
R — Cause for concern. No progress towards improvement completion. Needs evidence of action being taken to improve.

Nottinghamshire Healthcare NHS Foundation Trust

Number	Improvement needed	Context	Action to be taken to address the cause of the issue/gap	Outcome required	Lead	Planned Start Date	Revised End Date	Completion Date	Progress Rating	Progress	Evidence outcome required has been achieved
1	There must be enough staff on wards to ensure patients have access to leave and one to one session with their named nurse.	Staff shared concerns about staffing and problems securing additional staff when needed which impacted on patient care and staff morale.	Undertake an inpatient staffing review and act on the findings. Commence rolling programme of recruitment Vacancy Tracker to be monitored via AMH Business Meeting.	Staff, patients and carers will feedback that there are sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet patients needs and the requirements of the service.	Associate Director of Nursing for local mental health services.	01/07/19	31/01/2020 Revised to 30/04/20	30/04/20	B	• A staffing review has been completed. There is a rolling recruitment programme in place. A safe staffing oversight policy has also been developed. • £1.5m investment in nursing staff.Recruitment of 24 extra Health Care Assistants across in-patient services, review of Occupational Therapy and Activity Co-ordinators, uplift of two nurses per ward from Band 5 to Band 6 to assist retention of staff. • Physical healthcare lead posts created. • Recruitment to inpatient psychology posts • 40 Trainee Nurse Associates commenced March 2020. • Vacancy Tracker monitored via AMH Business Meeting. 4.Live staffing risk report developed. • Staff bolstered by allocation of bed management. • Daily staffing escalation meetings	Outcome of staffing review led to an increase staffing establishment from 207.5wte to 287.7 with a rolling programme of recruitment. Nov 2019: Increase 2 Band 5s per ward to Band 6; Dec 2019: Increase in Psychology capacity with 5.5 psychology assistants accepting positions and 3.5 8a shortlisted psychology posts also moved to interview stage Rolling recruitment for Band 3 and 5 in situ. Inpatient Registered Nurse Vacancy rate reduced to 13%. This is to be kept under review. Notwithstanding that staffing continues to fluctuate, it is under active and continuous management. The Trust Staff Staffing Resource guide has been published. **03/08/2020: The CQC re-inspected between 19-29 July 2020 and their draft report confirmed that the Trust had achieved compliance with this standard. They had the right number of staff on shifts to meet patients need.**
2	Physical health observations must be carried out after rapid tranquilisation in line with trust policy and national guidance.	The CQC found the majority of staff knew about recent changes to the rapid tranquilisation policy in relation to the medication that they used. Staff could not however locate the physical health observations or a record of patients refusing these observations after rapid tranquilisation had been administered on Lucy Wade Unit, Orchid ward and Rowan 1 wards. In these areas, CQC saw nine instances where rapid tranquilisation had been administered but records did not contain evidence that staff	□ Introduce aide memoire of key physical obs requirements post RT to be formulated. □ Deliver face to face practice-based Rapid Tranquilisation training. □ All Registered Mental Nurses to read and sign they have read the Rapid Tranquilisation Policy. □ Rapid Tranquilisation compliance checklist to be sent to all General Managers and Matrons to screen against incident reporting □ GMs plus Matrons requested to embed RT checklist for compliance post RT and assurance (includes physical obs monitoring) following IR1 and to be demonstrated in IR2. □ Risk Management Team to forward RT incident R1 list to matrons on a weekly basis. □ Matrons set up a weekly system to monitor IR2s completed by ward managers are ensuring physical	□ Patients' physical health will be appropriately assessed on admission. In their care plans and risk assessments will reflect their physical healthcare needs throughout their time in hospital. □ Staff will consistently assess and respond appropriately to deterioration in patients' physical health. □ All NEWS2 assessments will be properly completed and used to identify the deteriorating patient. □ Risks to people's health and safety will be assessed and controls to manage identified risks will be applied and kept under review. □ NEWS2 across will be correct and where appropriate will lead to an escalation of the risk in line with policy	General Manager	01/07/19	01/07/20	01/07/20	B	• The Rapid Tranquilisation training was moved into the Basic and Hospital Life Support training, alongside the management of anaphylaxis training. • An 8-minute Training video has been created. • Ward Managers have been provided with routine incident reports on Rapid Tranquilisation. • A revised version of the Rapid Tranquilisation Policy was approved in January 2020. 01/05/2020: Additional actions agreed for the delivery of NEWS2 training and NEWS2 trend reporting 01/06/2020: Improvement in results. Continue action plan to check improvements are sustained. 17/07/2020: 86.6% compliant during June with a tolerance of 85%.	January 2020 audit showed 93% of records were fully complete or complete within 1 item. 7% had not followed up with 15 min obs. Some issues were linked to bank staff and mitigations have been introduced including more scrutiny by Matrons. Increasing number of Band 6 staff on the wards by March 2020 will provide a consistent senior nurse roster. July 2020 independent well-led inspection found staff understanding of importance to meet this standard was good. **03/08/2020: The CQC re-inspected between 19-29 July 2020 and their report confirmed that the Trust had achieved compliance with this standard. Improvements had been made in the monitoring of the physical health of patients following the use of rapid tranquillisation.**
3	Ensure that staff carry out checks of resuscitation equipment on all wards to ensure it is safe to use and ensure adrenaline is fit for use and stored in a place where there is immediacy of access.	□ The CQC found: all wards had the right clinical and resuscitation equipment. □ Adrenaline was available for emergencies. □ On B2 ward the adrenaline was stored in a locked cupboard making it more difficult to access in an emergency. □ On Lucy Wade and Orchid ward, the adrenaline did not have a tamper proof seal intact. □ Records showed that staff checked emergency equipment each week on six of the eight wards they visited.	Matrons will review practice on the wards with ward managers and provide immediate assurance on practice.	All wards check resuscitation equipment according to policy. Adrenaline will be easily accessible	General Manager	15/07/19	30/11/19	03/10/19	B	Green emergency zone boards have been fitted across the in-patient services. All anaphylaxis adrenaline is stored correctly in clinics – ward by ward training has been agreed for all Registered Nurses Training is also included in Basic and higher Life Support training.	Spot audits continue to show compliance in relation to checking of resuscitation equipment and that Adrenalin is stored appropriately in clinic cupboards, only staff members with drug keys can a+L13access this. **03/08/2020: The CQC re-inspected between 19-29 July 2020 and their draft report confirmed that the Trust had achieved compliance with this standard. The required improvements had been made in the monitoring of equipment in clinic rooms.**
4	Blanket restrictions on one ward must be reviewed so that patients are individually risk assessed for restrictions relating to accessing sleeping areas and bedrooms.	The CQC found there was a lack of clarity around why blanket rules were in place. This is a mixed sex ward. The female dormitory and bathrooms were locked meaning female patients had to ask staff to access their bed space or a shower room. Male patients could not access a shower room without asking staff.	Develop a process of oversight and review of all blanket restrictions applied on inpatient wards across the Trust.	If a ward needs to operate a blanket restriction over and above that described in the Code of Practice, this will be done for the shortest reasonable time, must be based on risk and monitored and reviewed through local governance arrangements. If the blanket restriction needs to be in operation for a prolonged period of time, this will be registered and monitored by the Mental Health Legislation Operational Group (LOG)	Medical Director	15/07/19	30/11/2019 31/01/2020 (linked to Trust wide work)	31/01/20	B	22/08/19: Blanket restriction assessment of all Trust in-patient wards undertaken. All options to be considered prior to deciding a course of action as some female patients state they support the current arrangements which is linked to the Trusts sexual safety work. 24/10/2019: Currently exploring the blanket restrictions in place across all inpatient services and communicating proposed process of oversight with the Divisions. Quality Review of identified ward where patient and staff views about the current arrangements were discussed and the various options to promote safety were explored. Spreadsheets containing all blanket restrictions developed and are kept under review at directorate restrictive practice meetings to ensure they either meet the requirements of the Code of Practice or are removed once the risk is no longer present.	A register of all blanket restrictions from reviews undertaken has been created. Proposed governance of blanket restrictions discussed at the Quality and Risk Mental Health meeting and next steps agreed. Report and register of blanket restrictions across the Trust. Process flow chart is under consultation to agree system to notify new blanket restrictions and review existing ones. **03/08/2020: The CQC re-inspected between 19-29 July 2020 and their draft report confirmed that the Trust had achieved compliance with this standard. Governance processes included oversight of blanket restrictions.**
5	Ensure that staff follow physical health care planning and complete physical health observations for patients when required throughout admission.	CQC said comprehensive care plans were present in 33 of the 36 care records and 31 of the 33 were up to date however, 45% of these could have been more holistic and 5 more recovery focussed. Also, staff had not continued to monitor blood glucose or neurological observations in some cases. Six times NEWS2 scores had not been fully completed and 3 MUST assessments on had not been done. The CQC reported that some good personal patient care plans had been developed that clearly demonstrated patient involvement and this was an improvement on their last inspection.	Physical Health Lead to link with the Quality Improvement Hub on continuing with the existing QI project plan. Physical healthcare modules to be included in the Trust's induction for all new starters Lester Tool to be completed for patients on admission Ward rounds to routinely assess physical healthcare	Patients' physical health will be appropriately assessed on admission. The care plans and risk assessments will reflect patients physical healthcare needs throughout their time in hospital. Staff will consistently monitor and assess people's needs. They will respond appropriately to any deterioration in patients' physical health. All NEWS2 assessments and other physical health monitoring forms including the Malnutrition Universal Screening (MUST) will be properly completed and used to identify the deteriorating patient. Risks to people's health and safety will be assessed and controls to manage identified	Associate Director of Nursing)	15/07/19	01/04/20	01/04/20	B	Weekly Physical Health clinics run on each ward across AMH and started WC 21st October 2019. Live Physical health tracker has been amended to identify each element of the Lester Tool, and record when all 6 elements are completed. Weekly meeting with Mental and Physical Health Matrons and ward managers to focus on individual ward performance against the above actions. Further work to develop a physical healthcare strategy is taking place. 09/01/20 – 64.2% 27/02/20 – 85.6% 12/03/20 – 87% The national target against the required parameters of the 6 areas of the Lester tool is set at 60%.	• 19/8/19 physical healthcare completion in practice report went Live for Rio users to allow Clinical leads/ Ward Managers to identify what has been done and is still outstanding for individual patients. This should help improve the timely delivery of physical healthcare interventions in practice. • 21/8/19 The Live report was launched with all Modern matrons for them to rollout to ward managers/clinical leads for use in practice. • Additional physical health/NEWS2 training is being provided in practice areas. • Physical Health Matron working with the Quality Improvement lead to review current position. Live reports regarding physical observations received weekly by ward managers to review. Matrons having weekly meetings with Ward Managers focussing on quality issues. • The national target against the required parameters of the 6 areas of the Lester tool is 60%. **03/08/2020: The CQC re-inspected between 19-29 July 2020 and their draft report confirmed that the Trust had achieved compliance with this standard. Physical health care planning had improved.**
6	The privacy and dignity of patients must be protected when observations are carried out	The CQC found on one ward that male staff looked through female patient's door blinds when completing safety observations without informing them. On one other ward the privacy blind of patient's doors were left open, including when patients were asleep in bed. Additionally, consideration had not been given to the support needs of patients who had experience past trauma. A patient said that staff left these blinds open as a matter of routine as it was easier for them	A review of practice has taken place. The clinical teams are to ensure that care is delivered in a way that protects peoples' privacy and dignity and takes account of each individual's background, needs and preferences. The teams will be supported to reflect on why practice that veered away from the expected standard occurred and lead the change required to meet people's right to privacy.	To provide a period of safety for people during a period of distress when they are at risk of harm to themselves, others or both. To see the patient under observation as a unique individual whose care should be delivered in a way that takes account of their age, gender, sexual orientation, ethnic group and their social, cultural and religious background.	General Manager	15/07/19	30/11/19	03/10/19	B	Live reports regarding physical observations received weekly by ward managers to review. Matrons are having weekly meetings with Ward Managers focussing on quality issues.	Clear statements needed: □ On respecting the dignity of patients under observation including gender of staff providing supervision and knocking on doors □ On admission that male staff may observe both genders and vice versa. □ On providing patients an opportunity to state their preference and record this. □ Quality Improvement project looking at the quality of information provided to patients on admission □ Observation poster is in situ □ Weekly audits of observation practice on one ward was shared with the CQC. **03/08/2020: The CQC re-inspected between 19-29 July 2020 and their report confirmed that the Trust had achieved compliance with this standard. Patients told the CQC they felt respected, their privacy was respected, and staff understood their individual needs, including their personal, cultural, social and religious needs.**
7	Effective governance structures must be in place to ensure that • Supervision and team meetings take place • Learning from incidents and complaints are recorded at ward level.	The CQC found inconsistent governance across wards. Risk and safety were not always well managed (having enough staff). There were issues with bed management and availability of beds for newly admitted patients and patients coming back from leave. There was inconsistent evidence of ward team meetings happening and learning from incidents and complaints was not discussed. Supervision compliance at Highbury hospital averaged 52%. Standardised practices were not in place on AMH sites. Rowan 1 did not	A short-term task and finish group will use QI methodology to support locally led changes. Minutes for team meetings to be taken to Ward managers meeting (1 from north, 1 from city) and shared with operational managers for oversight. Supervision rates are to be closely monitored.	There will be consistent governance and operating processes across sites.	General Manager	15/07/19	30/11/19	30/11/19	B	□ Service managers with ward managers scoped and mapped the skills of administrative staff and the training required. □ Supervision procedure and templates reviewed. □ Monthly ward meetings x2 to incorporate business and Quality and Risk. □ Standard agenda items and Terms of Reference to be agreed alongside training needs for chairing/minuting meetings. □ Proposed formalised structure of linking ward meetings to relevant directorate and divisional meetings agreed. □ One ward involved in QI in relation to sharing learning. □ Draft meeting agendas and Terms of Reference agreed. □ Monthly supervision figures are meeting targets □ New meeting structure has been launched with standard agendas and a focus on learning from incidents, serious incidents, complaints and incidents to begin in December 2019	Observation poster is in situ Draft agenda and Terms of Reference agreed. Monthly supervision figures are reviewed. Monthly meeting notes show improvements **03/08/2020: The CQC confirmed in their preliminary post inspection feedback that governance processes had improved.**
8	Risk assessments must contain all relevant risk information.	The CQC reported that risk assessments were present in 31 of the 36 records seen. These were completed at admission and were reviewed throughout treatment. Thorough risk assessments and robust risk management plans were seen in 24 of 31 records. However, 23% did not have a fully developed plan for the management of known risks.	□ To develop a QI project plan □ 2-day inpatient training incorporating: □ Care Planning, □ Team working and boundaries and communication; □ Trauma Informed Care 2-day training being rolled out across the 3 seeded sites To support this further, each ward is being allocated a risk assessment and care plan buddy/coach. They will be allocated to a specific area and will support the Ward Manager to review all the risks assessments and associated documents for the patients, and to offer enhanced support and leadership to all the nursing staff, and if required the wider MDT. 17/07/20: Clinical Director to work with the MDT to ensure care plans are central to the ward rounds. Deep dive planned in August 2020 into the quality of risk assessments.	Risks will be identified early and assessed as to the best way to manage or control them and to reduce their effect.	General Manager	15/07/19	01/09/20		B	• Quality Audit completed – risk assessments are being completed but improvement is needed. • All preceptors have been supported in risk assessment processes and education. • Two leaders rolled out individual training sessions with Preceptors. • Discussions with the Learning and Development team to create a bespoke Training package around risk assessments as the current E learning package does not relate clearly to practice required on the wards. • Training sessions for all qualified staff starting in January 2020 focussing on admission process including risk assessments. • Refreshed Buddying approach to Risk Assessment and Care Plans with one senior clinician per ward acting as a mentor to the ward. To be led by the Head of Nursing for AMH from March 2020 12/03/20 Two Quality Practice Improvement Facilitators have been working across AMH to support staff to formulate accurate and effective risks assessments, linked into care plans and MDT treatment strategies. They have supported Preceptor nurses through quarter 3 of the year, and have moved on to offer support to all other qualified nurses since then. They report that whilst risk assessments completion has improved, the quality remains variable, and electronic note keeping has compounded this. 22/4/20 training review has been completed. New psychology staff now working alongside wards and model good practice. 17/07/20: Buddies focussing on coaching staff, separate team will audit progress. We are 94% compliant on staff training in risk assessment.	**03/08/2020: The CQC re-inspected between 19-29 July 2020 and their draft report confirmed that the Trust had achieved compliance with this standard. Staff formulated risk assessments which considered historic and current risks for patients.**

2019 CQC Core and Well Led Quality Improvement Plan - COMPLIANCE ACTIONS

Provider: Nottinghamshire Healthcare NHS Foundation Trust
Core Service: Community Based Mental Health Services for Adults of

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NHS Foundation Trust

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9	Every location must comply with guidance on: The correct storage of medication, Room temperature monitoring, Fridge temperature monitoring, The safe storage of medication when taken out into the community.	The CQC saw that good medication management including transportation, storage and dispensing at four Local Mental Health Teams (LMHT) however, at one the CQC found some improperly stored medication which was subsequently disposed of, a fault with temperature gauges that monitored fridge temperatures and transportation of medication did not follow best practice guidance with staff taking medication out into the community in their own bags.	: Staff in all clinical areas will work to standard operating procedures. : Remote fridge temperature monitoring will be implemented, guidance, materials and training will be provided to clarify expectations, a task and finish group to improve safe storage of medicines in the community will be formed. : Undertake an internal Quality First Review to assess if improvements have been sustained.	To prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Audits will show compliance with the required standards	General Manager	15/07/19	30/11/19	30/11/19	B	• A memo regarding the disposal of expired and unwanted medicines and the transportation of medicines has been sent to all general managers. • The installation of room temperature monitoring equipment has been completed in all areas. The implementation of the programme is in progress and is being tested. • Standard Operating Procedures for dealing with ambient room temperatures has been agreed. • Further meetings planned to review results of pilot for transporting medicines in the community. • Quality First Review scheduled in September 2020	• A copy of the memo has been obtained. • The use of remote fridge temperature monitoring has been approved and implemented • Bags for the transportation of medicines provided.

2019 CQC Core and Well Led Quality Improvement Plan - COMPLIANCE ACTIONS

Provider Nottinghamshire Healthcare NHS Foundation Trust

Core Service CHILD AND ADOLESCENT MENTAL HEALTH WARDS

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Nottinghamshire Healthcare NHS Foundation Trust

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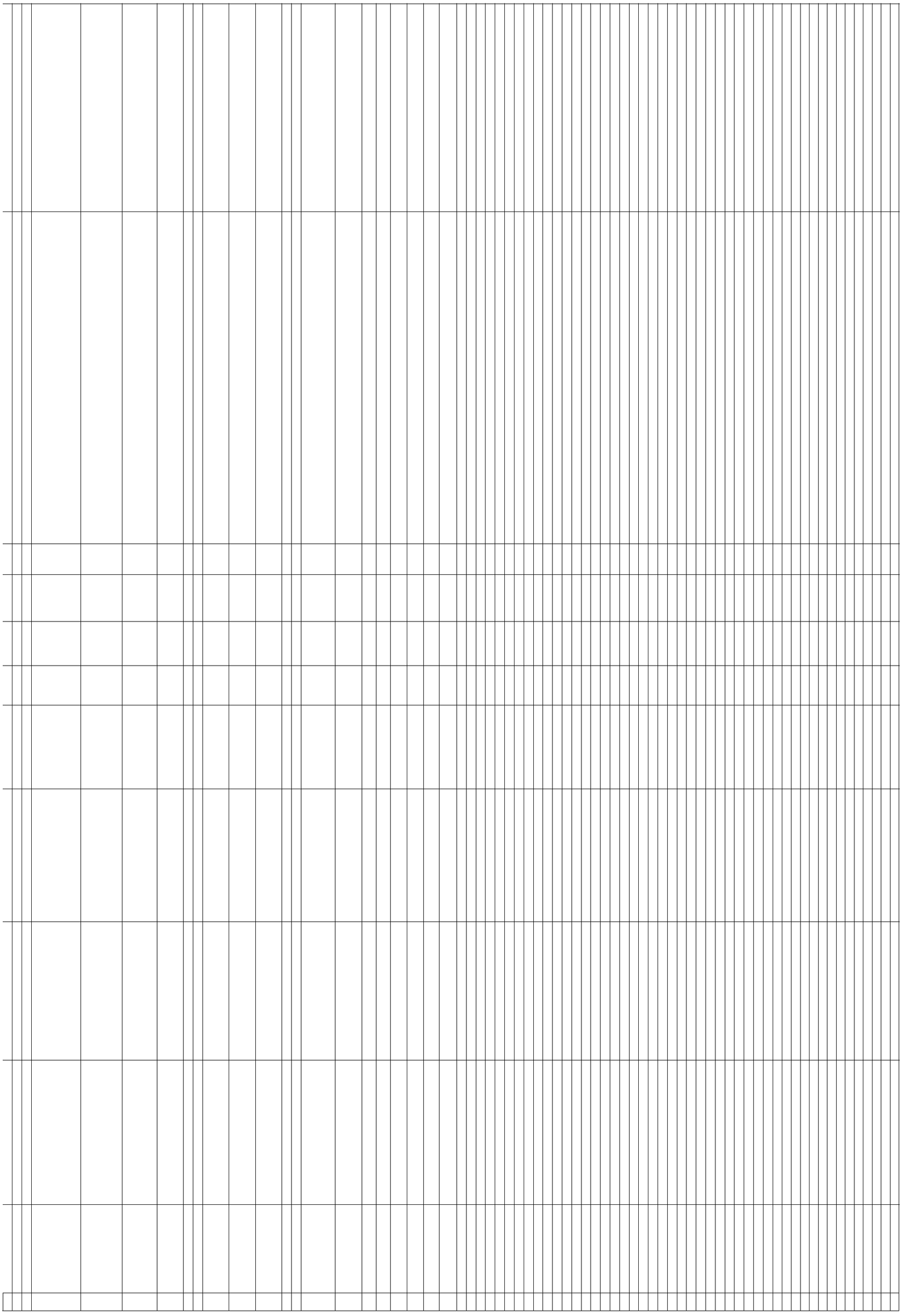
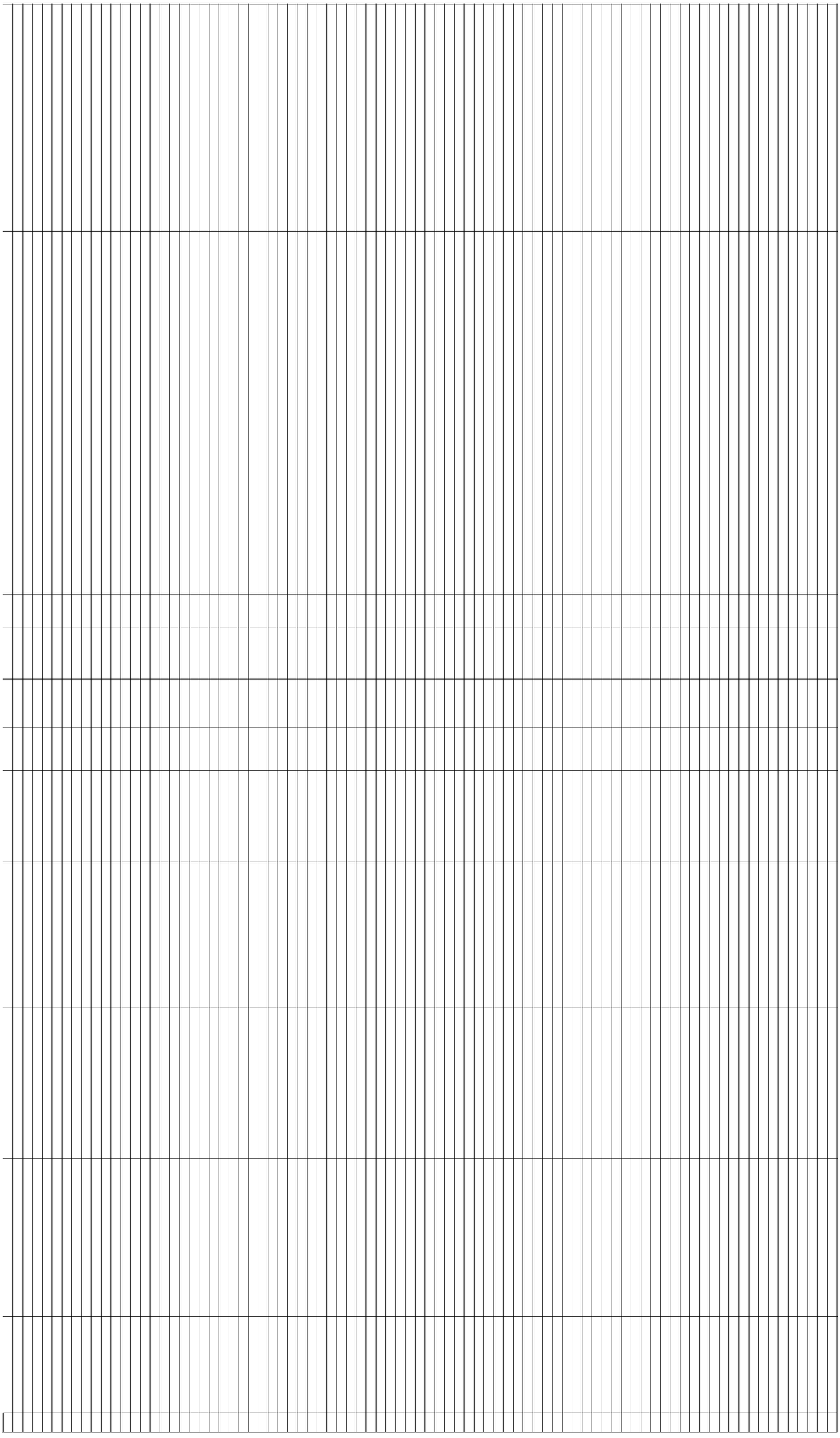
10	All staff must safeguard patient's information so that it cannot be seen by visitors to the ward or other patients.	The CQC said patient information was not always kept secure even though blinds were fitted to assist this, they were not always used. On Phoenix and Pegasus wards, CQC clearly saw patients on closed circuit television cameras because the manager's office door on one ward was left open and staff had not closed the office blinds on another	The range of options to be considered which will enable staff to have quick access to patient information but keep this private from unauthorised people. Undertake an internal Quality First Review to assess if improvements have been sustained.	□ Staff will respect patient confidentiality □ Patient information will be kept confidential.	General Manager	15/07/19	01/12/19 31/01/20 (Division wide approach taken)	31/12/19	B	White boards will have closure doors and staff aware to keep them closed. Fitting will be completed by 30 October 2019. CCTV switched off on one ward when not required not visible from other two wards. Privacy boards installed Division wide. Quality First review to be undertaken during Septemeber 2020	Screening ordered and received. Other options remain under consideration such as fitting monitors which will display a rolling reports detailing the core information required for each patient pulled from RIO. Folding information boards installed division wide.





2019 CQC Core and Well Led Quality Improvement Plan - COMPLIANCE ACTIONS

Provider: Nottinghamshire Healthcare NHS Foundation Trust

Core Service: Community mental health services for people with a learning disability or autism

G Positive impact of improvement found. It is embedded into practice and has been signed off by the appropriate forum.
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11	Staff must routinely provide patients and carers with information about how to raise a concern or complaint.	Except for residential and care home staff, patients and carers we spoke with did not know how to raise a concern or how to complain about the service they received. Staff reported they did not routinely offer this information during community contacts with patients.	Complaint materials will be reviewed with patients. We will access resources from 'Speak-up' who are experts in developing and delivering accessible information and resources that improve the lives of people with learning disabilities and/or autism. Undertake an internal Quality First Review to assess if improvements have been sustained.	We want to encourage people with a learning disability to complain when they experience poor services from the Trust. We must ensure that accessible information is readily available to patients and carers on how to provide feedback and complain about the services they receive.	General Manager	15/07/19	31/10/19	28/11/19	B	03/10/2019: Easy read leaflets for clients/carers have been produced. • This issue will be a standard agenda item on all team meeting minutes • We will explore alternative ways for patients and carers to access the complaints procedure. • Staff in all bases have ordered and received leaflets for staff in their areas and these have been issued to patients. Quality First review to be undertaken during September 2020	Easy lead leaflets amended and distributed

2019 CQC Core and Well Led Quality Improvement Plan - COMPLIANCE ACTIONS

Provider: Nottinghamshire Healthcare NHS Foundation Trust

Core Service: Mental health crisis services and health-based places of safety

G Positive impact of improvement found. It is embedded into practice and has been signed off by the appropriate forum.
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12	Staff must follow medicine management policies and procedures.	**Highbury Hospital:** The store room housing the medicines was left unlocked. The medicine key safe code was not periodically changed. The key to access prescription sheets was kept in an unlocked drawer. Medication was not transported securely to patients' homes. Patients did not sign to confirm they had received their medicines or other record of receipt not made. The sharing of learning at front line staff level was not routine. **GOOD PRACTICE NOTE:** Bassetlaw Hospital had good systems in place when staff delivered medication they stored it correctly and patients signed to say they had received their medication.	□Learn from compliant practice taking place at Bassetlaw Hospital □Standard Operating Procedure for s136 suite □ Circulate FP10 procedure. □Ensure secure storage of FP10s and review policy and procedure. □ Undertake an internal Quality First Review to assess if improvements have been sustained.	□ Staff will follow safe medicine management policies and procedures. □ Audit of medicine management in all clinical areas. □ A pilot to test bags for the transportation of medicines is taking place.	Ann Wright (GM) Supported by Michelle Malone (Clinical Director) Jo Hill (Operational Managers) and Matt Elswood (Chief Pharmacist)	15/07/19	31/10/19 31/01/20	31/12/19	B	FP10 procedure circulated to CRHT service managers and Team Leaders for dissemination to all team members. Audit of compliance to be undertaken by Matron before reviewing progress rating. 03/12/19 - Re audit of storage to be completed at Highbury site. Audits show compliance with standards. Quality First reviews scheduled for September 2020	Investigation into FP10 handling taken to Trust Medicines Oversight Group (TMOG). There is a Trust policy on FP10 which all local procedures must be aligned with.
13	Places of safety must be safe and secure.	In the Cassidy suite the trust had made number of environmental improvements, further work to fit a steel door frame was delayed due to COVID-19 and access to the required materials.	A steel door frame and improved soundproofing is required at the Cassidy suite. There are arrangements for staff to follow to mitigate the risk of this. The Jasmine suite should display a clock to meet requirements should the room be used for seclusion. □ Undertake an internal Quality First Review to assess if improvements have been sustained.	The premises where care and treatment are delivered will be suitable for the intended purpose and properly maintained.	Ann Wright (General Manager) Chris Ashwell (Associate Director) Jo Hill (Operational Managers)	15/07/19	~~01/01/20~~ 01/04/20		B	One of the doors at the Cassidy suite has been improved two are due to be completed at the beginning of November 2019 with all items required on order. The soundproofing is more complex work hence the caution about meeting the timescale for action. 29/11/19 Update Capital bid for sound proofing approved 28/11/19. Instruction to be given to Estates for the work to be completed this financial year. 08/01/20 - Works required at late stage design, out to tender by 17 January 2020. Planned completion date estimated end of March 2020 given the lead time on the new door sets and security frames. 10/03/20 - Timescale changed due to delay caused by awaiting structural arrangement drawing for new steel door frames, on receipt of these doors can be ordered and installed in 6-8 weeks. Quality First reviews scheduled for September 2020	Environmental improvements have been completed by estates and facilities.
14	Staffing levels must be safe when using restraint.	The CQC found that the trust policy says there must be three staff to use physical restraint. In the Cassidy suite this would be hard to follow if staff were either deployed elsewhere or if requests for extra staff were needed from the ward. .	□ Whilst acknowledging there were three staff on the Cassidy suite during the inspection, the CQC were not assured that this number of staff would always be quickly available for the purposes of applying physical restraint where needed in line with Trust policy. Actions to address this are linked to improvement 1 (AMH - Inpatient) □ Undertake an internal Quality First Review to assess if improvements have been sustained.	Staff, patients and carers will feedback that there are sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet patients needs and the requirements of the service. The staffing requirements on the s136 suites will be determined by taking into the presenting needs of the patient and other factors. There will however be three staff quickly available to use restrict safely if needed.	Ann Wright (GM) Jo Hill (Operational Managers)	15/07/19	31/01/20	01/01/20	B	• Linked to AMHIP - improvement 1 in the AMH in-patient section. • A staffing review has been completed □Recruitment programme is in place □Development of a safe staffing oversight policy. □Identify any gaps in staff confidence and training □Revised Standard Operating procedure for staffing in the services □Effective job planning and deployment to ensure right staffing, in right place at the right time. □ All staff MVA trained. □ Quality First reviews scheduled for September 2020	Established staffing is appropriate for need. All staff are MVA trained.

2019 CQC Core and Well Led Quality Improvement Plan - COMPLIANCE ACTIONS

Provider	Nottinghamshire Healthcare NHS Foundation Trust
Core Service	Forensic In-patient Wards

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NHS Foundation Trust

Number	Description of issue	Context	Action to be taken to address the cause of the issue/gap	Outcome required and how you will know it has been achieved	Leads	Timescales (--/--/--) Planned Start Date	Planned End Date	Completion Date	Progress Rating	Progress Comments	Evidence outcome required has been achieved
15	There must be enough staff to support the safe and effective care and treatment of patients.	The CQC found staffing was an issue across services: patients said there were not enough staff to support their care and treatment needs; It was not always possible to have a nurse available in the communal area of the ward. Staff were regularly moved to other wards to support with unforeseen increased observations or activities. Therapeutic staff often covered for staff shortages; Staff morale affected by frequent staff shortages.	• Undertake an inpatient staffing review. • Development of a safe staffing oversight policy and a recruitment and retention strategy to ensure a consistent and proactive approach is taken. • Revised Standard Operating procedure for staffing • Actively work with the university's, attending and delivering forensic sessions, organising open days and attending job fairs. • Raise profile within the social media frame work as well as reviewing its advertisement for Qualified staff. • Daily oversight of rosters, shift patterns, skill and gender mix. • Robust on call system in place to ensure cover in times of staffing issues. • Consideration of flexible working patterns and annual leave requests to ensure service needs are met but that staff have a fair, just and supportive approach to their work life balance. • Feedback opportunities via advocacy and patient experience to capture concerns from patients regarding vacancies in staffing effecting the quality of care they are receiving.	Staff, patients and carers will feedback that there are sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet patients needs and the requirements of the service.	General Managers	15/07/19	01/06/20	01/06/20	B	• A staffing review has been completed. • A rolling recruitment programme is in place and services over recruited to staff nurse posts. • Daily reviews of the actual staff available on a shift-to-shift basis versus planned staffing levels are undertaken by senior staff. Where shortages are identified, they work together to find a solution, such as the pooling of staff from other clinical areas, or the deployment of bank or agency staff. • Staffing is kept under review at roster review and approval meeting. There is a robust consistent and graded approach to reviewing and granting flexible working patterns and annual leave requests to ensure service needs are met but that staff have a fair, just and supportive approach to their work life balance. Feedback via advocacy is that there have not been any complaints from patients regarding vacancies in staffing effecting the quality of care they are receiving. Reporting indicates a reduced percentage of cancelled activities due to staffng issues. **Wells Road:** • Staff Fill Rate - the overall fill rate for shifts in June 2020 was 95% and was 94% in July. • Total sickness rate decreased from 213 calendar days in June 2020 to 138 calendar days in July 2020. **Arnold Lodge:** • Staff fill rate - the overall fill rate for shifts in June and July 2020 was 106% • Total sickness rate decreased from 336 calendar days in June 2020 to 327 (40 episodes) in July 2020.	See progress comments - Internal Quality First reviews have commenced and will continue during September /October 2020
16	Staff must follow best practice when storing, dispensing, and recording the use of medicines, including rapid tranquilisation.	Arnold Lodge and The Wells Road Centre, CQC saw: staff did not always label medicines, including insulin, that became short-dated once they were opened; at the Wells Road Centre there were gaps in signing of medicine cards; one item was omitted as not available but checks were not made to see if stock was available on other wards. Arnold Lodge staff were not all aware of lessons learnt. One ward at Arnold Lodge had large quantities of out of date medicines, another did not record Rapid Tranquilisation observations on the form directed in the policy.	• All ward staff to be informed about the requirement to dispose of expired medication in a timely and appropriate fashion • All wards to have blue and red pharmacy return bins in the ward dispensaries to dispose of "single tablets" and "whole container" medications. • Medication assessment" tool to be reviewed to ensure it includes process of safely disposing expired medication.	Staff follow safe medicine management practices	General Managers	15/07/19	31/01/20	31/01/20	B	• The use of remote fridge temperature monitoring has been implemented therefore manual checking of clinic room and clinic fridge temperatures is no longer requirednd the real time online system is functioning appropriately. • Medication audits have been introduced on all wards. They show that all topical creams/lotions etc are labelledappropriately and expiry dates clearly indicated and stored apropriately. • A learning the lessons publication was produced and sed with all staff in the forensic division for discussion at team meetings. Medication audits have been introduced on all wards. • An internal 'Quality First' review in July/August 2020 took place to review practice at Arnold Lodge and Wells Road against the CQC fundamental standards showed this standard had been met. This found: **Arnold Lodge:** Staff showed a good knowledge around medicine management and storage and this was evident in all areas. **Wells Road:** Although the issues raised by the CQC had been met, improvements were required in some areas to ensure effective stock rotation of medicines.	See progress comments - Internal Quality First reviews have commenced and will continue during September /October 2020
17	Staff must carry out physical health observations after administering rapid tranquilisation in line with trust policy and national guidance. **Relevant to one ward at Arnold Lodge.**	The CQC found that the number of rapid tranquilisation incidences (301) had increased from the previous 12-month period (112). At Arnold Lodge one ward was unable to provide the observation charts that had been used to record the monitoring of one patient. Staff used National Early Warning Score charts however, this was not in accordance with trust policy which specified staff should use a specific rapid tranquilisation monitoring form, either electronically or in paper form, and upload to the patient's notes.	• All qualified staff have been asked to read and sign the policy: the policy directs staff as to where they should be recording observations to monitor patients following rapid tranquilisation. • ALL qualified staff to be in date with rapid tranquilisation training: the training package directs staff as to what observations and where to record them. • Aide memoire distributed to all qualified staff. • A laminated copy will be provided to all wards that must be displayed for reference in all clinic rooms. • The use of the rapid tranquilisation monitoring form at each episode of Rapid Tranquilisation is stored in patients healthcare record. • Incident forms are completed for each episode of rapid tranquilisation and the rapid tranquilisation check list used by the ward manager for each ncidet form. • An algorithm to guide staff will be developed. • Guidance on intranet in the form of a policy • Short teaching video for nursing staff on the safe administration and monitoring of rapid tranquilisation. This is with the 'Crocodile' film company	The correct rapid tranquilisation form will be used to record physical health observations in line with Trust policy.	General Managers	15/07/19	01/07/20	29/05/20	B	**Arnold Lodge:** An internal 'Quality First' review in July/August 2020 took place to review practice at Arnold Lodge against the CQC fundamental standards showed this standard had been met. Staff showed good knowledge around the monitoring requirements following rapid tranquilisation. Staff were aware of the need for physical health observations. They had close links with the practice nurses and knew how to refer. The new policy has been updated and released.	See progress comments Internal Quality First reviews have commenced and will continue during September /October 2020
18	Ward environments must be clean, secure and well-maintained	The CQC found cleaning records were completed at Arnold Lodge and Wathwood. At the Wells Road records did not demonstrate regular cleaning of the ward environments including one seclusion suite. There was also a broken window that had been boarded up for several weeks and no curtains in one dining room. On two wards, staff did not record fridge temperatures where patient food was stored or date when food had been opened in the fridge or freezer. On another ward patients were allowed cables which were a ligature risk. On another ward convex mirrors had not been installed to cover blind spots. At Wathwood staff did not consistently record fridge temperatures where patients stored their food.	Although CQC found most ward areas were clean, had good furnishings and were well-maintained cleaning records on one ward at Wells Road needed to consistently demonstrate regular cleaning of the ward environment including when the seclusion suite or low-stimulus area had been deep-cleaned.	Records will show when cleaning has been undertaken and the area cleaned will meet expected hygiene standards. The environments will provide safe spaces for patients and staff.	General Managers	15/07/19	31/09/19	31/09/19	B	• Cleaning schedules are in place and action plans to resolve issues. Auditing of areas in force and actions to correct known issues addressed. PLACE audit undertaken for 2018 however deferred Nationally by NHSI in 2019 until ~October 2019. Assessments will then be undertaken and Quality Improvement Plans generated as a result • There are cleaning schedules displayed and completed by ward staff, as well as cleaning schedules for domestic service staff. • Each ward has a consistent team of domestic services staff, these schedules are monitored by the ward manager and hotel services team leader on a weekly basis as well as checked quarterly by the matrons. • There is also a monthly schedule in place for the larger cleaning duties, behind washers, dryers and cookers etc. this is completed by hotel services. An internal 'Quality First' review in July/August 2020 took place to review practice at Arnold Lodge and Wells Road against the CQC fundamental standards showed this standard had been met. Clinical environments at Arnold Lodge were cleaned to a high standard. Environments at Wells Road were generally clean tidy and bright.	See progress comments Internal Quality First reviews have commenced and will continue during September /October 2020
19	All staff must have easy access to and know how to use emergency equipment	The CQC said: On one ward CQC noted that emergency medicines and equipment were spread across two clinic rooms with the potential for confusion or delay when they were needed.	All staff must be able to access these medicines in an emergency. CQC confirmed this was rectified during their inspection. Improve access to emergency equipment on one ward where equipment was kept in two areas. This had potential for confusion or delay when they were needed. Ensure informaiton on emergency equipment is included in all ward inductions	There will be easy access to all emergency equipment	General Managers	15/07/19	31/03/20	31/03/20	B	• Immediate actions were taken to ensure all staff were confident about how to access emergency equipment. Signage was put in place to direct staff to the designated areas where the emergency equipment is kept. • All staff receive training annually in the correct use of the equipment. Regular live medical emergency drills are undertaken for staff facilitated by the physical healthcare department. Emergency bags and equipment are checked weekly, as part of routine ward checks. Photographs are now in situ depicting correct equipment to aid routine checks. • This was an issue for one site only however, for assurance, all other sites checked they were meeting expected standards. There are appropriate resuscitation bags to provide full cover across the hospital sites, this equipment is taught within the hospital life support training with is annually for all clinical staff. There is also annual basic life support training for all non-clinical staff in place, as well as training for qualified staff regarding medical devices. Wathwood has also developed a training package for all band 2-3 staff including bank staff regarding physical health and observations training which was shared with other core services. • An internal 'Quality First' review in July/August 2020 took place to review practice at Arnold Lodge and Wells Road against the CQC fundamental standards showed staff had a good awareness of the protocol relating to the emergency equipment. However, the green 'I am Clean' Stickers need to be used across the Wells Road Site.	See progress comments Internal Quality First reviews have commenced and will continue during September /October 2020
20	All clinical equipment must be checked in line with the trust's policy	The CQC found staff had not checked the emergency bag on two occasions at Wells Road. At Arnold Lodge the available emergency medicines did not match what staff had been trained to use within the trust.	Link with the Quality Improvement Hub on developing a QI project on 'Managing the Clinic Room'.	All wards check resuscitation equipment according to policy and staff will be trained in the use of these.	General Managers	15/07/19	30/11/19	31/03/20	B	•'I am clean' stickers provided and used for document when the equipment is cleaned and by whom. Cleaning schedule on nightly basis to clean all clinical equipment. • Medical equipment is cleaned after every patient use. • All Equipment is also cleaned on a weekly basis as part of the weekly infection control duties. • All equipment is checked to ensure that they are functioning properly. • Medical Devices: Resus bag checked on a weekly basis as part of weekend duties. • Weekend duties include checking Blood Monitoring machine. Medical devices cleaned daily. • An internal 'Quality First' review in July/August 2020 took place to review practice at Arnold Lodge and Wells Road against the CQC fundamental standards showed staff had a good awareness of the protocol relating to the emergency equipment.	See progress comments Internal Quality First reviews have commenced and will continue during September /October 2020
21	Effective governance arrangements must be in place to monitor and review practice; ensure environments are safe; and audits and complaints are used effectively to identify issues and encourage improvement.	The CQC found that at **Arnold Lodge**, staff were not aware of any medication audits or lessons learned as a result of these audits. This suggested these lessons or messages were not always communicated with all staff. Effective systems and processes are needed to ensure standards are met.	Effective systems are needed to ensure: • Wards are clean; • that staff are aware of any audits or lessons learned as a result of these audits; • that complaints and audits are used to learn lessons and develop practice • that supervision is undertaken in line with policy	There will be effective Governance structures and staff will be well informed about the outcome of audits and complaints and the impact this should have on their practice.	General Managers	15/07/19	~~31/10/19~~ 31/01/20	02/12/19	B	• All wards receive Lessons Learnt information from the Forensic Division and the Trust which is discussed in designated forums and cascaded to the staff. • All wards have folders in place which is easily accessible for staff to read this information. Action plans are also discussed within teams and again these are available on the wards for all staff to view. • All Wards conduct staff meetings and send out a weekly communication email to their staff teams to inform them of any wards/units matters/updates. • All action plans discussed at ward managers and incident monitoring meetings that take place monthly and any actions/amendments to practice is discussed and taken forward. 6 monthly ligature review -Wathwood have Annual Fire drills/Hospital life support/Emergency planning live and table top events. -Wathwood have been a part of the one off forensic wide ligature review. -Wathwood have the PLACE (Patients Lead Audit of Clinical Environment) audit undertaken by patient, staff and carers. -Health and safety meetings consider all risk in the environment. • Risk reports are considered monthly by the Directorate Management Team, meeting. Patients hold the managers to task in the fortnightly patients forum • All ward teams have monthly team meetings where lessons learnt are discussed and disseminated, lessons learnt form part of all non-clinical team meetings as well as part of the senior manager governance meetings. Supervision is monitored monthly and feeds in to wards and wathwood balance score cards, this is also monitored monthly via managerial supervision with all clinical managers. • Wathwood has also developed a teaching package that is delivered annually to all staff. • Audits are also disseminated to team meetings and where appropriate to the patient's forum • Arnold Lodge has been part of the Quality Network for Forensic Mental Health Services Peer Review process since February 2009. This process includes an annual independent peer review of compliance against the Standards for Forensic Mental Health Services. For our last Peer Review we obtained 93% compliance against these standards, with the remaining 7% of standards scored as 'Partly Met'. Staff have an active role attending governance meetings at Wathwood, feeding back issues the senior management team are visible and accessible at all times.	• An internal 'Quality First' review in July/August 2020 took place to review practice at Arnold Lodge and Wells Road against the CQC fundamental standards showed staff had a good awareness of audits and lessons learned. All staff interview had a good awareness of how to raise issues and concerns. Lessons learned from incident reporting is fed back through the Trust Connect, Email, staff meetings, handover and bulletins. Where appropriate patients and carers are also informed. Supervision rates have improved at Arnold Lodge and is recorded above 90% and on some wards 100%. The staff group are now working on the quality and content of the supervision received. A Notts HC bulletin and local lessons learned information is kept in communication file. Staff are expected to read this, and information is shared at hand over and team meeting.
22	Staff must use tools to monitor deterioration in patients' physical health in line with national guidance	The CQC found that staff did not consistently respond appropriately to deterioration in patients' physical health. They reviewed 161 National Early Warning Scores across the three hospital sites. Of those reviewed, 87 (54%) score sheets had omissions or errors. Errors included missed monthly National Early Warning Score scores (as per trust policy), incorrect scoring and a lack of escalation in line with policy. We found staff had not consistently completed or scored the National Early Warning Score charts and did not complete follow up observations as indicated in the National Early Warning Score escalation procedure. This presented a serious risk to patient safety.	•Review the training in relation to guidance around the use of NEWS •Nurse in Charge to ensure all physical observations are recorded on NEWS 2 by the end of the shift (including post Rapid Tranquilisation) •Ward Managers to assure Deputy/ Modern Matron about NEWS 2 recording during seclusion and Rapid Tranquilisation at least once in 24 hours (excluding weekends) •Duty Co-ordinator to check that all patients in Seclusion & Rapid Tranquilisation have had their physical observations recorded on the NEWS 2 chart for the day during their Night time (midnight) review. • Roll out hand held devices for recording observations	Patients' physical health will be appropriately assessed on admission. Their care plans and risk assessments will reflect their physical healthcare needs throughout their time in hospital. Staff will consistently assess and respond appropriately to deterioration in patients' physical health. All NEWS2 assessments will be properly completed and used to identify the deteriorating patient. Risks to people's health and safety will be assessed and controls to manage identified risks will be applied and kept under review. NEWS2 scores will be correct and where appropriate will lead to an escalation of the risk in line with policy	General Managers	15/07/19	30/09/20		B	• Training reviewed • Inconsistencies around the frequency of NEWS 2 was found across the Division. • The NEWS2 record has been introduced into RiO electronic record in forensic Services. • There is a training package for all band 2-3 staff including bank staff regarding physical health and observations training. Rapid tranquilisation training is delivered annually • NEWS2 documentation is checked by the ward manager and again quarterly as part of the governance checks by the matrons • Hand held physical observation devices will be provided to record observations therefore the issue will remain open until these are available.	An internal 'Quality First' review in July/August 2020 took place to review practice at Arnold Lodge and Wells Road against the CQC fundamental standards showed staff had a good knowledge around the monitoring requirements. Staff are aware of the need for physical health observations and they have close links with the practice nurses and know how to refer. This action remains open until the handheld devices have been acquired. Internal Quality First reviews have commenced and will continue during September /October 2020
23	The trust must ensure that staff follow the trust's policies and procedures for the use of observation. **Relevant to Arnold Lodge and Wells Road**	The CQC found that staff did not consistently follow observation policies and procedures including to minimise risk from potential ligature points. At The Wells Road Centre, staff undertaking zonal observations recorded they had seen patients when they had not. Instead, staff were completing the observation records before they had seen patients. This presented a serious safety risk to patients. At Arnold Lodge and The Wells Road Centre, staff did not always record patient observations at intermittent intervals, in line with the trust's policy. Instead, staff recorded patient observations at exactly five or fifteen-minute intervals, such as 12:00, 12:05, 12:10 or 12:15, 12:30, 12:45 and so on. This increased the risk that patients at risk of self-harm could predict when staff were due to complete their observations and enable them to harm themselves within this interval.	All new procedures or ratified procedures are disseminated to teams for reading. All staff are to read procedures and sign to say they understand expectations.	Staff will consistently follow observation policies and procedures including minimising risks from potential ligature points. All staff undertaking zonal observations will accurately record when they had seen patients. Staff will record patient observations at intermittent intervals, in line with the trust's policy and not at exactly five or fifteen-minute intervals, such as 12:00, 12:05, 12:10 or 12:15, 12:30, 12:45 and so on.	General Managers	15/07/19	Revised to 31/09/20	31/09/20	B	• All staff have been reminded of the Trusts policy in line with observations. All observations are now completed in real time. The Matron team are undertaking regular spot checks to ensure this practice is embedded. Electronic devices are being rolled out to record observations – planned implementation October 2019. • All managers attended the procedure review meetings. Staff at ward level assisted in the review of ward level of procedures. • All new procedures are sent to all managers to disseminate to staff for reading and signing; all new staff have a list of core procedures to read as part of induction. • All managers attend the procedure review meetings. Staff at ward level assist in the review at ward level of procedures. There is a delay in rolling out the hand-held devices therefore the issue will remain open until resolved. Staff expect to be moved to cover other wards as necessary. Whilst the moving of staff from ward to ward ensures that the care and safety is maintained this movement may impact on the patient. For example, when leaves and planned activities are cancelled. Patients report that they get 1:1 time offered with their named nurse. This sometimes need to be rearranged if staff get moved. On the whole the patients who were interviewed said that they feel that they get 'enough' time with their named nurse and are able to access to other staff when they need to.	• Hand held observation devices are used at Wathwood and Wells Road which ensures that observations are recorded in real time. Internal Quality First reviews have commenced and will continue during September /October 2020
24	Effective systems must be in place to record when changes are made to the care environment because of recommendations from environmental risk assessments. **Relevant to one ward**	The CQC found that staff one one ward out of the three hospital sites did not always record when changes to the environments had been made. For example, staff completed the most recent risk assessment in January 2019 and could identify and explain the key environmental risks. Although staff had taken action to reduce the risks in these identified areas and highlighted this as an action in the risk assessment, staff had not recorded that the action had been completed.	Staff will record when actions to improve the environment and reduce risks have been completed.	A record will always be made of when changes to the environment have been made and risks have been mitigated..	General Managers	15/07/19	31/03/20	31/03/20	B	• Changes to the ward environment are discussed and agreed with the Clinical Team (which always includes the Ward Manager). On completion the changes are inspected and signed off by an Estates Lead in conjunction with the Ward staff. If there are any concerns arising as a consequence of the inspection, these will be brought to the attention of the Ward Manager and / or Senior Management for resolution. • All Health and Safety Risk Assessments have been uploaded on to Odyssey environmental risk system however there was an issue accessing some documents on this new system which has now been resolved. All staff should be aware of the latest ligature risk assessments and the actions taken. • An internal 'Quality First' review in July/August 2020 took place to review practice at Arnold Lodge and Wells Road against the CQC fundamental standards showed ligature audits were completed every six months. All staff on duty knew where the ligature cutters were located and had received training. Every member of staff including bank staff should be able to articulate the areas of ligature and other risks within the ward environments and how these are to be managed. However, some staff were not clear on the policy and local protocols. This appeared to be linked to staff who had been moved from their usual base. Immediate action was taken to review the ligature and environmental audits to ensure compliance and raise awareness amongst all staff groups. Environmental risk information is being pulled together in accessible formats to ensure all staff and visitors have access to this and can articulate where risks are and how these are controlled.	See progress comments Internal Quality First reviews have commenced and will continue during September /October 2020