UPDATED ACTION PLAN FOR 2011/3518

ACTION PLAN DEVELOPED BY: - Lynn Randall/Frances Wood DATE: - 25* November *2011
***ACTION PLAN SIGNED OFF BY: -* Hilliary Killer *DATE* 3.1.12; Update 17.5.12; Updated 1.11.12 / 6.12.12/ 6.6.13 / 2.1.15 / 21.10.15**

Action No.	Root Cause/ Contributing Factor	Level of Risk	Agreed Action	Evidence of Completion	Review Status 2.1.2015 (Rag rating*)	Review Status 23.10.2015 (Rag rating*)
1.	Lack of appropriate supervision and induction for all staff within Childrens Hospital (CH) returning to work following >3months absence	Med	1. All Staff returning from a prolonged period of absence to be seen on their return and a period of supervision agreed 2. All staff returning from a prolonged period of absence to undergo an agreed return to work programme (RTWP). 3. RTWP to include information contained in the induction of all new staff	Documentation of Supervision in member of staff's records. Review of data for Medical staff kept by Junior Doctor Administrator	All actions completed Remains compliant	Remains compliant • All medical staff with >3 month absence have a phased RTWP **In addition** • All medical staff who are on leave for > 3 weeks receive a return to work review with the CAU medical lead to assess any supervisory requirements • Medical staff on leave >3 months are offered 'keep in touch' days to attend prior to their return
2.	Lack of educational supervisor for medical staff within CH returning to work following >3months absence	Med	1. All medical staff to be allocated an education supervisor immediately they return to work 2. All meetings to be documented by the Educational Supervisor and shared with the member of medical staff being supervised	Review of data for Medical staff kept by Junior Doctor Administrator Random review of supervision documentation	Completed Remains compliant Lead Consultant responsible for junior doctors identified	Remains compliant • Feedback from junior medical staff that they have an education supervisor and a clinical supervisor allocated to them on commencement
3.	Medical staff lack of recognition of abnormal results		1. Poster with normal blood gas results and the ranges for routine blood samples to be circulated to all clinical teams 2. All clinical areas in CH to display laminated posters with normal blood gas results 3. All clinical areas to display posters with normal levels for blood results	Audit of all clinical areas Training Program	All actions now completed	Remains compliant • Spot check - Poster remains in place for both blood gasses and blood results • Feedback from medical staff- blood gas results remain embedded in teaching sessions by Consultant for CAU

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3. Cont.	Medical staff lack of recognition of abnormal results	Low	4. Blood results to be added to scenario training 5. Regular teaching sessions/informal basis by Consultant of junior staff in CAU			
4.	Medical staff not escalating information regarding sick child to on-call Consultant or at Medical handover	Med	1. On call Consultant to review all patients remaining on CAU at 08.30 hours each day 2. Employment of Paediatric Ambulatory Consultants to be based on CAU (transfer to 'single front door' when developed. 3. The Ambulatory Consultants to undertake sessions to review all admissions on CAU and lead / supervise staff 4. Change of pathway of care in collaboration between paediatrics and ED. 'Single Front Door' 5. New Ambulatory Consultants to support new system and provide guidance and support to junior medical staff 6. In preparation of 'Single Front Door' Children's Policies and Guidelines used in CAU and Paediatric ED to be reviewed by Lead Consultants and Managers 7. Agreement to be made on Policies and guidelines to be used jointly in CAU/ Children's ED. 8. Review of escalation documentation (SARS) to identify if a single document should be used by both CAU and Children's ED	'Consultants appointed. 'Single front door' pathway implemented Monthly CAU Case Note Review Appointed 4 Consultants 2 for CAU and 2 for ED. Working collaboratively to manage patient's flows between ED and Childrens Hospital. Electronic handover used by both nursing and medical staff throughout the Children's Hospital One door front solution being reviewed and new timescales agreed.	Agreed actions 1, 2, 3, 5, 6, 7 and 8 completed. Agree Action 4 ongoing	Not fully compliant **Feedback** • 'Single front door' is not in place as yet – part of the development for the Children's Hospital • Majority of on call consultant complete ward round each morning. However if on call Consultant also has clinic may not be able to complete the round due to time restriction • X1 consultant down therefore not always able to provide continued consultant presence on the ward between 09:30 – 21:00. About to be advertised • Business case being formulated to support a second consultant to improve consultant presence • Current review of increasing to x2 SpR's during twilight hours (busiest time) • Electronic handover not in use within Children's – subsequent lack of hardware and interfacing of systems. Plans to incorporate it once EDRM is established • Escalation policy revised – out for consultation. Agreed and implemented 17/11/2015. • Implementation of "Mission Control" MDT review and planning meeting at 0900, 1315, 1630 for co-ordinated planning of emergency and critical care. Evening review between Paed and Paed ED consultants. • SARS now replaced with PEWS **Recommendation** • Risk assessment to be undertaken with regards to what actions can be implemented to mitigate the gaps in current consultant cover

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5.	Nursing handover did not provide adequate information on the child's condition		1. To identify all information that must be handed over when child's care transferred to another nurse/area 2. To develop a handover document for the safe transfer of all patients from CAU to the ward using UHL Internal Professional Standards 3. To implement the transfer document informing and educating all staff of the change and how to use it. 4. To audit the use of the handover document 5. To review document following audits to ensure it remains fit for purpose. 6. Include in Nursing Metric	Audit of handover tool undertaken on Matron round Nursing Metric documentation Developed electronic handover for medical and nursing staff, this is being rolled out across all ward areas	Documentation in Place Included in nursing metrics and part of monitoring on paediatric Dashboard	Remains compliant **In addition** • CAU admission booklet updated. PEWS chart is detachable from the booklet so it remains with the child at all times • CAU admission booklet now contains transfer documentation which facilitates handover • New updated PEWS chart (age specific) supports easier identifiable trends in a deteriorating child • Handover documentation is audited bimonthly. • CAU now has access to EDIS (ED electronic admission system) in order to access all available information **NB**. Electronic handover not fully implemented due to lack of hardware. EDRM is now being rolled out and electronic handover/nerve centre will now be facilitated within the Children's Hospital
6.	Lack of documented induction for regular agency staff on CAU (in line with UHL standards).	Med	1. To identify all aspects of patient care and service delivery required in induction package for all new staff in CAU 2. To develop a written package of induction for all new starters in CAU 3. Package to be shared with senior team in CAU and education team. 4. Induction package to be utilised with all new staff (inc agency) in CAU 5. All competencies in the induction to be signed off by either senior team/education team 6. Staff to be supervised until signed off as competent	Documentation of Supervision and completed competency package Spot checks carried out on temporary staff re documentation	Documentation in Place no regular agency now employed UHL Policy and documentation in place. UHL Policy and documentation in place.	Remains compliant **In addition** • Competency documentation for agency staff are filed as they are for permanent staff • Agency staff booked for set periods of time are supervised for the first 2 weeks of employment • Ward sister undertakes spot checks of all staff's documentation

7	Frequency of observation not undertaken regularly on a sick child	Med	1. Review of educational support for nurses caring for sick children. 2. Review of annual mandatory training into care of sick child 3. Development of a program of education for the sick /high dependency child including scenario training. 4. Course content to include the significance and parameters of clinical observations. 5. All junior nursing staff on CAU and ward nurses caring for sick children to attend the identified sessions on this course of education 6. Review of guidelines relating to all clinical observations of children.	Training records Documentary evidence of course content Documentary evidence of updated guidelines Training records Action 5 requires work plan with evidence that all staff attended Documentary evidence of updated guidelines This training has now been amalgamated into the annual mandatory training for all staff within the children's hospital.	Completed	Remains compliant • Feedback from all clinicians on ward that this is embedded on the ward • Staff know how and where to access guidelines **In addition** • Mandatory Session on 'recognising the sick child' still on Training Day 1 schedule • Mandatory Training Day 2 is now ward specific to ensure key medical/nursing issues relevant to the ward are addresses and training provided. Specialist Nurses, Matrons and ward sisters are involved in this • Audit of compliance with observations are reported in the nursing metrics • The PEWS observation system have been reviewed and updated again to incorporate colour coded visual alerts
8.	CH observation tool not adequate to guide identification of sick child		1. POPS tool reviewed for its use in CAU. 2. POPS tool immediately withdrawn from use in CAU 3. CAU team informed POPS not to be used. 4. CAU staff informed that all observations including baseline observations to be recorded on the POC form 6. SARs now in use. 7. Nursing Metrics	Use of POPS discontinued in CH new documentation including SARs introduced on CAU	Completed	Remains compliant **In addition** • SARS now superseded by PEWS • PEWS document identifies level of clinician to review child at certain scores • POPS continues to be used in ED

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9.	Paediatric observation tool (POPS) in use in Children's ED		Review of POPS in Children's ED in preparation for 'Single Front Door' and sharing of policies and guidelines			• 'Single front door' is not in place as yet – part of the development for the Children's Hospital • POPS continues to be used in ED
10	Nursing and Medical documentation not sufficiently robust to identify need for escalation	Med	1. To review all medical and nursing documentation in use in CAU 2. The Senior team both medical and nursing for CAU to update the joint documentation for the child's assessment, review and escalation. 3. To implement the introduction of the new documentation. 4. All team members to be educated in the completion of the various aspects of the document. 5. Following introduction of new documentation to be included in regular audit of its use in clinical practice 6. Add to nursing Metrics	Monthly audit of documentation Sept 11 Monthly Nursing Metrics continues Documentation reviewed and update to include visual triggers as well as numerical triggers	Completed	Remains compliant **In addition** • The PEWS observation system has now been introduced and updated again to incorporate colour coded visual alerts • PEWS document identifies level of clinician to review child at certain scores • HCA have to clearly document the plan and who is informed if a score triggers a review • Audit of observation compliance included in Nursing metrics • Spot checks undertaken by the ward sister. • Staff receive feedback both positive and negative depending on spot check findings
11.	Child with a specialist condition not referred for reviewed by the Cardiology Team	Med	1. Medical documentation to include a prompt for referral and advice from other specialities 2. Existing staff to be reminded to refer a child under the care of a specialist team for advise and agreed treatment plan 3. Information to be included on the Junior medical staff induction program	Annual audit of documentation Compliance will be audited within the existing medical documentation program Induction records	Documentation updated and included in medical staff induction	Remains compliant **In addition** • The CAU admission documentation includes a prompt for referral/advice from other specialties

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12.	Regular medications not prescribed or adequately reviewed prior to transfer to another ward	Med	1. New CAU documentation to include a prompt to prescribe regular medication. 2. Prompt for prescription of regular medication to include where not prescribed the rational for this action 3. Compliance will be audited within the existing medical documentation program	Annual audit of medical documentation	Completed	Remains compliant
13.	Lack of regular pharmacy support in CAU	Low	1. To review the support given by pharmacy to CAU. 2. To identify if this support could be provided on a regular basis to CAU 3. Place on CH risk register	Meeting minutes from CAU project board	Completed	Remains compliant **In addition** • a project is underway to scope the benefit of a fulltime prescribing pharmacist who can help manage a broad range of patients as well as review all medicines complex patients; sessions to record potential activity planned for Nov/Dec • General paediatrics pharmacy cover is on the Trust risk register not specifically CAU
14	Regular medications not being prescribed Culture of administering these medications	Med	1. All nursing staff in CH informed that no medication is to be administered by a nurse or a parent unless it has first been prescribed by a Doctor. 2. The exception to this is in an emergency situation when a doctor is present and gives a verbal order. 3. Review of Leicester Medicines Code in respect of verbal orders and parental administration. 4. Section 2 and 19 of Leicester Medicines Code to be reviewed by the Paediatric Medicines Management Board in respect of the administration of emergency medication for specific conditions	Amendment to policy; Audit of medication administration Nursing board Minutes Monitor reported incidents. 1. Section 2.8 of LMC reviewed and re-circulated to the CH staff; 3. verbal orders included in policy-practice requirements to be reinforced to staff	Agreed actions 1,2, 4, 5, 6 and 7 completed Agreed action 3 – Policy now updated	Remains Compliant **Feedback** • 3 –Parents have never been permitted to administer meds – the on-going developing self admin policy would require adjustment to the list in section 13

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14. (cont.)	Regular medications not being prescribed Culture of administering these medications (cont.)		when the medical staff are not present 5. Findings of review to be presented to the Paediatric Medicines Management Board. 6. Any changes agreed to be included in the Leicester Medicines code and circulated to all staff prior to implementation. 7. Any changes made to be audited with the regular medication audit	4. Section 19 now revised to section 13.Amendment to policy; Audit of medication administration Nursing board Minutes	Awaiting update of policy	
15	Ambiguity of emergency calls via the switchboard leading to a delay in Emergency call	Med	1. To discontinue the use of 'Fast Bleep' system in the CH. 2. All emergency calls to use '2222' system. 3. Switchboard no longer to request identification of type of emergency (respiratory or cardiac) on all emergency calls in the Trust. 4. Team in switchboard informed of change in practice for '2222' and fast bleeps (in Children's only). 5. Staff in the CH informed of change of practice 6. Laminated poster with information of change placed by all phones in clinical areas	Communication of change in all wards communication books. Posters by all phones in clinical areas.	Completed	Remains compliant **Feedback** • 'Fast Bleep' system discontinued in the Childrens Hospital • Spot check on ward confirms presence of laminated signs by the phone

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16.	Cessation of resuscitation without checking 'Do not resuscitate' order	Med	1. Resuscitation not to be discontinued without first confirming this with documented evidence 2. Clinical teams to be reminded of their roles and responsibilities with regard to 'DNR' orders by the Senior Resuscitation Officer for the Trust 3. Incident to be included in scenario training provided by trust to clinical staff	'E' mail to all clinical staff Scenario training programme Induction records	Completed	Remains compliant **Feedback** • Spot check on ward confirmed both medical and nursing staff were aware of where a DNR order would be filed in the patients notes and the correct process if there was uncertainty whether a DNR was in place **In addition** • Incident still referred to in induction training • 'DNR' specifically referred to in induction training
17.	Recognition and treatment of a sick child – medical.	High	1. SpR to constructively reflect upon incident 2. SpR's practice reviewed 3. SpR to undergo a period of 3 months supervision by a Consultant in the intensive care area 4. Learning aims and objectives to be identified by Educational Consultant supervisor 5. SpR to be regularly seen and reviewed by Educational Supervisor 6. At end of period of supervision aims and objectives to be identified as having been met. 7.SpR's practice to be confirmed as safe prior to returning to the CH Rota 8. Report to Deanery lead for CBU	Staff Personal records	Completed	Not relevant currently

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18.	Recognition and treatment of a sick child – nursing.	High	1.Ward Sister and Nurse's to constructively reflect upon incident 2. Ward Sister and Nurse's practice reviewed 3. Inform agency of incident and action taken by her 4.Nurse 'A' to undergo a period of supervision by agency 5.. Nurse 'A' to receive education and training for care of sick child provided by agency 6. Increased Senior Nursing and Medical input/support on CAU Matron on a regular basis for a minimum 1 month 7. Daily Matron's rounds of all clinical areas in the CH to proactively identify and act on any issues. 8. The development of 2 hourly walk rounds on CAU by the nursing team to identify and address any concerns by parents. 9. Weekly CAU team meeting (Medical/Nursing/ Management/admin staff) to highlight and resolve identified issues.	Staff Personal records May 2012 meeting with Lead and CAU staff to review and reflect on lessons learnt for incident and subsequent actions. 'e' mail records to agency Matron's round documentation Daily 2 hrly nursing walk round records Minuted actions from CAU meeting	Completed	Actions 1 – 5 previously completed **Feedback** • Mixed feedback from the ward staff: Confirmed regular attendance of Head of Nursing, but some felt there was an irregular attendance by Matrons • 2 hourly ward rounds undertaken by the Housekeeper • Ward meetings not arranged on a regular basis – possibly due to current levels of activity. Staff not aware of current themes with incidents, complaints, etc, although felt that any key issues would be communicated at handover • Implementation of "Mission Control" MDT review and planning meeting at 0900, 1315, 1630 for co-ordinated planning of emergency and critical care. Evening review between Paed and Paed ED consultants. **Recommendation** • Feedback to Matrons about perceptions of ward staff • Matrons to be allocated to the ward a minimum of once a month • Regular ward meetings to be re-launched. Meeting notes to be available for all staff to ensure improved communication • Introduction of safety huddles

***Rag Rating** - Green = completed actions; Amber = partially completed actions; Red = actions not completed in progress