Butterwick Hospice Action Plan in response to Care Quality Commission letter of 19 May 2021

Regulation 12: Safe care and treatment.
Care and treatment must be provided in a safe way for service users
Things the registered person must do to comply with this include:

Requirement	Action	Priority	Responsibilities	Timeline	Progress monitoring & reporting

Assessing risk to health and safety of service users	1. Conduct a gap analysis and review all care related policies and procedures (P&P's) to identify:
	  a. Urgently required P&P's
	  b. Missing P&P's
	  c. Outdated P&Ps
	  d. Redundant / duplicate P&P's
		Critical	1. Head of Care, Clinical Governance Lead and senior clinical leads	1. Before end of June 2021	**Present updated Policy Log** and new, revised/updated P&P's for approval to Board, sub-committees and SLT

	2. Review and update P&P Log initially for all care related and HR P&Ps then other organisational P&Ps and priorities	**Critical**	2. Head of Care, Clinical Governance Lead, senior clinical leads HR manager	2. Before end of June 2021	**Report recommendations** to Board and SLT for P&P approval, redundancy and archiving

	a. Agree date and timeline that prioritises P&P's for urgent review/update i.e., to ensure safe:
	    i. Care
	    ii. Staff
	    iii. Environment
	    iv. Equipment
			a. Service leads	a. Before end of June 2021	

	b. Identify governance processes for sign off and approval of all P&P's by:
	    i. Board
	    ii. Sub-committee
	    iii. CEO / Senior Leadership Team (SLT)
		Critical	b. Board / sub-committee, SLT	b. Before end of June 2021	**Establish standing agenda item** on Board, sub-committee and SLT business agenda 'Approval of P&P's'

	c. Reporting to Board, relevant sub-committee and SLT	**Medium term requirement**		c. For next Board, sub-committee and SLT meetings	

Mitigating risks to health and safety	1. Review risk register
	  a. Update to include risks related to meeting CQC Regulations 12 and 17
	  b. Identify mitigations/ action to reduce risk
	  c. Identify leads for risk assessments
		Critical	1. Quality & Compliance Manager, Clinical Governance Lead with support of SLT	1. Before the end of July 2021	**Present risk register** to Board and SLT
					Establish standing agenda item on Board, business agenda 'Review of Risk Register'
					
					Summary report to Board, sub-committees and SLT

	2. Review risk assessments to identify	**Critical**			

	a. Urgently required missing risk assessments 3. Agree processes for annual review of risk assessments 4. Procure Vantage Management System to include risk assessment systems	**High**	2. Quality & Compliance Manager, Clinical Governance Lead with support of SLT 3. Board, Sub-committees and SLT 4. CEO / Quality & Compliance Manager	2. Before the end of July 2021 3. Before the end of August 2020 4. Procurement in process	Prepare Board, sub-committee and senior management team reports to support periodic executive review of risk register

Ensuring persons providing care have appropriate qualifications, competence and skill to practice safely	1. HR to produce contemporaneous spreadsheet of:
	  a. **Fitness to practice** data including:
	    i. Practitioner registration status (NMC, GMC, HPC, GSCC)
	    ii. DBS status / periodic sampling audit
	    iii. License to practice
	    iv. Practicing privileges
	  b. Organisational training
	    i. Induction and annual health and safety training
	    ii. Doctor appraisal PREP
	    iii. Confirm Designated Body / Responsible Officer arrangements
	    iv. NMC, HPC, GSCC revalidation
	    v. Competence training
	    vi. Annual appraisal
	    vii. Performance management
	2. Identify personnel related P&P's that assure the Hospice of clinical / professional staff fitness and license to practice
	
	3. Produce HR quarterly monitoring spreadsheet
	  a. Progress reporting to:
	    i. Board
	    ii. Sub-committees
	    iii. CEO / senior management team
		Critical
		
		Urgent
		
		Short term requirement
			1. Human Resource Manager and HR team, Clinical Educator
			
			2. Human Resource Manager and HR team, Director of Care, Clinical Educator
			3. Human Resource Manager and HR team
				1. Before end of June 2021
				
				2. Before end of July 2021
				
				3. August 2021 or for next full cycle of Board, Sub-committee and SLT meetings
					Present HR staff report and spreadsheet to Board and SLT
					
					  b. (iii) Review and update service level agreement re Designated Body cover and Dr responsible officer arrangements

Ensure premises used by service users are safe for such use	1. Review Risk Register to ensure risks associated with premises are actioned:	**Critical**	1. Quality & Compliance Manager with support of SLT	1. Before end of July 2021	**Establish standing agenda item** on Board, business agenda 'Review of Risk Register'

	a. Safe access and egress to Hospice premises
	b. Adequate internal/external and emergency lighting
	c. Fire safety and evacuation
	d. Safe equipment and plant
	e. Safe clinical equipment
	f. Hazard warning signs
	g. Safe storage / use of medical gases
	h. Appropriate signage i.e., visually impaired / dementia
	i. Conduct periodic environmental audits
	2. Review and update Business Continuity Plan (BCP)
	   a. Review significant risks in event of emergency / catastrophe that threatens continuity of service delivery
	   b. Identify mitigations to key risks
	   c. Develop action plans in event of emergency / catastrophe that threatens service continuity
		High	2. Quality & Compliance Manager with support of SLT	2. Before end of August 2021	**Present Risk Register and risk mitigation plans** to Board and SLT for executive oversight
					
					Present BCP and mitigation plans to Board and SLT for executive oversight

Ensure equipment used to provide care is safe for use and used safely	1. Develop clinical equipment asset register
	   a. Include annual or manufacturer maintenance / service schedule / PAT testing
	   b. Where relevant secure training for clinical staff is use of specific medical devices / equipment
	   c. Embed processes for timely response to Medical Device Alerts
	   d. Review alert log and action plans
	   e. Conduct periodic equipment audit
		Critical	1. Quality & Compliance Manager, SLT, Director of Care, Clinical Governance Lead and Clinical Leads	1. Before end of July 2021
				   a. Immediate for medical device alerts
					Summary report of asset register update/status for operational review by SLT

Ensure equipment and medications supplied by provider are in sufficient quality to meet service user needs	1. Periodic review of medical equipment / device asset register
	   a. Repair / replacement of equipment
	   b. Recommendations for the procurement of new equipment where relevant
	   c. See above re: maintenance / service schedules
	   d. Review of essential medical device requirements before opening service to service users
		Short to medium term	1. Quality & Compliance Manager, SLT, Director of Care, Clinical Governance Lead and Clinical Leads	1. Conduct review before re-opening service to service users. No later than end of July 2021	**Maintain, update and present** medical device/equipment alert log and action plans for operational review by SLT

					1. (e) Review pharmacist sessional input

Ensure safe medicines management	1. Confirm with Pharmacy Provider review of:
	  a. Processes for medicines reconciliation and optimisation
	  b. Storage capacity and medicines security
	  c. Stock requirements and review
	  d. Safe receipt, storage, use and disposal of Controlled Drugs / POMs and patient own medication
	  e. CD stock check audits and stock balance conciliation
	  f. Regular audit of stock levels, prescribing and medicines management
	  g. Weekly compliance audit of MAR charts
		Urgent	1. Director of Care (CDAO), Clinical Governance Lead, Prescribing practitioners, clinical leads and pharmacist	1. Conduct review before re-opening service to service users. No later than end of July 2021	**Summary report of Medicines Management review** to relevant sub-committee and SLT of medicines management stock issues

Assess risk and take appropriate steps to control, prevent and minimise the spread of infection	1. Review Infection control P&P and practical measures including:
	  a. Covid 19 preventative measures
	  b. Notifiable disease, MRSA / C. Diff reporting
	  c. Signage
	  d. PPE / Handwashing
	  e. Safe disposal of contaminated materials
	  f. Decontamination
	  g. Uniform Policy
	  h. Isolation / Barrier nursing process
	  i. Decision to close access to services in the event of contagious infections
	  j. Water Safety and Legionella risk assessments / standards
	  k. Meet National Standards of Healthcare Cleanliness (2021)
	    i. Meet NHS Commitment to Cleanliness Charter standards
		Urgent	1. Director of Care, Clinical Governance Lead, Clinical leads, nursing and allied health practitioners Quality and Compliance Manager and housekeeping staff. Expert advice from NHS Trust infection control lead	Conduct review before re-opening service to service users. No later than end of July 2021	**Present Report inspection reports** from NHS Trust infection control lead to relevant sub-committee and any action plans identified from the inspection report

Where responsibility for care and treatments is shared or transferred to other persons work with such persons to ensure timely care planning to ensure safety of service users	1. Procure SystmOne integrated clinical record for all care records
	  a. Train staff in use of SystmOne
	  b. Adopt SystmOne palliative care module and adapt to organisation
	  c. Shared records and communication with other key care partners:
		Urgent	Director of Care, Clinical Governance Lead, Clinical leads, medical, nursing and allied health practitioners, social work and bereavement counsellors	Procure and implement SystmOne as soon as possible and embed before or as soon after decision to open service to service users	Integrate SystmOne as the organisation wide care record system.
					
					Clinical Educator Report on uptake and completion of staff training in using of the care record

		i. Community palliative care teams
		ii. Primary Health Care Teams
		iii. Marie Curie Service
		d. Develop live multi-disciplinary team meetings for contemporaneous care planning:
		    i. Review and acceptance of referrals
		    ii. Discharge planning and transfer to other service providers
					Communicate with key care partners the transition to and adoption of SystmOne integrated care records

Regulation 17: Good governance.

Systems and process must be established and operated effectively to ensure compliance with requirements in this part

Without limiting paragraph 1 such systems or processes mut enable the registered person, in particular to:

Requirement	Action	Priority	Responsibilities	Timeline	Progress monitoring & reporting
Assess, monitor and improve quality and safety of the services provided in carrying out regulated activities (including quality of experience of service users in receipt of services	1. Adopt and adapt the NHS Friends and Family test for all service users and report to Board, relevant subcommittee and SLT	**High**	Clinical leads, medical, nursing and allied health practitioners, social work and bereavement counsellors. Admin support to collate results and feedback	Adopt Friends and Family test as organisation wide service user feedback and commence as soon as all services re-open to service users	**Summary service user feedback produced** for Board and SLT of findings from service user questionnaire feedback.
	2. Review incident trends, complaints and commendations	**High**	Board, CEO, SLT, Clinical leads, medical, nursing and allied health practitioners, social work and bereavement counsellors.	By end of July 2021	**Incident Trend Report produced** for Board, relevant sub-committee and SLT of incident trends analysis and action plans in response to lessons learned
	3. Continued drive to support a learning centred culture, with appropriate professional accountability, of all incidents and near miss reporting.	**Ongoing**	Already in place	Current	
	4. Introduce validated palliative care outcomes measures initially Phase of Illness, Karnofsky Score and Integrated Palliative Outcome Scores (IPOS) as measures of impact and clinical effectiveness of care interventions.	**High**	Clinical leads, medical, nursing and allied health practitioners, social work and bereavement counsellors.	Plan to introduce palliative outcome measures by end of July / early August 2021	**Produce report on findings and trends in outcome measures data**

	5. Introduce weekly Multi-Disciplinary Team (MDT) meetings that systematically review patient care, risks and outcome measures and revise and update plans of care in SystmOne service user record. Review of:
	  a. Personal Emergency Evacuation Plans (PEEP)
	  b. Mental Capacity to make decisions
	  c. Consent to treatment
	  d. Advanced decisions to refuse treatment (DNACPR)
		High	Clinical leads, medical, nursing and allied health practitioners, social work and bereavement counsellors	As soon as new in-patients accepted into service	**Weekly MDT review of care** Record and formally update MDT review 'live' in SytmOne records

	e. Status of Emergency Health Care Plans (EHCP)
	f. Safeguarding (adult and child)
	6. Introduce weekly clinical education sessions for all clinical staff to include:
	    a. Complex case review(s) following MDT
	    b. Seminars reviewing emerging best practice in complex symptom management in palliative care
	    c. Also to include journal reviews, review of significant events, clinical audit and other topics decided by the clinical team				

Assess, monitor and mitigate risks to health, safety and welfare of each service user and others who may be at risk which arises from carrying out the regulated activity	1. Review all service user individual risk assessments and action plans in response to outcomes:
	    a. **Mental Capacity status and consent to treatment**
	    b. **Mobility and PEEP** on admission
	    c. **Falls risk assessment** on admission to the service.
	        i. Fall risk prevention plan in place immediately following admission or within 4 hours of admission.
	    d. **Pressure ulcer (PU) risk assessment** on or within 4 hours of admission to the service.
	        i. PU risk prevention plan in place immediately after or within 6 hours of admission.
	    e. **Infection control risk assessment** on admission and plans to mitigate risk of spread of infection if patient admitted with MRSA, C.Diff or other high risk transmissible infection.
	        i. Introduce prevention / control of infection measures immediately where indicated
	    f. **Nutrition and hydration assessment** on or within 6 hours of admission.
	        i. Nutrition and hydration plan in place following assessment.
		Critical	For risk **1 'a' - 'g'** all clinical leads, all medical, nursing and allied health practitioners conducting admission assessments for new service users.	From now for current service uses and for all new users as services recommence	**Weekly MDT review of care**
					Record and formally update MDT review 'live' in SytmOne records

	g. **Veno-Thrombo Embolism (VTE) risk assessment** 100% compliance within 24 hours of admission h. **Medicines reconciliation/optimisation** on admission assessment by medical team or non-medical independent prescribers i. **Medical device and drug alerts**		**For risk 1 'h'** also weekly review at MDT with pharmacist advice and guidance. As above to conduct retrospective review of any current service user in day care or home care. **For risk 1 'i'** Director of Care, Clinical Governance Lead, Clinical leads and Quality & Compliance Manager for organisational non-clinical alerts		**To be added to staff shift handover report** **All risks to be reviewed on an ongoing basis and at weekly MDT**
	2. **Prompt recognition and timely management of PALLIATIVE CARE EMERGENCIES:** a. Uncontrolled bleed b. Malignant Spinal Cord Compression c. Hypercalcaemia d. Superior Vena Cava Obstruction e. Status epilepticus		**All** medical, clinical leads, nursing staff and allied health practitioners	Adopt best practice as outlined in: Northern England Clinical Networks Palliative and End of Life Care Guidelines Symptom control for cancer and non-cancer patients (2016) next review 2021	**Potential for / likelihood of palliative care emergency to reviewed on an ongoing basis and at weekly MDT**
Maintain and secure an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided	1. Contemporaneous update of SystmOne care records following each intervention / episode of care a. Feedback to colleagues at shift change / handover 2. Formal weekly MDT review all service user response to treatment and care outcomes and efficacy of clinical intervention and adjustments to plan of care in response to review	**Critical**	Clinical leads, medical, nursing and allied health practitioners, social work and bereavement counsellors. Clinical leads, medical, nursing and allied health practitioners, social work and bereavement counsellors.	From re-commencement of admission of service users	**Contemporaneous review of care and update of SystmOne care records** **Weekly MDT review of care** Record and formally update MDT review 'live' in SytmOne records

Maintain securely such records as are necessary to be kept in relation to:
  a. Persons employed in carrying on of the regulated activity
  b. The management of the regulated activity
	1. Confirm Hospice meets NHS Information Governance standards to:
	  a. Adopt SystmOne care record
	    i. SystmOne card access
	    ii. Encryption protocols for electronic records
	  b. Access ICE pathology / radiology results service
	2. Secure archiving, destruction and retrieval of records
	3. P&P for data management and data breaches
	4. P&P for approval of access to records by a third party or service users for their clinical records
		Urgent	IT Lead, SLT, all clinical and clinical admin staff Operational CEO / SLT, Director of Care and other service leads
			
			Registered Manager as Caldicott Guardian
				Once SystmOne installed and running
				
				Other IT systems such as SAGE, Donorflex Other electronic records HR and payroll
				
				Operational CEO/SLT and service leads
					CEO oversight and SLT review

Seek and act on feedback from the relevant persons and other persons on the services provided in carrying on of the regulated activity, for the purposes of continually evaluating and improving such services	1. Adopt a version of the NHS Friends and Family test for all service users and report to Board, relevant subcommittee and SLT a. Respond promptly to issues raised in service user feedback 2. Respond promptly and as per policy complaints raised by service users, their relative and or external feedback 3. Share commendations form service users / partner organisations 4. Accept and respond NHS Trust Infection Control lead periodic infection control audits as external 5. Clinical Commissioning Group (CCG) contract quality inspection meeting/reports and feedback in meeting of contract KPI's requirements	**High**	1. Operationally CEO, SLT and service leads 2. Strategic issues raised in complaints Board and CEO 3. CEO, SLT and Director of Care 4. CEO, SLT and Director of Care	From current service users and once in-patient services recommence	Operational CEO/SLT monitoring service user feedback for issues and trends Strategically Board and CEO for significant issues and concerns

The registered person must send to the Commission when requested to do so and by no later than 28 days on the days after receipt of the request
  a. A written report setting out how , and to the extent to which, in the opinion of the registered person
  b. Any plans that the registered person has
	Registered Manager to fulfil Care Quality Commission (CQC) reporting requirements for example:
	1. Fulfilling Duty of Candour
	2. Reporting Serious Incident Reporting (STEIS)
	3. Reporting Serious Harm to a person using the services
	4. Reporting Safeguarding concerns
	5. Reporting risk to the continued running of the service
	
	As outlined in action plan
		Ongoing	Director of Care as registered manager with support of CEO / SLT	Adopt CQC standard reporting framework Liaise with CQC engagement officer	**Written report** to Board, CEO and SLT as appropriate

for improving the standard of the services provided to service users with a view to ensuring their health and welfare				