University Hospitals of Leicester NHS
NHS Trust

CQC Action Plan

April 2014

Approved Quality Assurance Committee and Trust Board April 2014

Resuscitation
Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use the service
People who use services and others were not protected against the risks associated with unsafe or inappropriate treatment as resuscitation services were not consistent in provision, knowledge or equipment across all locations and as reflected in published guidance. Regulation 9 (1) (b) (iii)

Ref	Area for Improvement	Action to be taken	Risks to Delivery	Lead for Action	Action Completion Deadline	Progress RAG	Progress update/comment	Monitored by
1a	Adequate assurance that there is consistent provision of resuscitation services	Refresh resuscitation committee membership and terms of reference with clear lines of accountability reporting to Executive Quality Board		Medical Director (Deputy Medical Director)	May 2014	5	Sent to EQB in March 2014.	Resus Committee
		Agree a work programme for Resuscitation Committee		Deputy Medical Director (Chair of Resuscitation Committee)	May 2014	5	Sent To EQB in May 2014	Resus Committee
		Consider establishing resuscitation link nurses		Deputy Medical Director/Julia Ball, Assistant Director of Nursing (Senior Clinical Skills Facilitator)	June 2014	5	Senior Resuscitation Officer met with Assistant Director of Nursing to outline proposals. Confirmed responsibility of ward/clinical area manager.	Resus Committee
		Review resuscitation team staffing levels		Deputy Medical Director (Senior Clinical Skills Facilitator)	~~June 2014~~ ~~August 2014~~ **September 2014**	4	Julia Ball and Pete Rabey to redraft paper and liaise with Helen Mills and Lee Rowley.	Resus Committee
1b	Adequate equipment	Refresh plan for		Deputy Medical	June 2014	5	Standardisation of major	Resus

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	provision	equipment standardisation and present to Executive Quality Board		Director (Senior Clinical Skills Facilitator)			components complete or on track – Resuscitation trolleys, drug boxes and defibrillators. Ongoing plan will need continuous monitoring	Committee
		Improve checking systems for resuscitation equipment trolleys		Deputy Medical Director (Senior Clinical Skills Facilitator)	May 2014	5	Resus team have conducted a review of cardiac arrest trollies at LRI, significant problems were identified with checking of the trollies. LR presented finding to Nursing Executive Team (NET) and a change to Matrices have been made so senior nurse have to physically check the trolley.	Resus Committee
		Assurance of checking systems through regular reporting to resuscitation committee		Deputy Medical Director (Senior Clinical Skills Facilitator)	~~June 2014~~ October 2014	4	Checks are taking place. Reports to Resuscitation Committee to commence September 2014.	Resus Committee
		Standardise resuscitation equipment across the Trust - drug boxes		Deputy Medical Director (pharmacist)	August 2014	5	MF to implement the standardised Drug box into the cardiac arrest trollies. Adult boxes standardised	Resus Committee

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							and 2 sizes for paramedics to be reviewed/standardised.	
		Standardise resuscitation equipment across the Trust - equipment trolleys		Deputy Medical Director (Senior Clinical Skills Facilitator)	August 2014	4	Trollies being delivered on schedule in 25 batches.	Resus Committee
1c	To improve staff knowledge/skill	Review training provision and compliance and develop detail plan	Sufficient resuscitation trainers	Deputy Medical Director (Senior Clinical Skills Facilitator)	June 2014	5	Capacity not an issue. Overbooking to commence in August.	Resus Committee
		High level communication to all staff to stress importance of resuscitation training		Deputy Medical Director (Senior Clinical Skills Facilitator)	~~May 2014~~ June 2014	5	Prepared. To be sent out with wider message about mandatory training. Message on InSite in June.	Resus Committee
		Distribute quick reference guide to all staff 'what resuscitation training do I need and how to book training'		Deputy Medical Director (Senior Clinical Skills Facilitator)	May 2014	5	Clear guidelines re statutory and mandatory training	Resus Committee
		Review training provision to ensure it is in line with		Deputy Medical Director	~~May 2014~~ ~~June 2014~~	5	Training provision reviewed.	Resus

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		Resuscitation Council Guidelines		(Senior Clinical Skills Facilitator)	August 2014			Committee
		Establish gaps in training provision and agree trajectory to meet demand		Deputy Medical Director (Senior Clinical Skills Facilitator)	May 2014	5	Increases in training slots provided, but concerns about whether this is sustainable with current resources	Resus Committee
		Monitor levels of resuscitation training		Deputy Medical Director (Senior Clinical Skills Facilitator)	June 2014	5	System in place. Ongoing monthly monitoring.	Resus Committee
		Ensure all resuscitation training is captured on eUHL		Deputy Medical Director (Senior Clinical Skills Facilitator/ Learning Management System Trainer)	July 2014	5	System in place. Clarification of process for recognising external training and instructor status completed. Linkage of eUHL and ESR data in progress.	Resus Committee
		Feedback to CMGs and programme directors on staff who fail to attend		Deputy Medical Director (Senior Clinical	April 2014	5		Resus Committee

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		resuscitation training		Skills Facilitator)				
		Feedback to clinical leads of non-training grade medical staff who fail to attend resuscitation training		Deputy Medical Director (Senior Clinical Skills Facilitator)	April 2014	5		Resus Committee

*discussed at Resuscitation Committee on 11th June 2014.

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Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control
Patients on Fielding Johnson ward who have an infection which is contagious were not isolated; therefore measures were not in place to ensure that patients were not at risk from the spread of infections. Regulation 12 (1) (a) 2 (a)
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2a	Infection Control Isolation procedures and provision Cleaning equipment	Infection Prevention Committee to review compliance actions and produce detailed plan. To include actions arising out of Fielding Johnson ward in particular and also use of sterile water in the children's hospital / children's ED		Chief Nurse (Senior Nurse – Infection Prevention/ Deputy Director of Infection Prevention)	April 2014	5	Reports received and action plan provided	TIPAC
2b	Failure to comply with UHL Policy in relation to source isolation of patients with query or known infections/colonisation with pathogenic organisms	Reiteration of the importance to follow infection prevention policy and guidance through a detailed communication plan		Chief Nurse (Senior Nurse – Infection Prevention/ Deputy Director of Infection Prevention)	~~May 2014~~ August 2014	4	Timescale not achieved. Will be completed by end of August 2014	TIPAC

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		Letter to the Operational Team from DDIPAC to remind team of the responsibility to follow IP policy		Chief Nurse (Deputy Director of Infection Prevention)	April 2014	5	Completed	TIPAC
2c	Greater assurance/improved monitoring of compliance with Infection Prevention policy	Infection prevention nurses to complete report where staff fail to follow IP policy and review monthly		Chief Nurse (Senior Nurse – Infection Prevention)	February 2014	5	Process in place	TIPAC
		Review of DATIX reports by Trust Infection Prevention Assurance Committee and Executive Quality Board to identify non-compliant areas and any trends		Chief Nurse (Deputy Director of Infection Prevention)	May 2014	5	Completed	TIPAC

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		Escalation flow chart to be developed to provide clear management process following any identification of incident.		Chief Nurse (Senior Nurse – Infection Prevention)	June 2014	5	Completed	TIPAC
		DATIX reports to be viewed at the Clinical Management Group Infection Prevention group meetings monthly with actions taken to ensure staff are clear as to the standard of care required		Chief Nurse (CMG IP Leads)	May 2014	5	Process in place	TIPAC
2d	To ensure patient equipment is clean and therefore safe to use	Reiteration of the policy for nurses to clean near patient equipment in place as to Cleaning and Decontamination Policy through communication plan		Chief Nurse (Senior Nurse – Infection Prevention)	June 2014	5		TIPAC

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		Monitoring of cleanliness of equipment scores will be included in the quarterly Ward Review Tool audit to enable ward staff to view this at ward level and take action if required		Chief Nurse (Senior Nurse – Infection Prevention/ Heads of Nursing and Matrons)	July 2014	5	Added to the Ward Review Tool	TIPAC
2e	To ensure children's hospital follow infection prevention policies for the use of sterile water	Review of use of sterile water for mixing reconstituting oral medication		Chief Pharmacist (Head of Nursing – W&C)	May 2014	5	Children's ED are using sterile water for oral reconstitution appropriately	Medicines Optimisation Committee
		Ensure water used for mixing follows infection prevention guidelines (labelled and discarded after 24 hours)		Chief Pharmacist (Head of Nursing – W&C)	May 2014	5	Water is labelled and discarded in 24 hours	Medicines Optimisation Committee
		Ensure water used for irrigation is stored in		Chief Pharmacist	May 2014	5	Water is stored in the treatment room and used	Medicines Optimisation

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		treatment room and is used appropriately		(Head of Nursing – W&C)			appropriately	Committee
		Spot checks that use and storage of water is appropriate		Chief Pharmacist (Head of Nursing – W&C)	June 2014	5	Spot checks will be undertaken by Matron and Paed ED Sisters.	Medicines Optimisation Committee

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Care and Welfare of Service Users
Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users
People who use services and others were not protected against the risks associated with receiving unsafe care in the clinical decisions unit due to inappropriate admissions from the main A&E site. Regulation 9 (1) (b) (i) (ii)

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3a	Inappropriate admissions to CDU	Review operational protocols for CDU to ensure appropriate patients are admitted.		Chief Operating Officer (General Manager – RRC)	July 2014	5	CDU divert protocols have been circulated updated and signed off in ECAT. When level 2 Divert is on consultant to consultant referral will prevent inappropriate referrals. If an inappropriate pt arrives at CDU this will be managed by the DM and repatriated as soon as possible 23.7.14 – There have been no level 2 diverts since the last update. Any patient who is seen in CDU is managed via the pathway. If the patient requires other hospital services then this is escalated to the Duty Manager and transfer is arranged.	RRC Quality Board
		Review of patients that are admitted to Glenfield when on level 2 divert to ensure appropriateness		Chief Operating Officer (Matron -	July 2014	5	1.4.14 level 2 divert for 2 hours No patients were taken outside of the normal	RRC Quality Board

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				CDU)			respiratory / cardiology criteria. Monitoring by nurse in charge. 19.8.14 - No patients have been escalated as inappropriate	
3b	CDU design and flow	A working party will review the flow within CDU and implement any further improvement actions		Chief Operating Officer (General Manager – RRC)	October 2014	4	A working group has been established to discuss and implement improvements to flow and staffing. This is being feedback to ECAT. • Draft 1 staffing has been submitted to ECAT, Draft 2 is being worked on • DR Ian Sturgess is working with the team in assessing flow and suggested improvements • Matron has been appointed to provide senior nursing leadership and manage change (due to start in 2-3mths) • Targets have been set for diagnostics and imaging	RRC Quality Board

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Estates
Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises
Patients were not protected from the risks associated with unsafe or unsuitable buildings in that a roof was found to be leaking, access to OPD was difficult and other rooms were found to be too small to accommodate the service. Regulation 15 (1) (a) (c)

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4a	Greater assurance regarding CQC findings	Report reviewed and action plan produced for environmental observations raised following review of CQC report for Leicester General Hospital dated March 14.		Chief Nurse (Managing Director - Horizons)	April 2014	5	Report reviewed and action plan in place	EQB
4b	Improvements required to YDU Roof repairs required	Resolved	Access and availability of key personnel	Chief Nurse (Managing Director - Horizons)	March 2014	5	Completed March 2014	EQB
	6 side rooms observed to be small	CMG lead, Infection Prevention & estates to review location and develop revised risk clinical assessment and identify any immediate environmental improvements	Access and availability of key personnel	Chief Nurse (Managing Director - Horizons)	May 2014	5	The following works have been undertaken since CQC visit. to include:- 2 side room doors expanded, general decoration, Lighting upgrades Privacy systems to toilets Previous risk assessment produced are under review	EQB
	One toilet for 6 side rooms							EQB

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							to incorporate recent environmental improvements. Completed.	
	Bath poorly fitted	Bath replaced with shower unit			March 2014	5	Completed March 2014	EQB
4c	OPD Access (compliance actions page 45)	Initial review of area being undertaken by estates compliance team to identify specific areas of reduced accessibility.	Access and availability of key personnel	Chief Nurse (Managing Director - Horizons)	~~April 2014~~ ~~July 2014~~ August 2014	4	Review completed and minor works identified to be undertaken under backlog capital expenditure.	EQB
4d	Consulting room sizes observed as small	Following survey a review meeting with CMG lead within OPD & estates- to review risk assessments and develop potential improvements for a scheme to be undertaken.	Access and availability of key personnel	Chief Nurse (Managing Director - Horizons)	May 2014	5	Clinical leads currently reviewing and undertaking risk assessments for review.	EQB

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4e	Investigation regarding comments received by the inspection team on the following space constraints. SURGERY 1. Obstetric Theatre 2 small for clinical delivery (Page 21).	CMG lead, Infection Prevention & estates to review location and develop revised risk clinical assessment and identify any immediate environmental improvements.	Access and availability of key personnel	Chief Nurse (Managing Director - Horizons)	May 2014	5	Clinical leads currently reviewing and undertaking risk assessments for review. Risk assessment completed for the Obstetric Theatre at LGH and will be placed onto the ITAPs CMG Risk Register. Mitigating actions as defined within the risk assessment will continue to be undertaken.	EQB
4f	2. Orthopaedic Ward with an area utilised for rehabilitation which had insufficient space (Page 21)	CMG lead, Infection Prevention & estates to review location and develop revised risk clinical assessment and identify any immediate environmental improvements.	Access and availability of key personnel	Chief Nurse (Managing Director - Horizons)	May 2014	5	Clinical leads currently reviewing and undertaking risk assessments for review.	EQB

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4g	ICU observed to have insufficient space between beds.	CMG lead, Infection Prevention & estates to review location and develop revised risk clinical assessment and identify any immediate environmental improvements.	Access and availability of key personnel	Chief Nurse (Managing Director - Horizons)	May 2014	5	Clinical leads currently reviewing and undertaking risk assessments for review. Risk assessment completed for the ITU at LGH and will be placed onto the ITAPs CMG Risk Register. Mitigating actions as defined within the risk assessment will continue to be undertaken.	EQB

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Staffing
Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing
Patients were not protected from the risks associated with a lack of appropriate numbers of appropriately qualified, skilled and experienced staff in that medical and nursing staff were not available to care for patients on some wards including ward 10 and maternity. Regulation 22
Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing
Patients were not protected from the risks associated with a lack of appropriate numbers of appropriately qualified, skilled and experienced staff in the clinical decisions unit care for patients. Regulation 22

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5a	To improve staffing levels	Continue with nurse recruitment plan. • Rolling programme of bulk recruitment in place for RN and HCA posts • Proactive recruitment with local nursing university. • International recruitment plan and further extension with the recruitment agency to source staff over the next 2 years.	Lack of rooms available to undertake robust induction programme for local and international recruits. Under resourced Education Team to deliver induction for staff groups.	Chief Nurse (Head of Nursing - RTC)	January 2014	5	Recruitment continues, discussed monthly at nursing workforce meetings, in collaboration with HRSS. International recruitment continues with a planned approach for all areas with nursing vacancies. Nursing workforce and vacancies reported monthly to Nursing Executive Team	NET
		Continue to embed real time staff monitoring and e-roster through: • Real time staffing	Risks with e-roster system and ability to provide accurate	Chief Nurse (Head of Nursing - RTC)	All ward areas live with e-roster by ~~May 2014~~	4	Real time staffing is monitored on a daily basis and at weekends by Corporate nursing team, E-roster implementation across all inpatient ward areas on	NET

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		monitoring on a daily basis and at weekends • Compliance reports at Nursing Executive Team • Roll out of e-roster across all inpatient ward areas Compliance reports to Trust Board as part of Safer staffing/Hard Truths agenda	nursing utilisation information. E-roster team providing updates for clinical areas. Concerns are with the provider company. Utilisation now addressed, utilisation function available in e-roster		August 2014		track, issues with utilisation tool. All adult in patients will be rostered by 26th May, women's and children's by 25th July. Planned and actual staffing is monitored monthly and reported to NHS England, also available on UHL's internet and NHS Choices website, this commenced June 2014.	
		Introduce nursing acuity	Potential risks	Chief Nurse	April 2014	4	Developing electronic tool	NET

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Patients were not protected from the risks associated with a lack of appropriate numbers of appropriately qualified, skilled and experienced staff in that medical and nursing staff were not available to care for patients on some wards including ward 10 and maternity. Regulation 22
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		tool. • Support real time monitoring of nursing acuity. • Ensure acuity and establishment reviews undertaken bi-annually	with IT solution. Robust completion of information at ward level. Ability for ward staff to be objective in relation to determining acuity of patients.				which will use AUKUH methodology to underpin real time monitoring of acuity levels. This will be used to review appropriate staffing levels at 6 monthly intervals in order to produce recommendations regarding establishment levels to the Board in June and December	
		Minimise impact of gaps – plan for risk assessment and action plan.	Risk of slippage to the recruitment plan and above activities to minimise gap.	Chief Nurse	April 2014	5	Risk assessment completed and on risk register. Staffing/recruitment plan in place.	NET
		Review midwifery staffing arrangements using birthrate plus tool - LGH		Head of Midwifery	~~May 2014~~ June 2014	5	Birth rate plus acuity tool being used to review midwifery staffing and birth to	NET

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							midwife ratio on the 16th May, a report in relation to this will be produced by the end of May.	
		Review obstetric staffing arrangements		Clinical Director – W&C	May 2014	5	Since the CQC visit there has been a comprehensive review of hours of consultant time available to delivery suite and a revision of the cover arrangements is underway aiming to start to increase cover form September 2014. We have also had approval for 2 further consultant posts which have gone out to advert.	W&C Quality Board
5b	CDU Patients were not protected from the risks associated with a lack of	The staffing model will be reviewed Minimal staffing levels will be established and monitored An escalation process for		Chief Operating Officer (Head of Nursing - RRC)	October 2014	4	Nurse staffing paper completed identifying level of increase. Medical staffing requirements still being worked up, to be completed by end of June'14	RRC Quality Board

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	appropriate numbers of appropriately qualified, skilled and experienced staff in the clinical decisions unit care for patients	staffing levels when they fall below the minimum standard will be put in place Staff appraisal will determine skill set and training needs					Increased leadership investment: Matron for CDU appointed and commencing in post mid-August. Ward sister appointed as secondment for 12 mths to ward 20, enabling the Sister on CDU to focus solely on CDU. Ward staffing numbers publicly displayed. Continual monitoring of CDU nurse staffing by Head of Nursing Appraisal rate above 95%	
5c	Assurance of adequate nurse staffing on ward 10 LGH	Review of staffing on ward 10 LGH		Chief Nurse (Head of Nursing - RRC)	May 2014	5	Daily review of staffing and staff redeployed according to skill set, activity and dependency Vacancies being recruited to, successful recruitment from Portugal for renal areas. Public displaying of staffing	RRC Quality Board

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							levels Monitoring of staffing by HON/DHON- completion of real time staffing Bank/over time utilised in to vacancies Monitoring of staffing incidents by HON/DHON Acuity review to be undertaken in October'14	

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Supervision **Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers** Staff were not supported in their role as they did not receive appropriate training, professional development and supervision. Regulation 23 (1)(a)								
Ref	**Area for Improvement**	**Action to be taken**	**Risks to Delivery**	**Lead for Action**	**Action Completion Deadline**	**Progress RAG**	**Progress update/comment**	**Monitored by**
6a	Robust medical staffing and supervision on Ward 2 LGH	Ensure adequate supervision of medical staff on ward 2, LGH		Medical Director (Clinical Director - Medicine)	May 2014	5	All doctors on ward 2 have received a letter outlining clinical and educational supervisors. Trust grades recruited where possible rather than agency staff. Advertised for substantive geriatricians to cover "extra capacity" areas.	ESM Quality Board
		Review operational protocols for ward 2 to ensure fit for purpose		Chief Operating Officer (Clinical Director - Medicine)	April 2014	5	There are operational processes for Ward 2 at the LGH.	ESM Quality Board
6b	Improved compliance with mandatory training for maternity staff	Ensure adequate uptake of conflict resolution training and safeguarding in maternity, LGH Aim for 95% by the end of Q3.		Chief Nurse (Acting Head of Midwifery)	~~June 2014~~ ~~September 2014~~ March 2015	4	The training figures currently for LGH are Conflict resolution 81.82% Safeguarding adults 71.97. Safeguarding children has always been compliant as it is mandatory face to face annually 95.3%.	W&C Quality Board
6c	Assurance that nursing staff	Regular assessment of staff re understanding of		Chief Nurse (Heads of	April 2014	5	Captured in nursing metrics and HAPU validation	NET

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	have had training in assessment of hospital acquired pressure ulcers	waterlow risk assessment through matron ward rounds, nursing metrics and HAPU validation monthly.		Nursing)				
6d	Assurance that staff are clear regarding training and induction for agency nurses	Ensure staff are clear about training and induction for agency nurses (LGH). Communication via heads of nursing and spot checks.	All agency staff sourced via the staff bank office will have required training; however local induction and orientation to the clinical area must be undertaken locally by the ward area and documented.	Head of Nursing - RTC and Heads of Nursing	May 2014	5	All agency staff sourced via the Staff Bank office, are compliant with all training requirements as legislated by UHL and NHSLA. Update information shared with all Heads of Nursing at Nursing Executive Team. Any concerns with agency staff performance must be escalated to the staff bank office for action. Agency checklist attached for information, which includes UHL specific in relation to safeguarding, and HAPU.	NET
6e	Assurance that sufficient staff have had	Training needs analysis of nursing staff on ward 10 (dialysis training)		Chief Nurse (Head of Nursing -	May 2014	5	Complete.	RRC Quality Board

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	dialysis training on ward 10 LGH			RRC)				

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Care and welfare of people who use services
Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
Patients were not protected from the risk of receiving care that is inappropriate or unsafe because assessments of needs were not always completed.

Ref	Area for Improvement	Action to be taken	Risks to Delivery	Lead for Action	Action Completion Deadline	Progress RAG	Progress update/comment	Monitored by
7a	To ensure there are robust systems for patients that protect them from the risk of receiving care that is inappropriate or unsafe because assessment of needs not always completed (regulation 9)	Increased audit of discharge lounge at LRI to ensure appropriate admission and assessment of patients including assessment for Hospital Acquired Pressure Ulcers		Chief Operating Officer (Senior Site Manager)	May 2014	5	A robust audit tool in place to ensure all patients are assessed and given on going care. A referral checklist for transfer to discharge lounge is being developed. Recruited new sister and have had input from an established sister at Glenfield.	NET
7b	Prompt/appropriate assessment of children admitted	Reiterate appropriate use of CAU and admission of children overnight to beds		Heads of Nursing – W&C	May 2014	5	All staff have been reminded of the importance of not delaying admission to wards Monthly audit of delays through EDIS.	W&C Quality Board
		Development of escalation policy for children's hospital		Heads of Nursing – W&C	~~June 2014~~ August 2014	4	Lead Consultant for CAU in process of developing escalation policy. First draft has been proceed.	W&C Quality Board
		Review paediatric bed capacity to ensure effective emergency and elective flow supports timely assessment		General Manager – W&C	~~July 2014~~ September 2014	3	Bed modelling being undertaken with support from EY team	W&C Quality Board

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		within the Children's Hospital.						
		Regular audit of pain relief of children in all admission areas through monthly nursing metric		Head of Nursing – W&C	May 2014	5	Monthly metrics being undertaken.	W&C Quality Board
7c	Recovery of patients post dental extraction	To undertake an options appraisal to identify most suitable accommodation for recovery after paediatric dental extraction that meets privacy and dignity requirements (and maintains safety) Presentation of option appraisal to CMG management team and escalation thereafter		Chief Operating Officer (Acting General Manager - ITAPS/ Matron - Theatres)	~~May 2014~~ July 2014	5	Option appraisal completed. UHL will need to make the service as nest a fit as it can in the current accommodation whilst new accommodation is sought. Meeting being pulled together.	EQB
		Option appraisal presented to Executive Team.		Chief Operating Officer (Acting General Manager - ITAPS/	~~August 2014~~ **September 2014**	3	Discussion at ET on 19th August. Advised to discuss with commissioners and attend ET again in September.	EQB

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				Matron - Theatres)				
7d	Introduction of a system to ensure patients receive blood transfusion in a timely manner including completion of appropriate documentation and escalation processes for non-compliance	Trust wide communication to all clinical and phlebotomy staff (Via CMGs) to emphasise the importance of correctly labelling blood transfusion request forms and blood samples, including message via Insite desktop.		Medical Director (Haematology Consultant/ HoS Transfusion Medicine)	April 2014	5	Communication sent out via CMGs. To repeat this via medical director's office as not all medical staff have received email.	Hospital Transfusion Committee
		Revise blood transfusion e-learning modules to further emphasise the requirement to adhere to correct procedures.		Medical Director (Lead Transfusion Practitioner	May 2014	5	Complete	Hospital Transfusion Committee
		Communication plan Include this item in the May issue of Blood Letter to raise staff awareness.		Medical Director (Transfusion Practitioner) Medical	May 2014	5		Hospital Transfusion Committee

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		Blood Transfusion Safety – "Right Patient, Right Blood" road shows at all three sites.		Director (Lead Transfusion Practitioner)				
		Blood Transfusion nursing team to escalate any datix incidents regarding non-compliance with correct labelling of blood forms or samples to CMG clinical leads and heads of nursing.		Medical Director (Lead Transfusion Practitioner)	April 2014	5	One Datix incident reported which has been followed up.	Hospital Transfusion Committee
		Communication to all matrons via CMG heads of nursing to ensure all clinical areas have robust procedures in place for ensuring that important messages are appropriately escalated and acted on in a timely manner.		Chief Nurse (Heads of Nursing)	April 2014	5	Assurance from Director of Nursing. ITAPs CMG – HoN escalates to Matrons any important messages and to all Band 6 and 7 staff. Monthly Matrons meeting and cross site meetings allow for staff to evidence actions from important information.	NET
7e	Appropriate triage	Make copies of all the		Chief Operating	May 2014	5	Complete.	ESM

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	of ED patients by reception staff	guidelines to all reception staff when on shift and ensure this is included as part of new staff launch		Officer (General Manager – Medicine/Senior Service Manager - Medicine)				Quality Board
		Spot checks		Chief Operating Officer (General Manager – Medicine/Senior Service Manager - Medicine)	June 2014	5	Spot checks completed. Will continue to monitor.	ESM Quality Board

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