UPDATE FOR THE YORK HEALTH, HOUSING AND ADULT SOCIAL CARE POLICY AND SCRUTINY COMMITTEE: THE RETREAT QUALITY IMPROVEMENT PLAN 2017

An update for the Scrutiny Panel to the response to the CQC inspections of November 2016 & February 2017 and the safeguarding investigation from February-July 2017.

The Retreat Community

Compassion Collaboration Community

One of the most important institutions for the care and treatment of mental health

Contents

Section 1: Introduction

The Retreat is a charity, delivering not-for-profit specialist mental health services. We work closely with the NHS and other service commissioners and individuals to provide services for people whose mental health gives them and their families cause for concern, from the complex and challenging to the less intensive but equally distressing and anxiety-provoking.

The CQC carried out a comprehensive inspection of The Retreat inpatient services in November/December 2016. This resulted in an overall rating of 'Requires Improvement' with two requirement notices. This inspection was followed by a focused inspection on The Retreat in February 2017 in response to a number of safeguarding concerns that we had raised with the City of York Council and about which we had notified the CQC. As a result of that focused inspection, on a single current unit for older males, we received an 'inadequate' rating and further requirement notices. In addition, as a result of the safeguarding concerns that were raised in February 2017 a major safeguarding investigation was carried out by the City of York Council. The outcome from this investigation was a series of recommendations, some of which were already covered as part of the CQC actions, some of which are included in the QIP as additional actions.

Outcome of The Retreat's most recent CQC inspection – November 2017 (Draft)

Due to the reflective and considered approach, the hard work and focus on improvement that The Retreat has had since the previous inspections and the safeguarding investigation, our most recent CQC inspection rated us as **'Good' in all areas** – safe, caring, effective, responsive and well-led. Whilst the report is still in draft, this indicates that the organisation has affected a significant turnaround, showing the capacity we have to change and to improve. The inspection report states:-

> "The organisation had made improvements following feedback from our previous inspections…and improvements meant patients received safe care and treatment. The unit managers had a good understanding of their units and shared good practice. Staff were respectful and courteous at all times. Staff treated patients with dignity and respect and saw each patient as an individual. Staff involved patients, carers, and advocates in decisions about their care and treatment and … helped patients engage with their environment and take part in meaningful activities".

In addition, the report states

> "The leadership and culture of the units reflected the organisation's vision and values. Staff knew who their senior managers were and spoke highly of the support they offered. Senior managers from the senior leadership team visited units and attended team meetings to listen to staff concerns and keep staff informed of service developments".

We are in the process of turning ourselves into a learning organisation, with a culture of continuous improvement.

The 'good' rating will not make us complacent – we understand that there is always room to improve and to provide better services for the people we care for. Our aim now is to work towards becoming an outstanding organisation, a centre of excellence for mental healthcare.

Section 2: Progress

We provided our Quality Improvement Plan to the Scrutiny Committee in July 2017. Section 2 provides an update indicating our progress on each of the actions in response to the CQC inspections and in response to the recommendations made as a result of the safeguarding investigation. We can provide evidence of the progress made, if required, though our most recent CQC inspection report of the inspection carried out in November 2017, which, as stated in the previous section, rated The Retreat as 'Good' in all five areas – safe, effective, responsive, well-led.

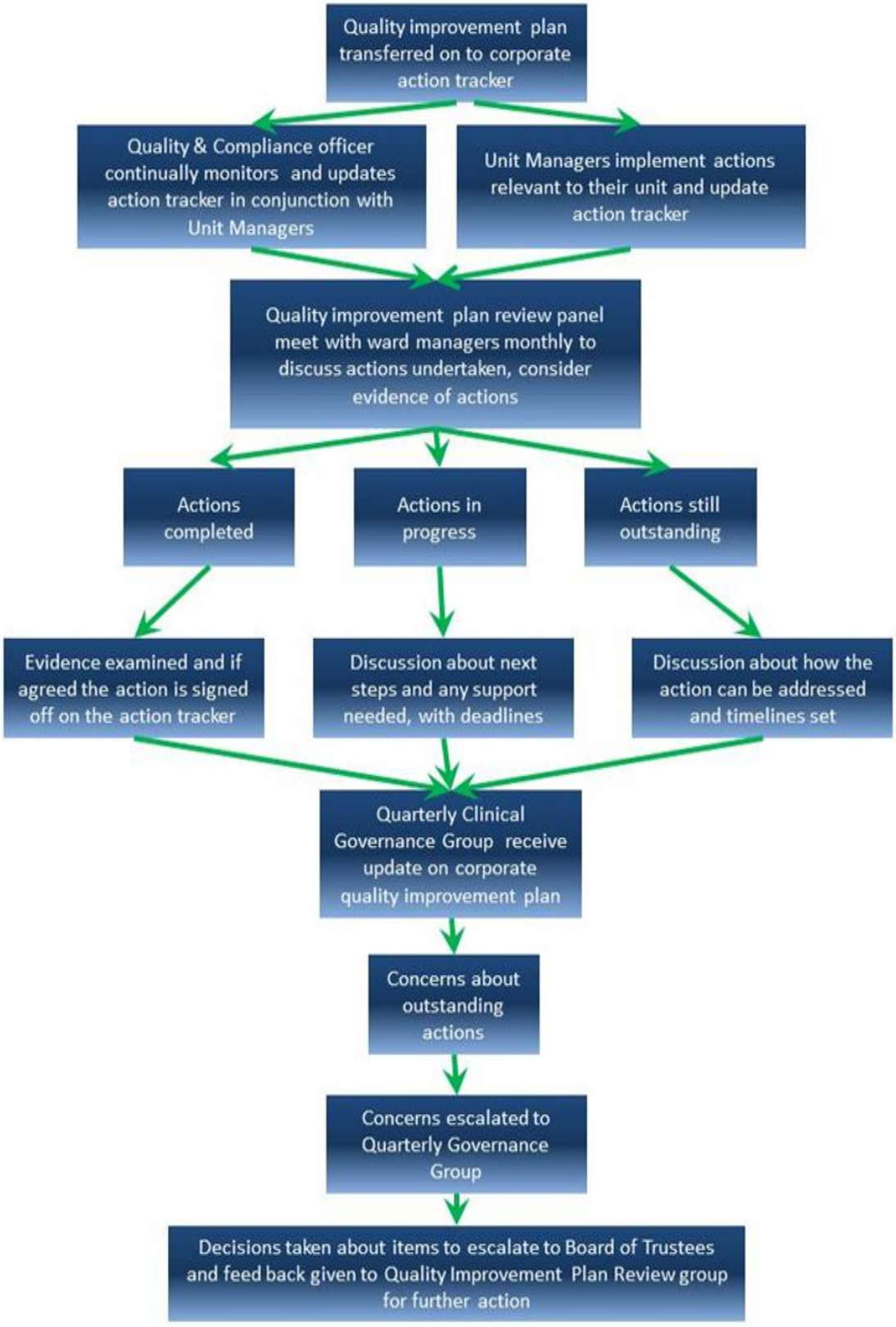
As the CQC acknowledge, we have monitored our progress carefully, using the governance process shown in Figure 1 below. In Section 3 you will see a detailed breakdown of progress made on all actions to date – green for completed, yellow for in progress and red for not yet started. Where an action is in progress or has not yet started we have outlined the impact on patients in the interim and mitigating factors.

In summary, we are pleased to confirm that we have made the following progress:-

Corporate actions	Unit specific actions	Safeguarding actions
68% completed – 31% in progress – 1 action not yet started	100%	43% completed – 57% in progress

As the Scrutiny Committee are aware, we are seeking to work more effectively with local partners, to become part of the wider mental health agenda with our STP, with local health commissioners, with NHS England and with the City of York Council to support the re-design and improved efficiency and effectiveness of our local mental health offer. We would be keen to support the implementation of York's mental health strategy and to be part of the wider implementation of the Government's Five Year Forward View.

Figure 1: Governance arrangements for monitoring progress on the QIP.



Section 3: Update on the Quality Improvement Plan

The CQC acknowledges the improvements we have made since our last inspection. Specifically, the progress we have made on our Quality Improvement Plan actions are shown in the table below, using this key:

Not yet started	In progress, with improvements being made	Completed

Quality improvement is a continuous process and we are still working on a number of areas to give us the chance to move, in the near future, from 'good' to 'outstanding'.

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 4:** Develop as a Centre of Excellence in compassionate care						
How the regulation was not being met 1: Patients on older people's units had significantly long lengths of stay. On George Jepson unit the average was 6.8 years and on the Katherine Allen unit it was 6.1 years; For some	**Immediate:** 1. Within the first week of admission, each patient will have a person centred discharge plan in place this will enable and support the client in their progress to discharge. Where possible the plans will reflect patient preference. For existing	31st August 2017		Patients may have longer stays than is beneficial for them	Unit Manager MDT	Care plan audit carried out every two months.

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
patients, the placement was not appropriate. We did not see evidence that the provider had made every effort to support patients to move on from hospital to less restrictive settings.	patients a discharge plan will be created to present at their next CPA and discharge planning will be added to the CPA checklist.					
	2. Discharge planning will be discussed at each CPA (every 6 month) this will be written into the CPA report which will sit on Care Partner. Discharge planning will include discussions with the patient where possible, their families and carers and care coordinators/ home teams.					Included in MDT Notes on Care Partner

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	3. Discharge planning will also be discussed at a named MDT every 3 month. This will be evidenced and documented in the clinical notes on care partner.					
How the regulation was not being met 2: On George Jepson 57.5% of non-medical staff had received an annual appraisal. On Katherine Allen 65% of non-medical staff had received an appraisal. On Naomi 59% of non-medical staff had received an appraisal. On Acorn 73% of	4. All non-medical staff will receive an annual appraisal after 12 months or more service	1st May 2017		N/A	All line managers	Managers' records On appraisal database
	5. Managers to record appraisal dates on the excel database provided. When an appraisal is not due dates of probation must be recorded and a date set for the forthcoming appraisal.	1st June 2017		N/A	All line managers	Monthly appraisal audit
	6. HR to produce policy and guidance on	30th August 2017		N/A	HR Manager	Evidence through policy

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
non-medical staff had received an appraisal. On Kemp 40% of non-medical staff had received an appraisal 33% of managers had an appraisal.	appraisal's which will include how /where statistics will be recorded.					
	7. HR department to set up and maintain and review their recording system so that they can provide a report on the percentage of appraisals completed.	30th August 2017		N/A	HR Manager	Monthly report on the percentage of appraisals completed.
Regulation 10 HSCA (RA) Regulations 2014 Dignity and Respect: The provider must ensure that patient dignity and respect are considered and acted in accordance with at all times **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff **The Retreat's Strategic Objective 4:** Develop as a Centre of Excellence in compassionate care **The Retreat's Strategic Objective 5:** Enable the people who use our services to find meaningful engagement within their communities						
How the regulation was not being met 1:	8. Enable access to the conservatory and garden area by clearing	Completed		N/A	Unit Manager	Visual inspection

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On George Jepson patients were unable to use the conservatory, quiet room or access the garden.	the furniture and other items and making a clear path through the conservatory to the garden					
	Immediate					
How the regulation was not being met 2: On George Jepson unit staff were unable to spend meaningful time engaging with patients as they were responding to other patient needs.	9. Timetabled activity programme to be put in place on George Jepson	Completed		Positive impact	George Jepson Unit manager	Briefing sheet outlining what meaningful activity looks like on George Jepson.
	10. Sharing the Learning: Katherine Allen to share how they record meaningful activity.	Completed		Activity already in place so impact negligible	Katherine Allen Unit manager	
	11. Put a key worker role in place to record individual, meaningful engagement which is fed into the MDT via the OTs.	Completed			George Jepson Unit manager OTs	MDT notes
	Longer term					

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	12. George Jepson will take a step by step approach to improving record keeping around meaningful activity.	1st March 2018		Negligible because activity taking place	George Jepson Unit manager	Care plans Activity records Meaningful engagement strategy document
	13. We are developing a Meaningful Engagement Strategy as part of our Strategy Work streams	31st March 2018		Negligible because activity taking place	OT Lead	Meaningful engagement strategy
How the regulation was not being met 3: Doors were locked on the units and patients were not risk assessed to be able to leave the units unescorted or without permission. Not all staff had swipe fobs to be able to leave the unit or	**Immediate**					
	14. Unescorted leave to be included on MDT forms and discussed at MDT and then incorporated into the risk assessment. This will be linked to the Restricted Practice Plan. This will occur on all units, not just to GJ unit.	1st September 2017		Some possible restrictions relating to unescorted leave, but mitigated by individual approach to patient requirements and MH status	Unit managers	MDT form MDT notes Restricted Practice Plan Risk Assessments Section 17 Leave Policy

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access to the duty room.	15. Section 17 Leave Policy revised to include risk assessment.	1st September 2017			MH Law Lead Policy Development & Ratification Group	Section 17 Leave Policy revised to include risk assessment.
	16. Agency staff will have monitored fobs, all of which will be numbered as part of the sign out process.	30th June 2017		N/A	George Jepson Unit manager	Fob records
	Longer term					
	17. There will be an identified person responsible for Security for each unit - responsible for distributing and recalling keys and alarms.	1st October 2017		N/A	Unit managers	Security person role description
	18. George Jepson will replace all mortice locks with fobs.	1st November 2017		N/A	George Jepson Unit manager Maintenance Lead	Mortice locks no longer in place

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
Regulation 12 HSCA (RA) Regulations 2014: Safe care and treatment **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff **The Retreat's Strategic Objective 4:** Develop as a Centre of Excellence in compassionate care						
How the regulation was not being met 1: George Jepson unit No reasons for missed dose codes were recorded or action taken to encourage administration or inform prescriber. The medicines electronic record in the daily notes did not always correspond to the codes documented on the medication	19. All nurses to have a medications competency assessment on a yearly basis.	31st December 2017		N/A	Unit Manager Deputy Unit Manager	Daily checking system to ensure appropriate codes are used/signature on medicine chart.
	20. Nurses will document missed dose codes and will be recorded on the IRF system as a medication error, triggering a reflective account. If regular medications missed the prescriber should be informed and review the patient.	Completed		N/A	Unit Manager Deputy Unit Manager	Absence of codes/signatures triggers an IRF and reflective account.

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
administration record or provide details of outcome of administration or reasons why medicines had been refused. Care plans did not always provide detailed medicines information or cover all aspects of care. They were not always updated when changes had occurred. Medicines were covertly administered to some patients, best interest meetings were documented in records but reviews were not documented at the frequency stated on the care plans.	21. Team managers to ensure nurses document in the daily clinical notes and reflect reason for non-administration of medication	Completed		N/A	Unit Manager Deputy Unit Manager	Results of random audit of 5 patients notes submitted as part of the monthly report
	22. Care plans should specify prescribed medications and PRN medications this should be updated after changes are made. A reference to the MARs sheet should be made for correct dosage.	30th October 2017		Minimal	Unit Manager Deputy Unit Manager	Use 'Quality of clinical records audit tool' to measure progress via monthly record keeping audit
	23. Best interests meetings will always take place where decisions will made about administering medications covertly. This will be care planned and include	30th September 2017		Minimal	Unit Manager Deputy Unit Manager	Weekly care plan checks carried out on each unit.

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
Body maps were not consistently used to identify the locations where transdermal patches had been placed.	dosage of medications and patients' preference for administration .Reviews will take place at MDT and will be recorded on Care Partner at the time of decision making.					
	24. Body maps to identify the locations of where transdermal patches are placed to be used each time a patch is replaced. These will be scanned onto the Care Plan.	Completed		N/A	Unit Manager Deputy Unit Manager	Body maps kept with the patient's medication chart.
How the regulation was not being met 2: Kemp unit Weekly stock checks had not been completed in line with the	25. Pharmacist to check stocks of medications on the unit weekly.	Completed		N/A	Pharmacist Unit Manager Deputy Unit Manager	Monthly Medicines management audit.
	26. All nurses to have an administration of	31st March 2018		Minimal because there are robust	Pharmacist	Records to be kept on each unit in a

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
hospital's medicines code. No system was in place to ensure staff had completed up to date medicines training or that they had read and understood the hospital's medicines code. Medicines reviews were not documented and completed in line the hospital policy As & when required reviews not documented as per hospital medicines code Nursing staff administration signatures did not always correspond with the prescribed medicines	medication competency assessment			checks in place around the administration of medication	Unit Manager Deputy Unit Manager	folder. Also logged on the individuals training record. Training records Clinical notes MAR chart
	27. All nurses to complete on line training in Medicines Management.	31st March 2018			Pharmacist Unit Manager Deputy Unit Manager	
	28. Medicine reviews to be documented in clinical notes and care plans reviewed where applicable. Reviewed alongside pharmacy in MDT / Report out	1st October 2017			Unit Manager Deputy Unit Manager	
	29. The timing of medication and the recording of the actual time medication was administered on the MAR chart will be more accurate.	1st August 2017			Unit Manager Deputy Unit Manager	

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
instructions.						
How the regulation was not being met 3: Naomi unit Medicines related care plans did not always provide detailed information with regards to dosages or patient preference for administration. For 'when required' medicines symptoms were not always indicated to guide staff when to administer. For patients with multiple medicines no written guidance was available as to which item was to	30. Nurses to update care plans to reflect information about medication administration where applicable e.g. liquid, tablet.	30th September 2017		Some risk that care plans may not be up to date in terms of medication, but as it's being worked on the risk is minimal	Unit Manager Deputy Unit Manager	Monthly Care plan Audit
	31. Prescribers to indicate when/why a PRN medication should be used. This should be included in the care plan also.	30th August 2017			Unit Manager Deputy Unit Manager	
	32. Specific instructions will be included in the care plan with regard to what medication should be given first, and the dose.	30th August 2017			Unit Manager Deputy Unit Manager	
	33. Reasons for omitting doses of medication	30th August 2017			Unit Manager Deputy Unit	

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
be given first or when to administer the second item. Reasons for missed doses were not documented in narrative and any actions taken were not recorded.	should be coded on the medicine chart and an entry made in the clinical notes as to why dose was missed.				Manager	
Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff						
How the regulation was not being met 1: Both units had ligature risks and blind spots. We found that staff could not always see patients on the unit.	**Immediate** 34. Update the Environmental Risk Policy (HSR 20) to include: • Changes in roles and responsibilities; • Inclusion of a specific Ligature Risk	7th September 2017		Minimal - mitigate risks through heightened awareness of environmental risk assessment process	Interim Registered Manager/Audit & Information Manager	New version of the Environmental Risk Policy HSR 20 policy & procedures (which includes formats for the assessment of environmental risks).

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	Assessment Form; • Review the current Risk Assessment Form in place for the overall unit environment (including bedrooms).					
	35. Complete all environmental and ligature risk assessments (including bedrooms) on each Unit as per guidance outlined in the policy. This will involve: • Ligature audits being completed annually unless there have been changes made to the room. • Risk assessments for patients should be completed regularly particularly on admission and when there is a change in circumstance with their clinical presentation.	30th September 2017		Minimal - mitigate risks through heightened awareness of environmental risk assessment process	All Unit Managers	MDT minutes. Individual Risk Assessments. Updated Care Plans. Unit Manager checks of Care Plans and Risk Assessments to be included in managers' monthly report.

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	• Uploading specific patient risks to individual risk management plans on the Care Partner EPR System. • Including Unit wide risk on the Unit Risk Register via the Ulysses System. This leads to identified risks in the environment consequently feeding into individual risk management plans on the Care Partner EPR System and these will be shared with the wider MDT and staff team. • Carrying out periodic checks on individual Care Plan and Risk Assessments to monitor that they reflect current unit environmental risks.					
	Longer term					

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	36. Improve the awareness, embedding and use of Policy HSR 20 and its procedures through the development and implementation of a staff intranet, which will allow the organisation to monitor awareness and understanding of all policies.	31st December 2017		Staff awareness, understanding and use of the environmental risk process is being closely monitored, so patient impact should not be negative	IT Consultant/IT Officer Learning & Development Manager	Implementation of an Intranet. Data from intranet quizzes and read audits.
	37. We are carrying out a site feasibility study to bring about change to the environments to include mitigation of ligature and blind spot risk. Risk areas that remain will be picked up on the unit environmental risk assessments.	31st December for feasibility study report Between June 2018 – June 2020 for the work emerging from the feasibility study		Risks mitigated through observations, environmental risk assessments, MDT discussions, care planning and individual risk assessments	Feasibility Study working Group Leadership Team & the Trustee Directors	Feasibility Study report Works plans

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
How the regulation was not being met 2: Patient risk plans were not all up to date and there were no patient risk assessments relating to the flooring work being completed on the George Jepson unit.	**Immediate**					
	38. To ensure that risk assessments are always updated each unit has a log to act as a prompt.	31st August 2017		Impact mitigated by additional monitoring by Unit managers are part of their monthly reporting	All Unit Managers Audit & Information Manager Risk & Quality Officer	Unit managers' monthly report and bi-monthly care plan audits as part of the annual Clinical Audit Programme. Monthly patient records check Management supervision notes
	39. It is the responsibility of the key worker & associate key worker to update the risk assessment. This will be outlined in our Risk Management Policy and Procedures.	31 August 2017		N/A	All Unit Managers All Key workers & associate key workers	Care Partner records and the monthly Care Plan Audit programme
	40. To address systemic issues relating to decision making for changes we have	Ongoing 2017 (already in place)		N/A	Leadership Team	Log of decisions made at Leadership Team and Board Level for operational &

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	implemented a Change Management system. A set of guidelines are available to all staff together with a Proposal for Changes template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our Change Management Policy which outlines the process to be followed when proposing operational or environmental					environmental change

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	change.					
	41. To ensure that we have up to date risk plans when change such as the flooring work on George Jepson is proposed the proposal for change process must always include relevant risk assessment and patient impact assessments. See Proposal for Change Protocol & guidelines	In place		N/A	Unit managers Leadership Team	Examples of proposals for change (George Jepson Phase 2 flooring)
	Longer term					
	42. Embed importance of incorporating relevant risk assessments into all Proposals for Change and subsequent project plans we are improving access to related	31st December 2017		Negative impact mitigated by additional monitoring by unit managers	Unit managers Leadership team IT Consultant Sales & Marketing Manager	Care Partner records

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	policies & procedures by implementing a staff intranet.					
How the regulation was not being met 3: Not all incidents were reported on the provider's incident management system; this meant the provider could not act on minimising all risks to patients.	**Immediate**					
	43. Ensure there is a robust IT incident reporting system that all staff are trained to use to report all incidents. The Risk & Quality Officer will visit all units to ensure they understand the system & how to use it. In addition, the Risk & Quality Officer will have a session during the staff induction programme on incident reporting	Completed		N/A	Risk & Quality Officer All staff – incident reporting is everyone's business	Daily incident reports Quarterly analysis of incidents for the Clinical Governance Group.
	Longer term					
	44. Implement a staff intranet to embed the importance of	31st March 2018		Negative impact mitigated by Risk manager and unit	Unit Managers Leadership Team	Intranet Checks of access to policies and

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	recording incidents and improve access to policies			managers raising awareness through attending unit business meetings and including it in Management Supervision.	IT consultant Marketing and Communications Manager Learning development manager	procedures
How the regulation was not being met 4: We found there to be unsafe and unsuitable staffing levels and skill mix on both units; during the move there was only one qualified nurse allocated to cover both units on a regular basis.	**Immediate**					
	45. In March 2017 Unit Managers carried out a review of their safe staffing levels which resulted in adjustments to the agreed establishment figures and budgets. Staffing levels will be discussed as a daily agenda item at the morning Unit Managers meeting.	31st March 2017		Minimal because patient care will only be impacted if staffing issues cannot be resolved. Even if staffing issues cannot be resolved the skill mix in the shift should minimise patient impact.	All Unit Managers	Actual staffing levels (from HR)
	46. Database of daily staffing records to be developed	31st March 2018		No direct impact on patient care	Director of Operations	Database records

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	47. Each morning the Site Co-ordinator will contact each of the Units to identify deficits in daily staffing, as will be stated in revised Site Coordinator Procedure.	Ongoing throughout 2017		Minimal	Site Co-Ordinators	Site Coordinator records in handover book
	48. If staffing levels are identified as low it is the role of the Site Coordinator to support and coordinate additional staffing. The process is as follows: Step 1 - The Site Coordinator will liaise with the nurse in charge to find resource within the hospital. Step 2 - Obtain staffing support from Bank. Step 3 - As a last resort obtain staffing support from agency. This procedure is outlined in	Ongoing throughout 2017		Use of agency staff can have a negative impact on patients – mitigated by this action	Site Co-Ordinators	Site Coordinator Procedure

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	the Site Coordinator Procedure.					
	49. Recruiting a Night Site Coordinator to manage the bank and oversee agency use. This will ensure that staffing is more closely monitored and that use of agency and bank are managed more effectively	30th September 2017		See above	Director of Operations	Presence of a Night Site Coordinator
	50. Learning & Development Manager will ensure that Site Co-ordinator training supports the requirements of the Site Co-ordinator procedure	31st March 2018		See above	Learning & Development Manager	Site Co-ordinator training programme contents and training stats
	Longer Term					
	51. Employer of Choice Work stream	31st December 2017	Work stream established, change	N/A	HR Manager & HR Consultant	New Recruitment and Retention

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	implemented to develop a Recruitment and Retention Strategy, which will be accompanied by implementation plans. Where additional staffing is required we will use our Proposal for Changes Template. (See Change Management Policy and Procedure for further information)		management process being used, but recruitment and retention strategy still in development			strategy Fewer staff leaving More staff recruited
	52. Employer of Choice Strategy Work stream includes a Rostering Project to improve the efficiency and effectiveness of staffing rotas.	31st May 2018	Work stream established, discussions ongoing relating to rostering	N/A	HR Manager & HR Consultant IT Manager & IT Consultant All Unit Managers	New Rostering system in place
	53. We're conducting a formal review of Bank and Agency usage. This	31st October 2017		N/A	Interim Registered Manager Night Site	New process for bank and agency use

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	will inform future planning for staff shortages.				Coordinator HR Consultant & IT Consultant	
	54. We are implementing a staff intranet to improve communication and improve access and embedding of operational policies and procedures	31st December 2017			Marketing and Communications Manager	Staff intranet to improve communication and improve access and embedding of operational policies and procedures
Regulation 17, (1 2 b c), Good Governance, of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 **The Retreat's Strategic Objective 1**: Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly **The Retreat's Strategic Objective 2:** Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes **The Retreat's Strategic Objective 3:** Improve the recruitment and retention of staff **The Retreat's Strategic Objective 4:** Develop as a Centre of Excellence in compassionate care						
How the regulation was not being met 1: Neither unit had an environmental risk register relating to	**Immediate**					
	55. To ensure that environmental risks are registered when bringing about	Completed		N/A	Leadership Team	Log of decisions made at Leadership Team and Board

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
the flooring refurbishment of George Jepson.	operational and environmental changes we have implemented a Change Management system. A set of guidelines are available to all staff together with a Proposal for Changes template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our new Change Management Policy which outlines the process to be					Level for operational & environmental change

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	followed when proposing operational or environmental change.					
	56. Unit managers to familiarise themselves with the Change Management Policy & Procedures	31/8/17		Minimal	Unit Managers	Part of key policy sign-off
	Longer term					
	57. To embed the importance of incorporating environmental risks into all proposals for change and subsequent project plans we are implementing a staff intranet.	31st March 2018	Intranet is now live but the embedding of environmental risks is an ongoing effort	Negative impact mitigated by the Risk & Quality Officer and Unit Managers raising awareness through attending unit business meetings and including it in Management Supervision.	Unit Managers Leadership Team IT consultant Marketing and Communications Manager	Examples of proposals for change (George Jepson Phase 2 flooring)
How the regulation was not being met 2:	**Immediate**					
	58. Undertake monthly Medication Audits	Completed		N/A	Pharmacist	Medication audits as part of annual

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There was no clinic room on Allis unit and medicines storage was not in keeping with best practice when we visited.	which include a question about the safe storage of medicines. If that indicates any issues with medicines storage the unit manager will take immediate action in line with recommendations from the Clinical Audit Action Plan.				Unit managers Audit & Information Manager	Clinical Audit Programme Log of decisions made at Leadership Team and Board Level for operational & environmental change
	59. All operational and environmental changes to be governed by the Change Management Policy.	Completed		N/A	Leadership Team	
How the regulation was not being met 3: We did not see, and were told by one nurse that worked on Allis unit, that there	**Immediate**					
	60. All units now have access to grab bags on their unit.	Complete		N/A	Unit managers Reception staff Site Coordinator	Presence of grab bags Grab bag checks
	61. The Resuscitation Policy (PC10) states that the	Complete		N/A	Unit managers	Grab bag checks

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
was no grab bag on the unit; a grab bag contains items to use in an emergency such as resuscitation equipment or emergency medications. The provider told us that the closest grab bag was on another unit directly below the Allis unit.	Unit Manager is responsible for the weekly auditing of grab bag contents and location using a checklist.					
	Longer Term					
	62. Weekly Grab Bag check results are part of unit weekly check records.	31st August 2017		N/A	Unit managers	Unit weekly checks
How the regulation was not being met 4: On George Jepson unit cleaning charts were not available in all patient bedrooms and support staff were not adequately protected when cleaning	**Immediate**					
	63. Discuss cleaning requirements with Unit Managers and implement appropriate improvements as per their recommendations	30th September 2017		N/A	Director of Development	Immediate actions
	Longer term					
	64. Create & implement a hospital wide cleaning	31st March 2018	Changes to the Domestic	The immediate actions will mitigate	Director of Development	Place assessments Completed

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	operational plan with Unit Managers. This will involve:- • A review of daily checking system and checklist • Domestics' Supervisor to check works complete against a checklist. • Once complete checklist should be signed by Supervisor and Unit Manager.		Services management arrangements have delayed this plan, but it is in progress	the impact, ensuring that cleanliness and records of cleaning are maintained	Unit managers Domestic Supervisors	checklists Reports from unit managers
	65. Training needs analysis for domestic team and training plans for the team, including:- • Defensible documentation • Infection control • Mental Health Awareness • Safeguarding • Incident reporting	30th November 2017	Changes to the Domestic Services management arrangements have delayed this plan, but it is in progress	The immediate actions will mitigate the impact, ensuring that cleanliness and records of cleaning are maintained	Learning & Development Manager	Training records

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	66. Conduct a review of culture and systems within Domestic services as part of strategy workstreams.	31st March 2018		PLACE and infection control identifies when things go wrong and immediate actions can be put in place.	Director of Development Interim registered manager	PLACE checks Staff survey Cleaning records Central Services Audit Quarterly Clinical Governance Report
How the regulation was not being met 5: The provider did not ensure that systems and processes were established and operating effectively to prevent abuse of service users. Staff did not report safeguarding concerns for patients on Allis unit	**Immediate**					
	67. New governance structure	31st July 2017		N/A	Audit & Information Manager Leadership Team	Governance structure organigram Terms of Reference for Governance Groups
	68. Implement a system to manage operational or environmental changes across the organisation. A set of guidelines are available to all staff together with a	Completed		N/A	Leadership Team	Log of decisions made at Leadership Team and Board Level for operational & environmental change

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	Proposal for Change template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our Change Management Policy, which outlines the process to be followed when proposing operational or environmental change.					
	69. Ensure works programme is communicated to all	31st December 2017		Should not be any significant impact because of other	Director of Operations Maintenance Lead	Works programme documentation

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	involved personnel and that it links to relevant strategic change procedures			measures		
How the regulation was not being met 6: Although there were no patients on Allis unit at the time of inspection, the unit was dirty, damp and cold; there was limited hot water and unsuitable kitchen, toilet and bathing facilities.	**Immediate**					
	70. Enter into a voluntary agreement with the CQC not to use the Allis unit unless significance works have been completed and approved by the CQC. We have no intention of using this unit again without CQC approval.	Completed		N/A	Chief Executive	Letter of voluntary agreement
	71. To ensure that a similar situation will never occur again introduce a Change Management system for all operational and environmental changes. A set of guidelines are	Ongoing (already in place)		N/A	Leadership Team	Log of decisions made at Leadership Team and Board Level for operational & environmental change

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	available to all staff together with a Proposal for Changes template to ensure that all operational/ environmental change proposals are presented in a uniformed way, containing all the necessary information to be considered by the Leadership Team and Board of Directors (if above £50,000 in cost). This process is documented in our Change Management Policy which outlines the process to be followed when proposing operational or environmental change.					
How the	**Immediate**					

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
regulation was not being met 7: The provider did not ensure that systems and processes were established and operating effectively to prevent abuse of service users. Staff did not report safeguarding concerns for patients on Allis unit	72. All staff trained on safeguarding prior to working on any clinical unit, as part of induction, with regular updates.	Complete		N/A	Safeguarding Lead Learning & Development manager Social work team	Training records
	73. Information about how to raise a safeguarding alert is clearly visible on the ward.	Complete		N/A	Safeguarding Lead	Check units for presence of poster
	74. All Management Supervisions include a check on safeguarding – reminder on management supervision template	Complete		Provided this check is in place and used, there should be no impact on patients	All managers	Management supervision template Management supervision records
	75. Ensure that we have a robust IT safeguarding reporting system that all staff are trained to use to record all safeguarding concerns and the Risk & Quality	30th September 2017		IT system and training already in place, but until it is all completely embedded culturally the unit managers will need to ensure it's	Risk & Quality Officer Unit managers All staff (safeguarding is everyone's business)	Training records Safeguarding reports (quarterly for governance and externally for LSB)

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	Officer visits all units to ensure they understand the system & how to use it. In addition, the Risk & Quality Officer has a session during all staff inductions on incident reporting which also covers reporting safeguarding concerns.			checked regularly to ensure all safeguarding concerns are being reported.		
	76. Social Work Team to visit all units to ensure they understand roles and responsibilities within safeguarding	Completed			Social work Lead All managers All staff	Social work team log
	77. Robust IT systems in place to report on and identify safeguarding themes.	Completed		N/A	Risk & Quality Officer All staff	Quarterly Clinical Governance report
	78. Service users and carers are also trained / and or provided with	Completed	Though this is a constant process, as service users and carers	Positive impact because they understand	Social work team Involvement team with Unit staff	Service users and carers' reporting

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	information on safeguarding.		change	safeguarding		
	79. Positive working with the CYC, Director sits on Local Safeguarding Board, Multiagency agency best practice Group, Safeguarding Training Group.	Completed		N/A	Director responsible for safeguarding Safeguarding Lead	Minutes of Local Safeguarding Board meetings
	Longer term					
	80. Have a safeguarding group within the new governance structure.	31st July 2017		N/A	Audit & Information Manager Safeguarding lead	Terms of Reference for the Safeguarding Group Minutes of the Safeguarding Group meetings
	81. Develop and implement a Safeguarding strategy.	31st December 2017		N/A	Safeguarding Lead	Safeguarding strategy document Safeguarding strategy implementation updates

Regulation	Action	Deadline	Progress to date (RAG)	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	82. To embed the importance of recording safeguarding concerns implement a staff intranet so that this is fully communicated and monitored.	31st March 2018		N/A	IT Consultant Marketing and Communications manager	Use of intranet Audits carried out through intranet
	83. Develop plan to address the issue of agency nurses accessing Care Partner and Ulysses	31st March 2018		N/A	Interim Registered Manager	Training records Agency use of electronic care records and reporting systems

Section 6: Recommendations for action

The following table sets out recommendations rather than mandates from the CQC inspections. These are organised under the relevant Key Lines of Enquiry (KLOEs)

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
Safe: people are protected from abuse and avoidable harm						
The provider should ensure that all shifts meet the planned staffing establishment level to ensure patient safety	84. As part of the 'Employer of Choice' strategy work stream, the processes and terms and conditions for staff will be reviewed	31/1/17	This has been implemented but it is a work in progress because we still have to use agency staff to ensure safe staffing levels	Patients do not respond well to agency staff who are new to the unit and risk levels may increase.	HR Consultant HR Manager	Staffing levels daily register Agency levels
The provider should ensure that all staff are offered regular supervision in line with its own policy. Supervision rates were low on the units and did not adhere to the provider's own policy.	85. Unit manager to ensure every nurse has line management supervision. Line management pro-forma to be reviewed to include compliance to policy standards on risk assessments and care plans	Complete		N/A	All managers across the organisation	Management supervision records
The provider should ensure that an	86. The provision and need of the ECG to be	Complete		N/A	Interim operational manager	ECG machines in place

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
electrocardiograph machine can be accessed on each site	reviewed					
The provider should ensure that informal patients are made aware of how they can leave the units.	87. Information for informal patients on all units is provided and will be included in care plans	31/7/17		If patients do not have the information they require their rights could be infringed	Involvement Lead	Information available Information in care plans
The provider should ensure that training in all courses including fire safety, record keeping, professional boundaries and prevention and management of aggression and violence meet training compliance targets on all units.	88. Management supervision pro-forma to include a question about training. Staff member who fails to meet mandatory training target to be performance managed	31/8/17		N/A	All line managers	Management supervision records Training records
The provider should ensure that all staff members have access to training	89. Management supervision proforma to include a question about other training					

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
specific to their role.	staff member requires for their role					
The provider should ensure that there is an effective process to ensure learning from investigations into incidents and complaints.	90. Re-introduce 'Sharing the Learning' information to be place in The Retreat Press, aiming to celebrate and share good practice. This will include a reflective account from a unit nurse / support worker on how they use de-escalation instead of restraint.	31/1/18	Changes in personnel delayed this slightly, but it should be in place by the end of January 2018	N/A	Marketing and Communications Manager	The Retreat Press evidence
	91. Use Share the Learning bulletin to communicate high level themes from investigations for example, complaints RCA, safeguarding and service evaluation.	30/9/17		N/A	Safeguarding Lead	Share the Learning Bulletin
The provider should	92. Develop a standardised	31/1/18	A local induction	There is a risk that	Director of	Check of the

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
ensure that all bank agency and staff covering shifts receive local inductions to units.	induction pack for agency and bank staff, with consistent section headings and local procedures for local induction.		is provided, but we have not yet produced a standardised pack	without a standardised and thorough induction agency staff will not understand how best to care for patients on the unit	Operations	induction pack Feedback from agency staff on usefulness of the pack
The provider should ensure that when patients refuse physical healthcare checks a care plan and risk assessment is in place to mitigate and reduce risk.	93. Include a section on choice in both care plans and risk assessments	31/10/17	Changes in personnel have impacted on the implementation of physical healthcare check record keeping, but this is in progress	Minimal	Director of Operations	Care Partner
	94. Implement a procedure to ensure risk assessments and care plans are updated to reflect mitigation of risk when patients refuse physical healthcare checks	31/8/17		Minimal	Unit Managers	Audit of care plans and risk assessments
The provider should ensure that people are supported if they wish to make a	95. Review Advocacy contract	30/9/17	And it is part of the agreement to have an annual review	Minimal	Director of Development	Reports from advocacy Complaints records

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
complaint.	96. Advocacy policy to be reinstated and reviewed with clear guidance for staff	30/9/17		Minimal	Director of Development	Advocacy policy Staff guidance for use of advocacy
The provider should ensure that informal patients are made aware of how they can leave the units.	97. Continue to roll out Positive Behavioural Support frame work in care plans	30/9/17		Minimal	Director of Operations Unit Managers	Monthly Care plan audit
	98. Every care plan to include section on restrictive practice reduction	30/9/17		Lack of PBS	Director of Operations	Monthly Care plan audit
	99. Every unit to have a restrictive practice reduction programme	30/9/17		There may be a minimal risk of restrictive practice, but our practice values do not support that approach	Director of Operations	RPR programme documentation
Caring: The provider must ensure that they involve and treat people with compassion, kindness, dignity and respect.						
The provider should ensure patients have	100. We will continue with a central register of	Complete		N/A	Involvement Lead Unit Manager,	Dignity council standards to be live

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
access to outside space and all facilities available on the unit.	dignity champions and roles on unit				Katherine Allen	and observed on all units
Actions determined by The Retreat related to involvement and dignity	101. Increase celebration of Involvement by including staff accounts of how they involve and a service user account of what this means to them in The Retreat Press	30/9/17	We have included some such accounts, but it is not a regular feature as yet	N/A	Marketing and Communications Manager	The Retreat Press
	102. Laundry service review with the aim of developing a personalised laundry service if capacity allows	31/10/17	The review has been carried out and there is an action plan in place, but personalisation has not yet been implemented	Risk of poor laundry service	Director of Development Lead Domestic Services	Feedback from patients and carers
Responsive: Services are organised so that they meet people's needs						
The provider should ensure patients have access to outside space and all facilities available on	103. Wherever possible, maintain an environment, across all our services, which	31/10/17		Risk of some restrictive practices	Director of Operations	Unit accessibility and use of outside space

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
the unit	provides service users with access to a range of facilities that promote recovery, comfort, dignity and confidentiality without the barrier of locked doors.					
Action from The Retreat	104. Service users will be consulted when changes such as relocating to another unit. The new change management policy stipulates the all views must be sought	30/9/17		Risk of lack of consultation with patients	Director of Development	Change management policy Proposals for change
The provider should ensure that there is sufficient space for all patients to access a seat in the dining room at mealtimes.	105. Patients and staff do not feel that the dining facilities on the Naomi Unit are big enough to accommodate everyone. This is on our corporate risk	Review 30/9/17	At present, we cannot change the environment on the unit, but this will be part of the options appraisal we are carrying out	Lack of space for patients when dining	Director of Operations	Naomi unit space Dining survey

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	register and we will continue to monitor it.					
The provider should ensure that people are supported if they wish to make a complaint.	106. Review the complaints, concerns and compliments policy to reflect current practise, best practise in line with government guidance.	30/9/17		Risk of some lack of willingness to complain	Risk Officer	Complaints policy Number and nature of complaints
Effective: People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.						
CQC reported that they saw patient care plans that had not been updated in the last three months	107. Remedial action to be taken to ensure care plans are all updated regularly and frequently	30/6/17		N/A	Unit Managers Director of Operations	Monthly Care Plan audit. Unit Managers' monthly report
Ensure all Mandatory Training courses have a minimum of 80%	108. Monitor mandatory training completion and follow up	30/6/17		N/A	Training manager HR Unit Managers	Quarterly Clinical Governance Performance Report

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
staff trained by Unit.						
The provider should ensure that all staff are offered regular supervision. Supervision rates were low on the units and did not adhere to the provider's own policy.	109. Monitor supervision and ensure staff have access to it on a regular basis	31/8/17	This was completed but it is an ongoing process and we need to monitor it regularly	N/A		Clinical Supervision Monitoring audit schedule in the Clinical Audit Programme for Q3.
Not all patients had an allocated social worker	110. Ensure all patients have an allocated Social Worker	31/7/17		Risk that some patients will not get the support they require	Social Work Lead	Social Work allocations
The CQC saw that three patients had no crisis plans visible. Crisis plans allow staff to know how best to look after patients when in crisis.	111. Ensure crisis plans are in place where appropriate	31/8/17		Risk that staff will not know how to support patients in crisis effectively	Unit Managers	Crisis plans in place

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
Well led: the leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.						
The provider should ensure that staff concerns relating to blame culture and victimisation continue to be monitored and ensure that action is taken to review and address progress.	112. All staff to be aware of the supervision process. Individuals to be aware of their own responsibilities within this. Managers to monitor the supervision rates and act accordingly.	31/12/17	This is checked at management supervision, but it is an ongoing process	N/A	CEO All managers across the organisation	Staff survey
The provider should review administrative and maintenance support to the units to ensure administrative tasks are undertaken in a timely manner where linked to patient care.	113. Review administrative services across the hospital	30/9/17		N/A	Director of Development Lead Administrator	Admin review document
	114. Implement recommendations from the administrative review, where appropriate	31/12/17		N/A		Feedback from units
	115. Admin lead to provide a Proposal for Change	31/10/17		N/A		Proposal for Change

Area for Development	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
The provider should ensure that an electrocardiograph machine can be accessed on each site.	116. New ECG machine to be provided, where necessary	31/8/17		Minimal, but there may be some delays	Medical Director	ECG availability
The provider should ensure that all staff have access to training specific to their role	117. Eating disorder specialist training to be sourced and provided	30/9/17	Some restrictions on training related to individual development has been imposed but this will be reviewed in early 2018	Minimal because all essential training is mandatory	Consultant Psychiatrist, Naomi Unit	Staff knowledge
	118. DID training to be sourced and provided	30/9/17			Consultant Psychiatrist, Kemp Unit	Staff knowledge

Actions from the Safeguarding Investigation carried out between February and July 2017

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
Risk assessments and care plans to be reviewed and updated in a timely way in response to an identified change in need and/or environment, in order to adequately inform safe and effective care delivery.	119. Units to ensure that system is in place to enable relevant staff to review and update risk assessments and care plans	31/10/17		N/A	Director of Operations Unit Managers	Care Plan Audits
	120. Unit managers to discuss the importance of updating risk assessments and care plans responsively, with their staff, in their individual management supervision	31/10/17		Risk of having out of date risk assessments and care plans, resulting in incorrect care being delivered to patients	Unit Managers	Management Supervision Records

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	121. Director of Operations to check with Unit Managers, during their management supervision, on their care plan audit outcomes against reviewing and updating care plans and risk assessments responsively	31/10/17		N/A	Director of Operations Unit Managers	Care Plan Audits Management Supervision Records
A robust audit system to be in place to ensure that care plans and risk assessments are up to date and accurately reflect and address the current risks.	122. Head of Nursing & Patient Safety[1] is to establish the frequency of risk assessment and care planning reviews, and embed into everyday monitoring practice, to ensure each care plan reflects and	30/09/17	This has begun and is in progress but until we are sure it is embedded we are not signing this off	N/A	Head of Nursing & Patient Safety Unit Managers	Nursing Practice Standards Care Plan Audits

[1] Please note that we have put in place interim arrangements for the Head of Nursing and Patient Safety role because the substantive post-holder is on long-term sick leave.

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	mitigates current risks.					
	123. Head of Nursing& Patient Safety to expand current care plan audit tool to ensure it is capable of measuring performance against the stated frequency for reviewing patient risk assessments and care plans.	30/09/17	Changes in personnel have impacted on this, but it is in progress	N/A	Head of Nursing & Patient Safety	Nursing Practice Standards Care Plan Audit
	124. Head of Nursing & Patient Safety to provide regular monthly KPI outcome measures, to the leadership team, to assure ourselves that the monitoring of risk assessments and care plans, and regular review of each, is effective and that any required corrective	31/10/17	Changes in personnel have impacted on this, but it is in progress	N/A	Head of Nursing & Patient Safety	KPI Dashboards Care Plan Audit

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	actions are taken in a timely manner					
Handwritten entries on daily monitoring charts should be signed, in accordance with defensible documentation standards.	125. Head of Nursing & Patient Safety to establish and communicate clear standards of practice in relation to all documented entries, including where handwritten entries are made.	31/10/17	In progress	N/A	Head of Nursing& Patient Safety Unit Managers	Care Plan Audits Nursing Practice Standards
	126. Head of Nursing & Patient Safety to create an audit tool capable of measuring performance outcomes against practice standards in relation to defensible documentation	31/10/17		N/A	Head of Nursing& Patient Safety	Nursing Practice Standards Audit Tool

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	127. Unit Managers to ensure all staff, including other colleagues, apply consistent practice against defensible documentation practice standards, and address any non-compliance with these standards, in a timely manner	31/10/17		N/A	Unit Managers	Nursing Practice Standards Audit Tool Management Supervision Records
Unit Manager/PMVA trainer to ensure that any identified staff training needs in relation to PMVA are addressed (including via 'bespoke' problem solving advice/support as necessary).	128. Director of Operations and Training Manager to conduct a full review of how PMVA training is managed, monitored and delivered	31/10/17		N/A	Director of Operations Training Manager	Revised PMVA Training Plan
	129. The PMVA Trainer to work with Unit Managers, staff and patients to ensure all	31/10/17		N/A	Training Manager Unit Managers	Care Plan Audit MDT Meeting

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
	PMVA requirements have been assessed, and PMVA responses are person centred , and is reflected in the patients care plan; regular weekly reviews will occur within the MDT process ; and that PMVA Training Needs have also been assessed and delivered					Minutes Training Needs Analysis
Ensure that care delivery is reflective of the care plan – in particular, where the care plan requires daily monitoring and recording, records should evidence this (e.g. repositioning, personal care) and should contain sufficient detail.	130. Unit Managers to ensure all care plans accurately reflect the care required, and that appropriate records and/or forms provide the necessary detail required to evidence the level of care required and provided.	30/09/17		N/A	Unit Managers	Care Plan Audit
Ensure an appropriate wound	131. Head of Nursing &	31/10/17		Risk of wounds not being managed	Head of Nursing &	Wound Assessment

Recommendation	Action	Deadline	Progress to date	Patient Impact in the interim	Person(s) Responsible	Audits & Evidence
management system is in place (including assessment and monitoring) and wound documentation is completed to evidence best practice.	Patient Safety to develop a wound assessment tool that incorporates NICE guidance and the National Early Warning Score mechanism, and takes into account: ✓ All complex cases e.g self-harming ✓ All pressure ulcers ✓ All leg ulcers			and reviewed in a timely manner	Patient Safety	Tool
A robust system of auditing is to be in place to ensure that actions cascaded down to senior staff to implement are followed up on to ensure their implementation.	132. Head of Nursing & Patient Safety to complete a gap analysis on current audit tools and to identify and bridge any gaps; develop and audit system capable producing regular dashboards.	31/10/17		N/A	Head of Nursing & Patient Safety	Revised Audit Tools