|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Must do**  |  | **Must do**  |  | **Must do**  |  | **Must do**  |
| **Safe Staffing** | * Process in place to ensure compliance re BLS trained member of staff
* Participate in NHSI’s Retention Programme
* Implement recruitment and retention plan
* Develop a minimum staffing policy
* Develop a Staffing in Extremis Policy
* Undertake Strategic Staffing Reviews in line with the National Quality Board 2017 guidance
 | **Privacy and Dignity** | * Zero tolerance on examinations being performed outside of cubicle space.
* Standards reinforced with staff.
* 2 hourly walk round to ensure zero tolerance of patients being assessed in unsuitable environment.
* Maintain capacity in Rapid Assessment Triage cubicles to always maintain assessment space.
* Risk assessment for ambulance corridor
* Ensure adherence to single sex accommodation
* Pilot Forget me not team
* Introduce care plan for dementia patients
* Implement ward Accreditation for Continuous Excellence (ACE) where standards for Privacy and Dignity are checked
* Introduce Dressed is Best
* Undertake a privacy and dignity audit in ED
* Ensure patients belongings are treated with respect – identify process and audit
* Call bells are in reach at all times for all patients
 | **Risk Management and Incident Reporting** | * Review incident reporting policy and serious incident policy and ensure definitions are explicit and clear
* Implementation of New Datix system on 1st December making it easier for staff to repot incidents and for senior staff to review grading
* Ensure links are made to the Board Assurance Framework
* SI action plan to be completed in a timely manner
* Duty of candour is carried out in a timely manner
* Feedback is given to staff following a report
* All incidents must show evidence of appropriate investigation
 | **Mortality and Morbidity** | * Morbidity and mortality meetings to be held in each directorate to meet minimum standards outlined in the quality governance meeting.
* Quarterly report to quality governance committee about M and M process and learning in each business group.
* Mortality review group initiated to co-ordinate the process for learning from deaths and compliant with the new national standards.
* Deliver board reports of rates of mortality review in line with national standard
* Ensure DNAR forms are completed correctly
 |
| **Care of Deteriorating Patients** | * Review EWS Policy
* Review themes from incidents
* Develop Care of Acutely Ill Patient Group
* Training and competency review of staff regarding EWS systems
* Communications material regarding EWS
* All risk assessments must be completed and updated regularly
 | **Cleanliness and Infection Control** | * Ensure practice is in line with Trust policies and procedures
* Ensure an electronic incident report is submitted should any patient not be cared for in line with these policies
* ANTT training to be rolled out
 | **Care of the patient with diabetes** | * Ensure staff attend Diabetes training
* Ensure staff are complaint with Diabetes management policy
* External review of diabetes care
* Review policy in line with national guidance
* Audit low blood sugars against datix process
 | **Access and Flow** | * Adoption of GM standards
* Introduction of integrated transfer team
* Ensure effective streaming process is in place that ensures our patients are directed and triaged appropriately at the front door e.g. AI,ACU,
* Development of Urgent Treatment Centre in line with Urgent Recovery Plan to support patients getting the right care at the right time by the right people
* Development of Surge Policy in line with Urgent care recovery plan
* Development of Frailty Unit and Model
 |
| **Medicines Management** | * All staff to comply with Medicines policy
* Complete regular audits of medicines security /storage (Duthie audits)
* Purchase of cupboard for resus area for the storage of lockable fluids
* We will review the Standard Operating Procedure in relation to patients own medication
* All areas must complete a review of medication administration
* All medications must be given in a timely manner
* All staff to complete appropriate medicines management training as per policy
* Audit EPMA to identify areas of concern and address accordingly
* All areas to review where thickening powder is stored when not in use
* All areas to implement safe storage
* All areas to remove out of date stock including all consumables
 | **Records Management** | * A task and finish group will identify a solution and complete a gap analysis of compliance
* Remind staff of the requirement to keep notes secure
* Identify a process to renew locks on trolleys, place records in locked cupboards or rooms to ensure safety of records balanced with the need to have records available at time of use
* We undertake record keeping audits on a monthly basis, action plans will be monitored through Quality Governance Group
* We will further develop a suite of nursing metrics that will include record keeping documentation audits
* Undertake a baseline audit of nursing risk assessments in November and December 2017 action plans will be monitored through Quality Governance Group
* Develop a suite of nursing metrics that will include audits
* Develop clear guidance to support nursing staff in undertaking risk assessments and care planning. We will ensure that this is compliant with EPR launch planned for Autumn 2018
* Move to a clinical correspondence typing hub
* Flexible use of peripatetic typists
* Daily patient level HCR data to be provided to the Business Groups by the Performance Team
* Business Group teams to work with medical teams to follow-up outstanding HCRs.
* IT Development team to develop bespoke reports to allow Business Group teams direct access to HCR data
* Performance against HCR target to be monitored through the Weekly PTL meeting chaired by the Performance Team
 | **Learning Organisation** | * Pathways are available on the intranet within the department
* As part of their local induction all clinicians are made aware of how to use pathways within the department
* We will ensure that locum staff are able to easily access pathways
* During daily huddles, the senior medic (Shop Floor Leader) prompts appropriate pathway use when required, thus communicating to all staff department standard to follow guidance
* Review audit policy
* Use the AMaT system to improve the monitoring of action plans
* Develop the Quality Governance Framework based on NHSI‟s Well Led Framework and GM Quality Framework
* Ensure all complaints are responded to within agreed timeframes
* Patient safety walk rounds by exec team, non exec directors and governors in place on a weekly basis
* Patient Quality Summit established
* Patient Safety Summit established
* Holding to Account sessions in place to support staff
 | **Emergency Department Specifics** | * A roiling programme of training is being implemented into ED
* The Associate Nurse Director will be monitoring a local training tracker weekly
* The ED risk register will reflect that all risks are identified and that appropriate control measures are in place
* Pathways are available on the intranet within the department
* As part of their local induction all clinicians are made aware of how to use pathways within the department
* We will ensure that locum staff are able to easily access pathways
* During daily huddles, the senior medic (Shop Floor Leader) prompts appropriate pathway use when required, thus communicating to all staff department standard to follow guidance
* Zero tolerance approach to examinations being performed outside of cubicle space
* Reinforced these standards with staff
* Introduced a 2 hourly walk round led by the senior nursing team in ED to ensure that patients are being cared for and treatment with dignity and compassion in suitable environments.
* Maintain capacity in Rapid Assessment Triage cubicles to ensure assessment space is available for use
* Completed a risk assessment that ensures patients are appropriately cared for in all areas of the ED
 |
| **Training and Development** | * All staff to complete appropriate training in a timely manner
* Individual Business group plans in place
* Complete data cleanse on stat and mand training report
* The Safeguarding team have delivered training using a ToolKit that they have developed – training currently at 93%
 | **Mental Capacity Act** | * MCA and DoLs training must be delivered to ensure compliance
* Audit staff knowledge through the Patient safety Audit and ACE accreditation schemes
 | **Environmental Standards** | * Review policy
* Audit standards
* Ensure that when a patient is required to be viewed in the ED that the area is fit for purpose until the planned new build enables the provision of a dedicated area.
* Remove out of date stock on all wards and departments
 | **Business Group Specifics** | * Develop a business case to increase the establishment by a further 1.00 WTE with the potential support of Macmillan cancer Support in order to meet the targets noted above and develop the service further to operate nurse led one stop diagnostic clinics
* Continue to undertake regular audits
 |