CQC Action Plan

Ref No:	Must Do Actions	Theme	Service	Improvement / Objective	Update following inspection	Actions Required	Lead (Executive & Local)	Deadline	Action Status / RAG Rating	Governance/ Approving Committee	Updates	Action Closed
MD1 - Page 8, 51 MD 11- Page 9	The trust must ensure it immediately reviews arrangements of dormitory accommodation with a view to eliminating this in line with national guidance. (Regulation 10(1)	Dormitories - Estates	Trust wide (Well Led)	The Trust will eliminate all dormitory accommodation in line with National guidance	Update: -The Trust reviewed its dormitory accommodation reprovision plan immediately post inspection. There is no potential for acceleration of the existing planned timescale. Agreed timeline for the programme of works is to be concluded by 2023. There is a clear governance process in place to ensure the progress of the plan is kept under review at the Estates and Medical Equipment Committee (EMEC) and any risks are escalated through to the Finance and Performance Committee (FPC). Post inspection an action plan was developed and shared with the CQC with further updates sent on the 25/11/21. This plan detailed actions taken to improve the dignity and privacy of patients, improve storage and laundry facilities. The two remaining actions from the Dormitory action plan on implementation of laundry facilities for Aston and Ashby Ward and permanent storage for the Bradgate Mental Health Unit and Willows are aligned to the delivery of the dormitory reprovision accommodation plan.	1. Review of dormitory accommodation reprovision plan to establish if timescales can be brought forward.	Richard Wheeler/Richard Brown	12/08/2021		Estates and Medical Equipment Committee, DMH DMT and Executive Boards.	12/08/21 Single dormitory programme has been reviewed - there is no potential for acceleration of the existing planned timescale. Agreed timeline for the programme of works progressing to ensure single dormitory provision is concluded by 2023. Actions taken to improve privacy and dignity and storage are detailed in MD7 and MD12.The estates programme is kept under review through monthly reporting to the Estates and Medical Equipment Committee (EMEC). The latest meeting on the 15/12/21 reported the dormitory reprovision programme continues to be on track for completion by 2023. The route of escalation for any ongoing concerns is to the Finance and performance Committee and Trust Board should any delays occur.	Closed
MD2 - Page 8 MD14 - Page 9	The trust must ensure that patients are able to summon for staff assistance effectively in all wards, to include communal areas and dormitories. (Regulation 12(1)).	Call Systems - Estates	Trust wide (Well Led)	The Trust will ensure that patients have access to call alarms to summon for staff assistance	Update: -We immediately reviewed the current usage and access of personal safety call alarms across all acute wards against the CQC Brief Guide on 'Call systems in mental health inpatient services for patients/service users and visitors' (July 2020). -We have a communication plan in place for ensuring ward staff are aware of process of utilising existing wrist pits and Standard Operating Procedure. -we have strengthened risk assessment processes. -An action plan was developed immediately and shared with the CQC post inspection with updates provided tot he CQC on the 25/11/21. -We have purchased additional wrist pits to strengthen accessibility for all patients on every ward to summon assistance. -we reviewed current usage and access of personal safety call alarms across all wards for visitors. - we have commissioned surveys on our estates to ensure alarms can be used and identify where upgrades are required.	1. Installation of new receivers 2. Implementation of newly purchased wrist pits to strengthen accessibility for all patients on every ward to summon assistance if they are alone temporarily on the ward based on individual clinical risk assessment. This gives full capacity for 100% usage if required.	Richard Wheeler/ Richard Brown	31/01/2022	Closed	Estates and Medical Equipment Committee, Directorate Management Team Meetings and Executive Boards.	A detailed action plan was developed immediately post inspection outlining immediate actions taken: **Risk assessment and wrist pits** 1. Established and confirmed that all acute wards have access to call bell alarm systems for patients and visitors and identified areas for further action. DMT sign off on 11/08/21 where further actions were agreed and guidelines were developed and put in place. 2. Risk assessment processes were strengthened. MDT Workshop held 17/08/21 to ensure oversight and co-ordination of delivery plan. Outputs of workshop were a) triangulation of patient safety data which showed no patient safety issues related to access to call bell alarm systems over past two years including via SIs and complaints. b) MDT clinical decision related to risk assessments of appropriate call alarm systems which was mobile -v- fixed. It was agreed to continue with mobile wrist based call alarm systems within Acute and Stewart House and Mill Lodge, as these are on a different alarm system. Guidelines and patient risk assessments were put in place by the 23/08/21 and this was confirmed 31/08/21 19/08/21 Additional wrist bands ordered - actions progressed: 1. Continued clinical risk management in line with Observation Policy and guidelines whilst wrist bands are on order. 2. Individual patient risk assessment developed with guidance for staff before provision of individual wrist pit. 27/09/21 - Half of the wrist pit order has been delivered. Awaiting the other half within the next 2 weeks. 06/10/21 - Outstanding wrist pits delivered. **Estates and survey** Estates arranged for a new site survey to be carried out by the provider. 19/08/21 - The Trust has placed a Purchase Order for the survey work at Bradgate / Bennion, requested for w/c 23/08/21. Pinpoint have confirmed that all other sites apart from Bradgate/Bennion have aerials/receivers which are compatible with new wrist fobs. 19/08/21 - Request made to confirm whether current systems are able to accommodate additional pit alarms at Belvoir ward and Herschel Prins 20/08/21 Confirmation received that neither the SAS or Guardian systems require any additional surveys as further pits can be added. As above, additional wrist pits ordered and received.	Closed
MD3 - Page 8	The trust must ensure environmental risks are identified and mitigated against including checks of the communal garden at Stewart House. (Regulation 15(1)(2)(a)(b)).	Environmental Risks / Estates	Rehabilitation	The Trust will have environmental risk assessments in place which includes communal garden areas.	Update: -The systematic checking of the garden was placed on the daily Ward Environmental Checklist. - A weekly check of compliance is carried out by the Ward Sister / Charge Nurse. - Work immediately undertaken to tidy the area and the Trust estates gardening team continue to maintain the horticulture.	1. A new 6 weekly Quality Round will be undertaken by Ward Sister / Charge Nurse and Matron.	Fiona Myers / Helen Perfect	31/01/2022	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	14/06/2021 – Site visit from gardeners and trimmed all bushes and shrubbery 09/07/21 Environmental checklist amended to include garden areas and communication shared with staff. 16/12/21 The quality tracker tool to be used on Step up to Great Quality Checks has been submitted to Quality and Safe meeting for sign off 16/12/21. All wards will have completed the first cycle of checks by end of January 2022 23/12/21 Quality and Safety Meeting cancelled due to response to Covid -19 pandemic Level 4. Email sent to the inpatient matrons with final version of the quality check attached. This included a reminder that each ward will have completed cycle 1 of the quality checks by end of January 2022. 07/01/22 Two non clinical staff identifed to commence audit work as Matrons now clinical in response to covid 19 pressures on ward staffing. Results will be monitored at Service line Quality and Safe meetings. 13/01/22 Audits have commenced. Two completed for Aston and Heather wards. On track for completing audits . 20/01/22 Additional staff identified to undertake the Quality Checks as the Matrons are supporting ward staffing due to escalation of Omnicron COVID-19 pressure. Plans received to demonstrate the checks will be complete by the deadline. 27/01/22 All wards have now participated in the 6 weekly step up to great quality round. Results will be collated and items not being delivered on are being escalated to Directorate Management Team meetings for ongoing assurance 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance.	Closed
MD4 - Page 8	The trust must ensure there are effective systems and processes in place to audit risk assessments across the service and action taken to address short falls in clinical documentation. (Regulation 17(1)(2)(a))	Auditing system - Risk Assessments	Rehabilitation	The Trust will have an effective system in place where risk assessments are audited and actioned to improve clinical documentation	Update: - A review of the current systems and processes has been completed using the PDSA approach as a quality improvement project 7th June 2021 - There is a process in place to review risk assessments and care plans, the PDSA identified further actions to achieve continued improvement re: risk assessment and care plans being updated following an incident.	1. The peer review audit tool will be amended to include questions on risk assessments. 2. Monthly audits will be carried out and the results entered onto AMaT. 3. Results will be monitored at the service line Quality and Safe Meeting.	Fiona Myers / Helen Perfect	31/01/2022	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	07/06/21 Review of PDSA cycle to improve risk assessment completed. Actions developed and embedded as part of QI work. There is a process in place to review risk assessments and care plans, the PDSA identified further actions to achieve continued improvement re: risk assessment and care plans being updated following an incident. 23/12/21 Action on track. Questions have been added onto the tool in AMAT and ready for implementation in January 2022. 29/12/21 WeimproveQ Team emailed for screen shot evidence of questions added to the audit tool. 07/01/22 Ward audit results are now available on AMaT which will be monitored at Service line Quality and Safe meetings. 13/01/22 Audits are on track for completion by 31/01/22. 20/01/22 Wards have started to use the revised audit tool, all wards will have completed an audit by the end of January 2022 and based on outcomes a quality improvement plan will be developed to ensure full compliance. 31/01/22 Confirmation received all wards have completed an audit. Monitoring of ongoing compliance will form part of directorate level governance.	Closed

MD5 - Page 8	The trust must ensure there are effective systems and processes in place to audit care plans across the service and action taken to address short falls in clinical documentation. (Regulation 17(1)(2)(a)).	Auditing system - Care Plans	Rehabilitation	The Trust will have an effective system in place where care plans are audited and actioned to improve clinical documentation	Update: - A review of the current systems and processes has been completed using the PDSA approach as a quality improvement project 7th June 2021 - There is a process in place to review risk assessments and care plans, the PDSA identified further actions to achieve continued improvement re: risk assessment and care plans being updated following an incident.	1.A peer review care plan audit will be carried out monthly. 2. The results will be entered onto AMaT. 3. Results will be monitored at the service line Quality and Safe meeting.	Fiona Myers / Helen Perfect	31/01/2022	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	07/06/21 Review of PDSA cycle to improve risk assessment completed. Actions developed and embedded as part of QI work. There is a process in place to review risk assessments and care plans, the PDSA identified further actions to achieve continued improvement re: risk assessment and care plans being updated following an incident. 30/11/21 The PDSA cycle now includes a process to monitor that risk assessments are being updated post incident. This is reviewed at the Risk Assessment Group. Awaiting evidence of results from audit cycle. 23/12/21 Action is on track questions have been added onto the tool in AMAT and ready for implementation for January 2022. 29/12/21 WeimproveQ Team emailed for screen shot evidence of questions added to the audit tool. 07/01/22 Ward audit results are now available on AMaT which will be monitored at Service line Quality and Safe meetings. 13/01/22 Audits are on track for completion by 31/01/22. 20/01/22 All wards will have completed an audit by the end of January 2022 and based on outcomes a quality improvement plan will be developed to ensure full compliance. 31/01/22 Confirmationn received that all wards have now completed a monthly audit. Monitoring of ongoing audits will form part of directorate level governance.	Closed
MD6 - Page 8	The trust must ensure at the Willows staff consistently apply and record appropriate contemporaneous records for seclusion. (Regulation 17(1)(2)(c)).	Seclusion Records	Rehabilitation	Documentation at the Willows will demonstrate high standards of record keeping in relation to seclusion	Update: - All staff have been identified who have not received local training on the seclusion policy and they have been scheduled for training. - the seclusion audit on AMAT is completed by the Matron following every seclusion incident to monitor the quality of care and record keeping.	1. All staff who have not previously received the local training will be trained by 31st January 2022	Fiona Myers / Helen Perfect	~~31/01/2022~~ revised date 28/2/22 due to the impact of Omicron Covid	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	17/06/21 Doctors were reminded of their roles and responsibilities for seclusion reviews. 23/06/21 Individual reflection session with practitioner held regarding use of appropriate language. 25/06/21 CDM's were reminded that out of hours they have an oversight and coordination role for seclusion as per Seclusion Policy. 01/09/21 – Bite size training in relation to language used by staff has now been developed and rolled out. 02/11/21 – The audit was discussed at the Positive and Safe meeting 25/10/21. A meeting is planned to complete the update of AMAT questions, and a revised version will be taken to the November Positive and safe meeting for sign off. Local training planned for staff who have not had previous training on the policy for completion by end of January 2022. 23/12/21 Meeting has taken place with team leaders at The Willows and 4 dates have been agreed to complete training. 29/12/21 Need training dates as evidence and minutes of Rehab Positive and Safe meeting in November 07/01/22 November 2021 Positive and safe meeting minutes received 13/01/22 Training booked as planned. One date was cancelled due to the impact of Omicron Covid 19 and the focus on providing safe patient care. The AMAT tool has been revised. 20/01/22 Delivered 1 session as planned, one session missed due to technical difficulties with IT - session re-booked. No further episodes of seclusion since inspection to be able to reaudit. 27/01/22 Awaiting confirmation that all staff trained following additional training being delivered 31/01/22 Currently 8 out of 18 staff have received update training, 7 members of staff are unavailable due to long term sick. Further training sessions had been arranged but as this is enhanced training and not mandatory the service has had to prioritise the safety of patient care. The wards have been adversely affected with staffing shortages due to a direct impact of Omicron Covid-19 sickness as discussed with the CQC within engagement meetings. ORR risk number 63. 03/02/22 List of outstanding staff requring training has been reviewed. Training recommenced 22/02/22 All available staff have now completed this training. This leaves only the staff currently on sick leave absence, and there is a plan for them to be trained on their return to work.	Closed
MD7 - Page 8	The trust must ensure that the privacy and dignity is protected around the respectful storage of patient's clothes; (Regulation 10(1)).	Storage - Privacy & Dignity	Rehabilitation	The Trust will have safe and respectful storage facilities for patients clothes	Update: - A review of all inpatient storage facilities was undertaken - The Trust invested in improving permanent storage facilities for patients personal belongings on the Rehabilitation wards, now completed on Acacia and Sycamore. -Access to plastic storage boxes/cupboards and laundry bins made available. - Patient lockers have been provided for personal items that need to be stored securely and items that may be considered a risk.	1. Storage cupboards work to start on Cedar Ward in December 2021	Fiona Myers / Helen Perfect	28/02/2022	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	immediate review of storage and additional temporary storage boxes arranged. Workshop held to review improvements required. 17/08/21 - Outputs of workshop were a) Confirmed that there is adequate storage on Ashby ward dormitories, as each bed space has access to a wall mounted wardrobe with four shelves. b) On Aston Ward we have identified an additional room for the storage of larger items for the 12 patients in the 3 dormitories to have access. Ongoing co-production through ward community meetings of patient property management and storage. The additional storage identified at the Willows has already been scoped and awaiting confirmation of the dates for works to commence. 31/08/21- Aston ward - additional storage facilities now in place in a designated room on the ward. 03/09/21- . Bosworth ward received new furniture in one bedroom. This was used as a pilot for all other wards. 06/09/21 The shelving for Sycamore ward at the Willows commenced installation 13/09/21 - Bedroom furniture evaluated by staff and patients, positive feedback received and agreement to cascade the furniture out to all the new bedrooms in line with dormitory works 13/09/21 The shelving for Acacia ward at the Willows commenced installation 21/09/21 - Acacia ward and Sycamore ward shelving complete 27/09/21- Directorate now scoping additional furniture for all rooms. 05/10/21 - Thornton ward and Bosworth ward furniture being manufactured and to inform plans for other wards (Ashby and Aston to commence in line with dormitory reprovision works). 14 week turnaround timescale. 11/10/21 - Furniture installation now extended to include all appropriate rooms – approved by Directorate of Mental Health and Anne Scott (Executive Director of Nursing/AHP's & Quality). The additional furniture has been manufactured and is currently being installed in Thornton ward. Bosworth ward to be installed at completion of Thornton ward during 2 week decant period commencing 29/10. 01/11/21 -Tilbury Douglas have started the works as planned, completing one room at a time. Timescales + 8 weeks to complete 08/11/21 - Thornton ward furniture upgrade complete. 15/11/21 - Bosworth ward furniture upgrade complete.	Closed
MD8 - Page 8	The trust must ensure protected characteristic needs are identified, care planned and actioned. (Regulation 10(1)).	EDI - Protected Characteristics	Rehabilitation	Trust records will document / action and care plan patients needs around protected characteristics.	Update: -The patients individual care plan was reviewed and revised to encompass all of their individual needs. - The Rehabilitation wards welcome pack was reviewed by the Trust Equality, Diversity and inclusion group to include how the unit meets patients protected characteristic needs. - The Matron has worked with the lead at the Community Knowledge Framework for LGBTQ to acquire materials and signposting information to local networks for inclusion in patient resources at Stewart House.	1. The peer care plan audit tool within the AMaT is currently under review as part of the PDSA work. This will also include questions on recognising and meeting the equality and diversity needs of all patients. The tool will be updated by 31st December 2021	Fiona Myers / Helen Perfect	31/03/2022	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	08/06/2021 MDT review of individuals care plan undertaken Additional review completed 22/06/2021 Review of welcome packs undertaken by Equality and Diversity and Inclusion Lead and ward provided with the most up to date version. 30/11/21 The Amat Tool has been changed to identify the frequency of expected audits reflecting the nature of the patient group. 16/12/21 narrative sent to WeimproveQ to be add to collaborative care planning review tool which will be completed and started to be used by 01/01/22 29/12/21 Email sent to WeimproveQ team for screen shot evidence of AMaT tool including audit questions on equality and diversity needs. 04/01/22 Screen shots of amended AMaT tool received. 07/01/22 Willows welcome pack now in use, audits using new tool to commence which will be monitored at Service line Quality and Safe meetings. 13/01/22 AMAT tool amended and audits underway 20/01/22 The questions are on AMAT and wards have started to use the revised audit tool, all wards will have completed an audit by the end of January 2022 and based on outcomes a quality improvement plan will be developed to ensure full compliance. 31/01/22 Confirmation received that all wards have completed the monthly care plan audit. Ongoing monitoring of audits to be part of directorate governance oversight. 03/03/22 - second round of 6 weekly checks due by 18/03/22 and to provide updated results by end of March. 17/03/22 - Awaiting AMAT report to review question regarding protected characteristics. One round already completed and outputs from 2nd round of 6 weekly checks to be provided as evidence by end of March. 24/03/22 A further round of care plan audits have been completed using the amended AMAT audit tool which includes questions of meeting the equality and diversity needs of patients. Learning from this has also involved revising the guidance for staff on how to complete the audits more effectively.	Closed

MD9 - Page 9	The trust must use patient feedback to make improvements of the quality and variety of food available. (Regulation 17(1)(2)(a)(e)).	Food quality	Rehabilitation / Estates	The Trust will improve (according to patients) the quality and variety of food choices on the menus offered.	Update: -Estates and Facilities are reviewing the process for managing patients feedback on meals and menus more productively. - A trends and themes report is being submitted to the LPT Nutrition group meeting to allow for discussion and monitoring of the quality and choice of the food provided to wards which is being included at the shared service meeting with the external catering provider to identify trends and themes of feedback and improve the quality of service received from the provider. - the Rehabilitation wards have monthly patient community meetings facilitating feedback. the agenda has been amended to include you said / we did responses. - Updated posters, co-produced with service users, have been developed to display on the ward.	1. Across the Directorate the Matrons will collate feedback from all wards patient community meetings regarding quality and choice of food to the Trust Nutrition Group Meeting to enhance availability of quality food choices with the external provider	Fiona Myers / Helen Perfect / Richard Brown	28/02/2022	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards Quality Forum	20/10/21 Estates and Facilities are reviewing the process for managing patients feedback on meals and menus more productively. - A trends and themes report is being submitted to the LPT Nutrition group meeting to allow for discussion and monitoring of the quality and choice of the food provided to wards, which is being included at the shared service meeting with the external catering provider to identify trends and themes of feedback and improve the quality of service received from the provider. - The Rehabilitation wards have monthly patient community meetings facilitating feedback. The agenda has been amended to include you said / we did responses. - Updated posters, co-produced with service users, have been developed to display on the ward. 10/11/21 Taste testing sessions took place at the Beacon Unit. 10/12/21 Minutes from the Nutrition Group are required detailing steps taken to evidence progress on this action. 16/12/21 Nutrition group meeting 16/12/21 received up to date patient feedback. Nutrition Group meetings have increased to monthly from quarterly. Amended feedback form is now discussed directly with clinical team for immediate actions to be taken. SOP to be devised to address how to escalate concerns in and out of hours to Catering. Independent Food review of our menus will be undertaken by the end of March 2022 with gaps identified and capital bids submitted to address the gaps. 23/12/21 Colin Bourne attended the Nutrition Group Meeting on 16/12/21 and provided feedback from mental health rehabilitation in-patients to the group. Colin will continue to attend and to provide feedback and link to ward. 29/12/21 Rehab food tasting sessions planned- Stewart House 25/01/22, Willows 26/01/22 06/01/22 Confirmed taste testing sessions will be prioritised to go ahead. 13/01/22 Food tasting sessions to continue as planned. Helen Walton will escalate any delays 19/01/22- Willows taster session has had to be postponed due to an outbreak of Covid 19 on the ward. The session will be re-arranged. 24/02/22 Taste testing exercises have been completed at Stewart House and the Beacon Unit to date with	Closed
MD10 - Page 9	The trust must ensure staff are up to date with mandatory training including Mental Health Act training. (Regulation 18(1)).	Mandatory Training - MHA	Rehabilitation	The Trust will achieve mandatory training compliance of above 85% in the number of staff trained in the Mental Health Act	Update: - The Rehabilitation wards have reviewed mandatory training to support recovery of compliance since Covid-19 - The number and frequency of scheduled MHA training dates has been examined to ensure that they meet the requirements of the number of staff requiring training and additional sessions can be provided.	1. Ward sisters/Charge Nurses are implementing a plan to ensure staff that are out of date for all mandatory training including MHA training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in Jan 2022	Fiona Myers / Helen Perfect	~~31/01/2022~~ revised date 28/2/22 due to impact of Omicron Covid	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	Ward sisters/Charge Nurses have been implementing a plan to ensure staff that are out of date for all mandatory training including MHA training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022. 16/12/21 staff training needs mapped out. MHA -Stewart House 73%, Acacia 59%. MCA - Stewart House 84%, Acacia 83%, Maple 83% 23/12/21. All staff reminded to complete all mandatory training including MHA 29/12/21 Evidence received all staff have been reminded to undertake training. 06/01/22 Training figures to be provided with comparison of ratio from July 2021 and current. 13/01/22 Evidence shows varying degrees of compliance. Discussed at DMH DMT and decision made to prioritise new starters. Mandatory training will continue to be available and staff booked on. In light of current staffing challenges and risk to patient safety due to the impact of Omicron Covid, some mandatory training for staff may be delayed. 20/01/22 Agreed this will be placed on Risk Register re: ability to meet the action deadline due to the inability to release staff. Wards will prioritise providing safe patient care. 27/01/22 Await an update on current position as this action is at risk of not achieving the deadline. Training compliance report for the 1st February 2022 required. 31/1/22 The service has had to prioritise the safety of patient care as the wards experienced staffing shortages due to impact of Omnicron Covid-19 sickness discussed with the CQC within engagement meetings. ORR risk number 63.New deadline proposed to executive board for approval 03/02/22 Workforce agreed to revert to providing the bespoke training reports for the next 6 months whilst training compliance is addressed and improving. The reports will also detail staff non-attendance. DMH to roster staff on to attend training as part of roster planning. 04/02/22 - Executive Board approved new deadline of 28/02/22. From 7/02/22 there awill be twice weekly training huddles to review planned training for staff on each ward. Ability to release staff for training or non-attendance will be checked at the daily safer staffing huddles. 23/02/22 All remaining available staff have completed their MHA training. There are 2 members of staff who are currently not available due to being on Maternity or long term sick leave, who will complete the training on their return	Closed
MD12 - Page 9	The trust must ensure that the privacy and dignity of patients is always maintained. (Regulation 10(2)).	Privacy & Dignity	Acute / PICU	The Trust will maintain the privacy and dignity of all patients	Update: - Estates and Facilities have implemented a new system whereby the replacement/ hanging of curtains is prioritised as soon as the wards report an issue. - A daily environmental checklist is carried out on the wards which includes all curtains, window and bed spaces, and the ward sisters oversee the checking for compliance. Any concerns are escalated to the Team manager / Matron. - Spot checks are routinely undertaken. - All wards display temporary laminated signs on patient bedrooms to remind staff to knock. - A more permanent solution is in development.	1. Permanent signage on bedroom doors will be co-designed with service user feedback and is in development. Permanent signage will be in place by 28th February 2022.	Fiona Myers / Michelle Churchard Smith	28/02/2022	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	17/08/21 Outcome of the MDT Workshop held : soundproofing including physical partitioning considered, it was confirmed that soundproofed curtains and physical partitioning would not meet the Fire, IPC and ligature risk requirements. Patients have access to lockable personal storage. We have also reviewed the safety risk assessments to ensure choice is included as a consideration and where personal care/physical care is required. Daily Environmental Checklist completed. Revised Privacy and Dignity Audit confirmed on 19/08/21. Monthly spot check audit commenced. Progress is being made to improve response timeframes. Communication sent to all staff regarding update on privacy and dignity and their responsibilities w/c 23/08/21 31/08/2021- Ward sister DMH meeting- new process in place that privacy and dignity issues are being prioritised by facilities team. They will prioritise hanging curtains if the wards highlight it is a privacy and dignity issue. 14/10/21 Completed privacy and dignity audits paper presented at Quality Forum. 08/11/21 Privacy doors between male and female place at Stewart House are in place. **Signage** 3/12/21 Patient Experience, and carer lead to ask the patients by experience group to consider wording for the signs. 7/12/21 Email sent to MH Ward Sisters and Charge Nurses to ask them to consult current inpatients on wards about the privacy and dignity signs for bedrooms/ curtains - email evidence attached. Feedback to be received by 21/12/21 for discussion and decision on wording at the Lead Nurses meeting on 22nd December 21. **Laundry** Initial review of laundry facilities completed, further scoping to determine extra capacity required. 23/08/21 - Review delayed by a week by external contractor 31/08/21- Scoping exercise complete 10/09/21 - Works end date requested from Tilbury Douglas 05/10/21 - Confirmation received that expected timescale of works is 8 weeks for both to be completed . 11/10/21 - Following Fire Officer review, this initial scope has been enhanced and 2 laundry rooms are now being upgraded. Surveys have been completed, scope and design agreed, Major works required to strip	Closed
MD13 - Page 9	Staff must ensure they routinely explain rights to informal patients, offer written information and record this. (Regulation 11(1)).	Patient Rights	Acute / PICU	Informal patients will be given information on their rights and that this will be clearly documented in the patients records	Update: - A new Bradgate Unit Welcome Pack, co-produced with patients, available on all wards which includes information for patients wanting to leave the ward. - Whilst the wards await full information packs to be distributed, leaflets regarding informal rights are available for patients on admission.	1. Immediately following inspection wards were supplied with information leaflets for informal patients as an interim measure until each ward is issued with the new information pack, including leaflets and posters, to be available by 31st December 2021. Ward Sisters / Charge Nurses will sign to confirm receipt of the information pack on distribution to the ward. 2. Offering informal patients a rights leaflet will be added to the admission check list, to confirm it has been provided to the patient and enabling auditing of the process. The first audit will be completed by January 2022	Fiona Myers / Michelle Churchard Smith	31/01/2022	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	Immediately following inspection wards were supplied with information leaflets for informal patients as an interim measure until each ward is issued with the new information pack, including leaflets and posters, to be available by 31st December 2021. 07/12/21 The admission checklist has been amended and sent to the inpatient Matrons. The updated form will be taken to the next quality and safety meeting on 21 December 2021 for sign off. 07/12/21 Ward booklets issued and will be updated due to NHS.net migration. 10/12/21 Evidence of the admission checklist audit required in January 2022 16/12/21 Checklist amended and provided as evidence, to be submitted to Quality and Safe meeting for sign off 21/12/21 23/12/21 Quality and Safe meeting cancelled due to Level 4 response to Covid -19 pandemic. Checklist approved by Chair outside of meeting and to be circulated. Information for informal patients has been sent to all Matrons. Communications and engagement officer will be completing a review of all patient facing leaflets. Agreed that an audit will be completed by Carol Scarborough and Apexa Patel in January 2022. 06/01/22 Audits to commence week commencing 10/01/22 20/01/22 Spot check tool has been developed to check leaflets are offered on admission. 31/1/22 Spot checks results for January 2022 received. Monitoring of ongoing compliance will form part of directorate level governance.	Closed

MD15- Page 9	The trust must ensure that all wards are properly maintained with requests being attended to in a timely way. (Regulation 15(1)).	Maintenance- Estates	Acute / PICU	The trust will have an effective system in place where wards report maintenance issues and Facilities attend to the repairs in a timely manner	Update: -A new environmental checklist has been developed which is being used by ward teams to identify repairs / maintenance requests in a timely manner. - The Ward sisters / charge nurses are maintaining a spreadsheet of all maintenance requests detailing job numbers for action with the estates and Facilities team. - A monthly estate meeting is now in place with site facilities coordinator, manager and estates link to review and escalate any outstanding works to the Business and Performance Meeting and Health and Safety Action group. - Trust Board have approved a business case and are investing in a facilities Management Transformation Programme.	1. The 6 weekly Matron / manager quality assurance audit tool will include questions on checking that the environment all checklists have been completed fully and relevant actions addressed. The first cycle will be completed by Jan 2022	Fiona Myers / Michelle Churchard Smith / Richard Brown	31/01/2022	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	29/06/21 1 Ward sisters/charge nurse check each week any works required to Ward are logged on the ward spreadsheet and any outside the timescales (as specified in the estates flowchart) are escalated to Dave Wright, Acting Site Manager and the spreadsheet is updated with details of escalation. 13/07/21 – Spreadsheet has been tidied up and ward sisters/ charge nurses have been contacted to discuss individual wards and setting up meetings to review outstanding jobs. Thornton jobs have been reviewed and a meeting is scheduled with Heather on 19/07/21. 21/09/21 Work is cotinuing with the wards to update logs and escalate all jobs over the 21-day SLA to estates. 05/10/21 – The number of outstanding jobs has reduced significantly. A meeting took place 04.10.21 to discuss outstanding issues. 23/11/21 First draft of Step up to Great Quality Checks sent to Head of Nursing for sign off. This quality check has had a question added about garden/courtyard spaces as follows: •Has the ward environmental checklist been completed? •Were any identified issues from the checklist escalated/managed appropriately? •Has the environmental checklist been signed off by the Ward Sister/Charge Nurse? 07/12/21 This Quality check will go to the next Directorate Quality and Safety Meeting on 16th December, with roll out from 20th December, all wards will have been completed by end January 2022. 23/12/21 Quality and Safe Meeting cancelled due to Level 4 response to the Covid -19 pandemic. Email sent to the inpatient Matrons with final version of the quality check attached, with a reminder for each ward to have completed cycle 1 of the quality checks by end of January 2021 04/01/22 Email received confirming that there is a process in place whereby centralised spreadsheets are reviewed weekly, the process is effective as the majority of maintenance requests are now up to date. 06/01/22 Two non clinical staff identifed to commence audit work as Matrons providing clinical support to the wards in response to covid 19 pressures on ward staffing. 13/01/22 Audits have commenced. 20/01/22 Plans received to demonstrate the checks will be complete by the end of Jan 2022. 27/01/22 All wards have now participated in the 6 weekly step up to great quality round. 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance.	Closed
MD16 - Page 9	The trust must ensure that managers review incidents in a timely way, in line with trust policy. (Regulation 17(1)).	Incident Review	Acute / PICU	Incidents will be reviewed as per Trust Policy	Update: - The sign off of all incidents, to ensure closure is undertaken within required timescales, is an agenda item at the weekly directorate incident review meeting and reviewed at the Incident Oversight Group. - The format of the AFPICU Incident Review Meeting has been amended. - A highlight report is to be presented at the Directorate Quality and Safety meeting in January 2022.	1.All outstanding incidents for Acute and PICU Services will be reviewed and will be signed off by the 31st Jan 2022 2. Incident management update training will be provided to all ward sisters / charge nurses and deputies to be completed by the 31st Jan 2022.	Fiona Myers / Michelle Churchard Smith	~~31/01/2022~~ revised date 28/2/22 due to impact of Omicron Covid	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	**1. Incidents**Directorate plan is in place for all outstanding incidents for Acute and PICU Services are being reviewed and will be signed off by the 31/01/22 07/12/21 Significant work has been undertaken to reduce the backlog such that only Beaumont and Watermead have historic EIRF's open that need actioning. The team manager and band 6s are allocating time to close outstanding EIRF's. A EIRF completion guide has been developed by the team manager to support the process and prevent any incidents exceeding 15 days without sign off for sustainability. 23/12/21 Bradgate mental health wards have progressed historical eirfs with a small number outstanding. Currently on track. Eirf system being used and monitored by team manager to highlight areas of concern each week to prioritise resources when close to breaching 15 day sign off target. 31/12/21 Need evidence from Directorate or IOG that outstanding incidents are decreasing. 06/01/22 DMH incident report submitted to the Incident Oversight group received. 13/01/22 Reviewing of timely incidents. Reduction in backlog of incidents, awaiting data for evidence. 19/01/22 Currently 137 incidents awaiting closure for PICU and acute wards. Plan in place to address these and developing sustainability plan to ensure processes are in place for timely closure going forward. 27/01/22 Confirmation received from Incidents Team only 2 incidents requiring sign off. 28/1/22 Confirmation received that the 2 outstanding incidents are closed **Action 1 closed and Green** **2. Training** Incident management update training is being provided to all ward sisters / charge nurses and deputies to be completed by the 31st Jan 2022. Session delivered ot Foundations for Great Patient Care on incident closure cross trust 24/11/21 16/12/21 Incident review training cancelled by CPST, training to be re-arranged Training booked in for 28/12/21 06/01/22 Additional training dates for band 6 and 7 ward staff arranged. 19/01/22 Further training session to be arranged for remaining charge nurses and deputies. Thornton, Belvoir, Ashby, Aston attended training. Awaiting potential dates from patient safety team for week commencing 24.01.22	Closed
MD17 - Page 9	The trust must ensure the acute and psychiatric intensive care wards have consistent and effective management of contraband items – to include lighters. (Regulation 17(1)(2)).	Checks Policy	Acute / PICU	The acute wards for adults of working age and psychiatric intensive care units will have an effective process in place in relation to managing items of contraband, including lighters	Update: - We have improved compliance with checking and searching training. - The Quality Improvement project that focuses on checking and searching patients has commenced. - A new checklist has been developed for the wards to use which logs patients lighter use. - The quality improvement starter has been approved and the first audit on the use of patients lighters is to be disseminated in December 2021. - Spot checks have been undertaken to ensure compliance with Policy.	1. The 6 weekly Matron/ Manager quality assurance audit tool will include questions on checking that patients who smoke have a care plan in place, log the equipment used for smoking and that the lighter checklist is in use. The first cycle will be completed by January 2022	Fiona Myers / Michelle Churchard Smith	31/01/2022	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	16/06/21 Ward sisters/ Charge Nurses reminded of the expectations of checking and searching when patients are returning from leave: 08/06/21 Training figures sent to ward sisters charge sisters on asking them improve compliance over the next few months. 02/1/21 – Improved compliance highlighted in the draft Nov 2021 training report however Ashby and Watermead remain under 85% compliance. Staff members have been contacted individually; some have now completed however team manager is collecting evidence as to why this is not reflected on the report. Ongoing compliance to be monitored. 03/11/21 Spot checks have been carried out over the past 3 months. Recent check indicated only 1 patient did not have a have a care plan. To move into 6 weekly Matron quality checks for sustainability. 23/11/21 First draft of Step up to Great Quality Checks sent to Head of Nursing for sign off. This quality check has had a question added about garden/courtyard spaces as follows: •Patients who smoke or secrete contra-band have a care plan detailing the checking and searching requirements •The wards are using the lighter checklist 07/12/21 This Quality check will go to the next Directorate Quality and Safety Meeting on 16th December 2021, with the plan to roll out from 20th December 2021, so all wards will have been completed by end January 2022 23/12/21 Quality and Safe Meeting cancelled due to Level 4 response to the Covid -19 pandemic. Email sent to the inpatient Matrons with final version of the quality check attached, with a reminder for each ward to have completed cycle 1 of the quality checks by end of January 2022 06/01/22 Two non clinical staff identifed to commence audit work as Matrons clinical supporting the wards in response to covid 19 pressures. 13/01/22 Audits have commenced. 20/01/22 Additional staff identified to undertake the Quality Checks due to the capacity of the Matrons with support regarding situation in relation to COVID-19. Plans received to demonstrate the checks will be complete by the end of Jan 2022. 27/01/22 All wards have now participated in the 6 weekly step up to great quality round.	Closed

MD18 - Page 9	The trust must ensure that all patients have appropriate access to a range of psychological therapies. (Regulation 18(1)).	Psychology Access	Acute / PICU	Psychological therapy will be available to patients who require it as part of their treatment	Update: - Since inspection a series of recruitment exercises to therapy posts have been undertaken. - The vacancies in OT Support Worker posts have been successfully recruited to, recruitment will continue to support turnover. - Recruitment to bank OT has been successful and will be ongoing. - The Band 8c lead psychology post has been recruited into.	1. Following successful recruitment to the lead post the remaining psychology posts and vacancies will be advertised by the end of December 2021 2. Any vacant occupational therapy posts will be re-advertised by the end of December 2021.	Fiona Myers / Michelle Churchard Smith	28/02/2022	Closed	Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards	23/07/21 Lead psychologist post interviewed and appointed. Once in post recruitment to wider team to be completed. Since the CQC visited staffing has increased by 4.0wte (8c lead and 3 Band 4 Assistant Psychologists) 01/09/21 – both band 3's and 5 appointed to and in post. Further recruitment will be ongoing due to staffing changes. 3/12/21 Request made for additional agency cover for 2 wte Band 8a psychologists. 09/12/21 - Inpatient OT vacancies for Band 3, 5 and 6 have been advertised with interviews on 9/12/21. Any posts not filled will be re-advertised by the end of December 2021. 5 of the 8 B3 OTA posts have been recruited to. Rehabilitation - The CERT B6 and B3 posts have now been successfully recruited to. 09/12/21 Recruitment plan for psychology posts updated with further adverts to go out . 10/12/21 Evidence required that recruitment continues through December 2021 16/12/21 No applicants as yet for advertised posts. Posts to be re-advertised week commencing 20/12/21. Chief Psychological Officer job description submitted for Agenda for Change. This will strengthen future recruitment. OT posts currently out to advert. 23/12/21 Re-advertised B8a vacancies - evidence received (link to job advert) 13/01/22 Recruitment to Psychology Post unsuccessful therefore readvertising. OT posts recruited to successfully. 20/01/22 Recruitment underway for both Psychological Therapies staff and OT 27/01/22 All OT posts recruited to remaining Psychology posts out to advert 03/02/22 All Psychology and OT posts have been recruited to and are in the onboarding stage 17/02/22 All posts recruited to, accepted and awaiting start dates	Closed
MD19 - Page 9	The trust must ensure that all clinical staff receive training in the Mental Health Act which is updated regularly. (Regulation 18(2)).	Mandatory Training - MHA	Acute / PICU	The acute wards for adults of working age and psychiatric intensive care units will achieve compliance of 85% or above of staff trained in the Mental Health Act	Update: - Since inspection the Acute and PICU wards have reviewed mandatory training to support recovery of compliance since Covid-19. - The number and frequency of scheduled MHA training dates has been examined to ensure that they meet the requirements of the number of outstanding staff requiring training.	1. Ward Sisters / Charge Nurses will implement a plan to ensure staff out of date for all mandatory training including MHA/MCA and life support training will be scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022	Fiona Myers / Michelle Churchard Smith	~~31/01/2022~~ revised deadline 28/2/22 due to impact of Omicron Covid	Closed	Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards	Ward Sisters / Charge Nurses have been implementing a plan to ensure staff that are out of date for all mandatory training including MHA/MCA and life support training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022. 16/12/21 Ward Sisters / Charge Nurses now have access to book staff onto training. 06/01/22 Head of nursing reviewing all training data with comparison of compliance from inspection to current figures. Impact of current pressures on ward staffing in light of emerging increasing incidence of Covid and required Trust response to Level 4 actions acknowledged. 13/01/22 Evidence shows varying degrees of compliance. Discussed at DMH DMT and decision made to prioritise new starters. Mandatory training will continue to be available and staff booked on. In light of current staffing challenges due to Covid and risk to patient safety some mandatory training for staff may be delayed. 20/01/22 Agreed that this will be put on Risk Register for meeting the deadline to complete training due to being able to release staff. 27/01/22 Await an update on current position. 1st February 2022 compliance report needed 31/01/22 The service has had to prioritise the safety of patient care. The wards have been adversely affected with staffing shortages due to impact of covid-19 sickness. ORR risk number 63. New deadline proposed to executive board for approval. 04/02/22 - Executive Board approved new deadline of 28/02/22 - as discussed with the CQC within engagement meetings. 7/02/22 Twice weekly training huddles have been implemented to review planned training for staff on each ward. Ability to release staff for training or non-attendance will be checked at the daily safer staffing huddles 23/02/22 All available Acute and PICU staff are compliant or booked on to mandatory training including MHA. All unavailable staff due to maternity or long term sick leave will complete the training on their return to work.	Closed
MD20 - Page 9	The trust must ensure that all clinical staff receive training in the Mental Capacity Act which is updated regularly. (Regulation 18 (2)).	Mandatory Training - MCA	Acute / PICU	The acute wards for adults of working age and psychiatric intensive care units will achieve compliance of 85% or above of staff trained in the Mental Capacity Act	Update: - Since inspection the Acute and PICU wards have reviewed mandatory training to support recovery of compliance since Covid-19. - The number and frequency of scheduled MHA training dates has been examined to ensure that they meet the requirements of the number of outstanding staff requiring training. - MCA training is available on U Learn.	1. Ward Sisters / Charge Nurses will implement a plan to ensure staff that are out of date for all mandatory training including MHA/MCA and life support training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022	Fiona Myers / Michelle Churchard Smith	~~31/01/2022~~ revised deadline 28/2/22 due to impact of Omicron Covid	Closed	Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards	Ward Sisters / Charge Nurses have been implementing a plan to ensure staff that are out of date for all mandatory training including MHA/MCA and life support training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022. 16/12/21 Ward Sisters / Charge Nurses now have access to book staff onto training. 23/12/21 - Charge nurses booking staff on training; training is future dated so returns not immediately available. Wards have been requested for updates in terms of numbers booked and several wards have booked all outstanding staff on future training already. Training compliance is closely monitored bi-weekly to track progress against each ward. Progress from 1st Dec – 15 Dec is minimal, this should improve over the weeks following staff attendance. 06/01/22 Head of nursing reviewing all training data with comparison of compliance from inspection to current figures. Impact of current pressures on ward staffing in light of emerging increasing incidence of Omicron covid and required Trust response to Level 4 actions acknowledged. 13/01/22 Evidence shows varying degrees of compliance. Discussed at DMH DMT and decision made to prioritise new starters. Mandatory training will continue to be available for booking. In light of current staffing challenges and risk to patient safety some mandatory training for staff may be delayed. 20/01/22 Agreed that this will be put on Risk Register for meeting the deadline to complete training due to being able to release staff. 27/01/22 Await an update on current position. 31/01/22 The service has had to prioritise the safety of patient care. The wards have been adversely affected with staffing shortages due to impact of covid-19 sickness. ORR risk number 63. New deadline proposed to executive board for approval. 04/02/22 - Executive Board approved new deadline of 28/02/22 - as discussed with CQC during engagement meetings. 7/02/22 twice weekly training huddles implemented to review planned training for staff on each ward that week. Ability to release staff for training or non-attendance will be checked at the daily safer staffing huddles 24/02/22 All available staff have completed or are booked on to MCA training.	Closed
MD21 - Page 9	The trust must ensure that all clinical staff are trained in basic life support, and qualified nurses undertake intermediate life support training. (Regulation 18(2)).	Mandatory Training	Acute / PICU	The acute wards for adults of working age and psychiatric intensive care units will achieve compliance of 85 % or above for clinical staff in BLS and 85% or above for Qualified Nurses in ILS	Update: - Since inspection the Acute and PICU wards have reviewed mandatory training to support recovery of compliance since Covid-19. - The number and frequency of scheduled MHA training dates has been examined to ensure that they meet the requirements of the number of outstanding staff requiring training. - Basic and ILS training within Covid secure guidelines has been restored.	1. Ward Sisters / Charge Nurses will implement a plan to ensure staff that are out of date for all mandatory training including MHA/MCA and life support training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022	Fiona Myers / Michelle Churchard Smith	~~31/01/2022~~ revised deadline 28/2/22 due to impact of Omicron Covid	Closed	Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards	Ward Sisters / Charge Nurses have been implementing a plan to ensure staff that are out of date for all mandatory training including MHA/MCA and life support training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022 16/12/21 Ward Sisters / Charge Nurses now have access to book staff onto training. 23/12/21 - Charge nurses booking staff on training; training is future dated so returns not immediately available. Wards have been requested for updates in terms of numbers booked and several wards have booked all outstanding staff on future trainings already. Training compliance is closely monitored bi-weekly to track progress against each ward. Progress from 1st Dec – 15 Dec is minimal, this should improve over the weeks following staff attendance. 06/01/22 Head of nursing reviewing all training data with comparison of compliance from inspection to current figures. Impact of current pressures on ward staffing in light of emerging increasing incidence of Omicron covid and required Trust response to Level 4 actions acknowledged. 13/01/22 Evidence shows varying degrees of compliance. Discussed at DMH DMT and decision made to prirority new starters. Mandatory training will continue to be available and staff booked. In light of current staffing challenges as a direct impact of Covid and risk to patient safety some mandatory training for staff may be delayed. 20/01/22 Agreed that this will be put on Risk Register for meeting the deadline to complete training due to being able to release staff. 27/01/22 Await an update on current position 31/01/22 The service has had to prioritise the safety of patient care. The wards have been adversely affected with staffing shortages due to impact of covid-19, sickness. ORR risk number 63.New deadline proposed to executive board for approval. 04/02/22 - Executive Board approved new deadline of 28/02/22 - as discussed with the CQC during engagement meetings. 7/02/22 twice weekly training huddles implemented to review planned training for staff on each ward . Ability to release staff for training or non-attendance will be checked at the daily safer staffing huddles 24/02/22 All available staff have completed or are booked on to BLS and ILS training.	Closed

MD22 - Page 9	The trust must ensure that all staff follow NICE guidance regarding the use of rapid tranquilisation and monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. To protect patients from the risks of over sedation and possible loss of consciousness. (Regulation 12(2)(f)).	Rapid Tranquilisation - NICE guidance	Learning Disabilities	The Trust will adhere to NICE guidance in monitoring the physical health of each patient receiving rapid tranquilisation.	Update: - Records demonstrate compliance in training, 100% of all available Registered Nurses have completed the ulearn training on rapid tranquilisation. - 5 episodes of rapid tranquilisation were reviewed by the ward manager and unit matron. Documented care provided evidenced all care had been delivered as per the policy and NICE guidance. - Guidance on how to monitor side effects and complete the template on SystmOne has been implemented and shared with the team and a laminated flow chart is on display. - There are clear systems in place for monitoring and reviewing records. - There is a clear system in place to identify clinical staff who require an update on their return to work. - Pharmacy are providing a daily and weekly summary report to the Charge Nurse on the use of rapid tranquilisation, which is reviewed by the Matron. - Following each administration the Charge Nurse and Matron are reviewing practice and documentation of the event. 04.04.22- Rapid tranq : 86.20% (13/15) 2 staff unavailable	1. All remaining clinical staff who require an update on the use of rapid tranquilisation will complete the ulearn module on their return to work.	Helen Thompson / Zayad Saumtally / Francine Bailey	31/01/2022	Closed	Service line weekly meetings, monthly DMT and reporting to Executive Boards	Records demonstrate compliance in training, 100% of all available Registered Nurses have completed the ulearn training on rapid tranquilisation. - 5 episodes of rapid tranquilisation were reviewed by the ward manager and unit matron. Documented care provided evidenced all care had been delivered as per the policy and NICE guidance. - Guidance on how to monitor side effects and complete the template on SystmOne has been implemented and shared with the team and a laminated flow chart is on display. - There are clear systems in place for monitoring and reviewing records. - There is a clear system in place to identify clinical staff who require an update on their return to work. - Pharmacy are providing a daily and weekly summary report to the Charge Nurse on the use of rapid tranquilisation, which is reviewed by the Matron. - Following each administration the Charge Nurse and Matron are reviewing practice and documentation of the event. For sustainability training and rapid tranquilisation are discussed at unit meetings. 16/12/21 All available staff have undertaken training. 23/12/21 One new starter in progress of completing rapid tranquilisation training. Audits completed -on physical health checks. 31/12/21 Rapid tranquilisation training - 87% 06/01/22 No episodes of rapid tranquilisation used in December 2021, only Preceptee staff remaining to complete training. 13/01/22 Waiting for one member of staff to complete. Two staff members not available. 20/01/22 Confirmation received that final available staff member has completed RT training. RT audit received 17.1.22 27/01/22 Evidence received that all available staff have completed training 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance. 13/03/22 No incidents of rapid tranquilisation throughout February. Rapid Tranquilisation:86.7% 13/15 staff members (2 staff members completed but not showing on system, ward manager has emailed L&D asking to reflect in uLearn)	Closed
MD23 - Page 9	The Trust must ensure that all staff are trained in basic life support and intermediate life support. (Regulation1 8(2)(a)).	Mandatory Training	Learning Disabilities	The wards for people with learning disability or autism will achieve compliance of 85% or above for clinical staff in BLS and trained nurses in ILS	Update: - Since inspection, the Unit has reviewed mandatory training to support recovery of compliance since Covid-19 by means of a designated member of staff who monitors staff training. - Monthly training compliance reports are being reviewed by the Team Manager and Charge Nurse and immediate actions being taken to ensure improved compliance. - There is now a process in place for the Charge Nurse and staff member designated to focus on training, are notifying staff when their training is due and supporting them to ensure they are booked on and compliant.	1. The outstanding members of available staff will be booked onto Immediate Life Support training, this is in progress with a completion date by the end of December 2021. 2. 3 available staff members will be booked onto Basic Life support training and will be completed by end of December 2021	Helen Thompson / Zayad Saumtally / Francine Bailey	31/01/2022	Closed	Service line weekly meetings, monthly DMT and reporting to Executive Boards	25/11/21 All available remaining staff are booked onto life support training. 09/12/21 - ILS 66.7% on Trust compliance report. 10 out of 11 currently available staff are trained. Further support has been put in place for one staff member to help them achieve their competencies. BLS - 72.5% on Trust compliance report - 30 ot 40 staff complete all other available staff are booked on. 16/12/21 Positive trends in training - need evidence 23/12/21 Update: ILS 10/15 (2 booked and 3 unavailable). BLS - issue with non-attendance / sickness. 31/12/21 ILS - 67% (maximum that can be achieved is 80% due to staff not available) BLS - 75% (anomolies identified with reporting) actual figure 83% 06/01/22 BLS training now 80.5%, ILS 71% of available staff showing steady improvement. 13/01/22 - ILS 9 out of 12 staff are compliant (2 unavailable) one member of staff has failed 3 tims and due to resit on 17/01. BLS remains at 80.5%. 7 staff remain non-compliant, one on long term sick. 4 staff booked on this morning (one DNA'd) and need confirmation of other 3 booked on in January. 14/01/22 3 remaining staff to complete BLS, 1 booked for 17th Jan and 2 are not available 20/01/22 ILS - no change, one person still to complete. BLS - Remaining available staff now completed therefore full compliance of available staff 27/01/22 BLS now at 92% all available staff have completed the training. ILS now at 85% which equates to 12 out of 14 staff in data with remaining 2 staff currently unavailable to complete training due to absence. Therefore all available staff have completed training. 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance. 13/03/22 ILS training compliance for February: 80%- 13 out of 15 staff members have completed the training (this is all available staff, 1 completed 7th March and 2 staff members are off sick). BLS training compliance for February: 92.1%, Staff member booked for 29th March. New starter- started 7th March, booked 25th march. 1 x staff member was sick, rebooked 22nd April 04/04/22- BLS- 92.10% and ILS 80% (12/15) 2 staff unavailable, 1 booked 22nd April and 1 new starter. Actual = 93.33% Rapid tranq : 86.20% (13/15) 2 staff unavailable	Closed
MD24 - Page 9	The trust must ensure there are effective systems and processes to monitor the quality of clinical records, in particular seclusion records, physical health monitoring post rapid tranquilisation (Regulation 17(2)(b)).	Clinical Record keeping audits	Learning Disabilities	The wards for people with learning disability or autism will have an effective system in place where clinical records are audited and actioned to improve the quality of clinical documentation.	Update: - Following each episode of rapid tranquilisation use, care records are being reviewed by the Charge Nurse. - In addition the Unit Matron is carrying out monthly reviews of all episodes of rapid tranquilisation administration and seclusion to quality check practice, documentation and adherence to policy and NICE guidance.	1. Monthly auditing of individualised patient records will be carried out to review all care, including physical health monitoring, and will be reviewed at service meetings to ensure sustained compliance	Helen Thompson / Zayad Saumtally / Francine Bailey	31/01/2022	Closed		Guidance on how to monitor side effects and complete the template on SystmOne has been implemented and shared with the team. 25/06/21 A laminated flow chart is on display in relevant clinical areas. 09/12/21 - 3 Rapid Tranquilisation's in November 2021 all of which have been audited and care in line with NICE guidance. 16/12/21 To be discussed in Directorate Operational Meeting 21/12/21 23/12/21 Discussed in Operational Meeting and DMT minutes will be provided. Since update on Audit of records in November 2021, no further episodes of seclusion. 31/12/21 Evidence of completed audits received 06/01/22 No episodes of rapid tranquilisation during December 2021. 13/01/22 Still no episodes of rapid tranquilisation. One episode of seclusion. 20/01/22 90.7% compliance with seclusion audit Jan 2022 27/01/22 Evidence received - Rapid Tranquilisation audit form 17.01.22 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance.	Closed
MD25 - reinspection Feb 2022	The Trust must ensure that staff carry out regular testing of patient wrist worn alarms and fixed room alarms and that this is recorded as per Trust policy. Regulation 12(1)(2).	Testing of patient alarms	Acute / PICU	The testing of patient wrist worn alarms will be completed and recorded daily as per the Patient and Visitor Safety Alarm Guidelines. Fixed room alarms will be tested and recorded daily as per the Patient and Visitor Safety Alarm Guidelines.	Update: - The Nurse in Charge allocates a responsible member of staff on a daily basis to complete the daily environmental checklist which includes the checking of patient wrist worn alarms.	1. The Patient and Visitor Safety Alarm Guidelines will be reviewed and updated by 30/05/22. 2. The core daily environmental checklist will be amended by the 30/06/22 to include the testing of fixed and personal safety alarms. 3. All wards will map fixed alarm points and display by 30/05/22. 4. The patient safety alarm Learning Board will be updated and disseminated to wards by 30/06/22.	Fiona Myers / Michelle Churchard Smith Jane Martin	30/05/22 30/06/22 30/05/22 30/06/22	Closed		26/05/22 First draft of the Acute wards amended Guidelines has gone out for comment and to be taken to DMT 01/06/22. A quality tool has been devised to check the use and documentation of fixed, patient and visitor safety alarms. 09/06/22 Action 1 complete as the Patient and Visitor Safety Alarm Guidelines have been reviewed, updated and disseminated. Action 3 complete as wards have mapped and are displaying posters of their fixed alarm points position. 16/06/22 A trial started on the 13/06/22 for 4 weeks of the Core and Directorate daily environmental checklist, which Thornton, Watermead and Stewart House are trialling. In the interim until the pilot finishes the additional questions will be added to the daily and weekly checks to ensure testing takes place. The Learning Board has been updated and is out for comment.	Closed
MD26 - reinspection Feb 2022	The Trust must ensure that risk assessments for wrist worn alarms are uploaded into the electronic patient care record as per Trust policy. Regulation 12(1)(2).	Risk assessments for patient alarms	Acute / PICU	Completed patient risk assessments for the use of wrist worn alarms will be uploaded onto SystmOne as per trust Policy.		1. The risk assessment template will be available on SystmOne to document directly into by 30/09/22 2. In the interim the paper risk assessment tool will be amended by the 30/06/22 to document a weekly update. 3. The Patient and Visitor Safety Alarm Guidelines will reflect that in the interim the paper risk assessments will be located in the 'patient handover information folder' and uploaded onto SystmOne on discharge 30/06/22	Fiona Myers / Michelle Churchard Smith Jane Martin	30/09/22 30/06/22 30/06/22			26/05/22 The process has been established and commenced in requesting that the risk assessment template be built into SystmOne. 09/06/22 The required SystmOne change request form has been submitted as the first part of the process in building the risk assessment template into SystmOne. Action 2 complete as the paper risk assessment tool has been amended to document a weekly update. Action 3 complete as the Patient and Visitor Safety Alarm Guidelines have been amended to reflect that the paper risk assessments will be located in the patient information folder and be uploaded onto SystmOne on discharge until the risk assessment is available on systmOne.	
MD27 - reinspection Feb 2022	The Trust must ensure that for each patient who wears a wrist worn alarm a care plan is in place for its' use in the electronic patient record, as per Trust policy. Regulation 12(1)(2).	Care Plans for patient alarms	Acute / PICU	SystmOne will document an up to date care plan for each patient risk assessed for the use of a wrist worn alarm.		1. The Patient and Visitor Safety Alarm Guidelines will be amended to reflect for patients needing a personal safety alarm their care needs will be documented in the collaborative care plan 30/06/22. 2. Ward Sisters will communicate via the updated learning Board to all Qualified Nursing staff that it is their responsibility to document within the collaborative care plan if a patient has a personal safety alarm 08/07/22	Fiona Myers / Michelle Churchard Smith Jane Martin	30/06/22 08/07/22	Closed		09/06/22 Action 1 complete as the Patient and Visitor safety Alarm Guidelines have been amended to reflect that for patients requiring a personal safety alarm their care needs will be documented in the collaborative care plan. 16/06/22 To new posters have been designed for patients and staff regarding the use of personal safety alarms. These will also be included in the July Bradgate Newsletter for wider dissemination. 23/06/22 - Action 1 complete. Action 2 Final version of Learning board received as well as table confirming wards that the new Learning Board has replaced the old version and confirmation of communication sent to each ward detailing changes. 07/07/22 Action 2 complete	Closed