Appendix 1

Thornhill Action for Improvement Plan arising from LEVEL 3
Care Assurance Report, November 2017
Thornhill Hospital MDT
Care Assurance Ratings

Bronze	**Each Standard achieves at least 75% compliance**
Silver	**Each Standard achieves at least 85% compliance**
Gold	**Each Standard achieves at least 95% compliance**
Exemplary Award	**3 consecutive Gold assessments achieved in succession**

Standard	**Percentage of compliance**	**Standard level achieved**
Falls	**85%**	**Silver**
Pressure Area Care	**94%**	**Silver**
Food Fluid and Nutrition	**93%**	**Silver**
Relationship Centred Care	**73%**	**Working towards Bronze**
Cognition	**65%**	**Working towards Bronze**
Medicine	**89%**	**Silver**
Discharge / Transfer	**80%**	**Bronze**
Staff and Skill Mix	**81%**	**Bronze**
Infection control	**97%**	**Gold**

Level Achieved
Working Towards Bronze

	Ensuring Safe and Effective Clinical Practice **Standard 1 – Falls**			
Standard number	Standard(s)	Improvement Actions	By when	Who is responsible
1.2 1.10 1.14	Patients, and where appropriate, relatives /carers are encouraged to actively participate in minimising the risk of falls i.e. by providing and using appropriate foot wear, glasses, mobility aids, flexible visiting etc 40% Patients who are more vulnerable to falls or have had a fall within the last 6 months have Multi-disciplinary Assessment completed 0% Ask the staff how they have updated their knowledge on falls prevention in the last 6 months 0%	The team will have a discussion of this improvement work and the actions 'we will' undertake (detailed below) which we believe will support improvement in peoples outcomes. 1. We will undertake MDT Falls assessment at admission and / or transfer. This along with completion of the post falls bundles where appropriate. 2. We will aim to ensure that handouts and information are provided to patients and visitors. The provision of this information (discussion and/ or leaflets) we will record in the relevant care plan, evidencing that this has occurred as part of the persons plan of care for monitoring and evaluation We will discuss with patients and carers the 'Must D with me' and record conversation and agreed outcomes 3. We (Nursing Staff and / or physiotherapists) will assess footwear and discuss the benefits of this with the person, documenting this as part of falls assessment and care plan. Where necessary, we will ask families / carers/ to provide appropriate footwear for the person 4. We will identify RN's to undertake investigation training , and DATIX recording to improve the learning and sharing of learning across the team at safety briefings - arising from all incidents, but in this case falls. 5. The Nurse Managers and Lead Nurse will investigate the need for further record keeping training to be delivered now that records have been in use for some months, some staff have not undertaken. 6. We will begin to Identify other equipment that can be used in falls prevention i.e. assistive technology	28.2.18	SCN, with the team Nurse Managers to undertake record keeping planning

	Standard 2 – Patient Safety and Pressure Area Care			
Standard number	Standard	Improvement Actions	By when	Who is responsible
2.11	All grades of pressure ulcers have been reported and recorded on Datix. 0%	JS to take as an action to SCN Meeting Regionally and for P&CC requesting that we all remember to record where PU's have been recorded on Datix, preventing confusion, duplication or non reporting. We will Involve podiatry in assessment of lower limb ulcers RN's to be given access to Datix for reporting, reviewing and checking. This will also include investigation training	9.2.18 ongoing	JSwan Registered Nurses

	Standard 3 – Food Fluid and Nutrition			
Standard number	Standard	Improvement Actions	By when	Who is responsible
3.2 3.7 3.12 3.20	Patients are offered the opportunity to clean their hands prior to mealtimes. (Handwipes) 80% Has the MUST been completed within 4 hours of admission including specific dietary requirements? Staff are aware how to access picture menus from the intranet Staff are aware how to obtain an alert tray for patients who need assistance with their meals.	Please refer to Medication Standard Actions for Wrist Band wearing improvement actions to be undertaken We will: 1. Check wrist bands on immediate admission/transfer. 2. Identify an individual in the team at all mealtimes, to prepare patients and environment for mealtime including hand washing/wipe opportunity. 3. We will all ensure that we are reminding people why hand washing/ wipes are necessary 4. We will undertake a MUST assessment with all people upon admission and review those who are transferring into Thornhill Hospital 5. We will ensure that where a patient cannot be weighed, upper limb measurement methodology is used. 6. We will ensure recording of any refusals to be weighted are recorded and consideration given to how monitoring of FFN (and weight) could be undertaken differently without weight. We believe this should be rare as the limb length methodology can be used. 7. We will ensure that Care Plans for FFN needs are commenced for each person 8. We will discuss further with cooks where appropriate the need for individuals meal/ dietary needs i.e. supplements.	February and ongoing	JSwan , Medical, AHP and nursing team at Thornhill Hospital

Enhancing the Patients Experience **Standard 4 – Relationship Centred Care**				
Standard number	Standard	Improvement Actions	By when	Who is responsible
4.3 4.10 4.11 4.13 4.14 4.15 4.16	Patients receive information leaflets / verbal information appropriate to their care needs / diagnosis 60% All patients communication issues have been recorded on the 'Patient Information Record' Any communication concerns identified have an appropriate person centred care plan. DNACPR decisions are fully discussed with the patient and if appropriate relative, / carer or Power of Attorney. All discussions are clearly documented in the patient records DNACPR document is fully completed and review date recorded. Patients who should have a 'Health Passport' ('This is Me', 'Health Passport' or Anticipatory Care Plan) have them kept at the patient bedside Staff use the Health Passports to provide person centred care and this documented in the patient record care	1. We will when a persona arrives for admission or transfer to our hospital establish if the person has a passport and DNACPR/ POA information 2. We will ensure that the Patient information record is completed for any communication concern. 3. We will ensure Cortix is updated with all relevant alerts and treatment/ care plans to be commenced for any 'identified patient need'- not only relating to physical or mental health, this could be family/ environment, communication etc. 4. We will commence early discussions with people and their families regarding DNACPR & This is me status. 5. We will Request this 'This is me ' is brought in for person if not available upon transfer/admission 6. We will commence new passport when required. 7. We will consider writing 'this is me' at the bottom of each persons bed , if they have a passport to highlight it is present and to be used. We will further develop our idea to create a list of available	February and Ongoing	JSwan , Medical, AHP and nursing team at Thornhill Hospital

	plans.	patient information leaflets. This to include where they are available from. Signage for staff and relatives/ patients to be made with this information and displayed. Allowing all staff to provide relevant information leaflets from this list to patients / or relatives as appropriate and record same as part of care plan.		

Standard 5 – Cognition				
Standard number	Standard	Improvement to be implemented	By when	Who is responsible
5.1 5.2 5.3 5.4 5.8	There is written evidence within the patient records that the patient or where applicable POA / Guardian/ Family have been included in decision/ discussions regarding discharge/ transfer. 40% The patient and or patients relatives /carers/ Welfare Power of Attorney / Guardian are made aware of any referrals. 20% All patients over 65 years old have a Cognition AMT 4 assessment on admission. (Medical Admissions only) 0% All patients over 65 years old have a 4AT delirium screen on admission. (All surgical admissions or medical admissions if AMT 4 <4 All patients who have a power of attorney invoked have the completed printed document within the patient records	1. We will ensure that we involve the relevant POA/ Guardian/ Advocate of the person in discussions pertaining to discharge, we will record these discussions (see also Standard 7 Discharge and transfer) 2. We will ensure that the POA/ relatives/ carer/ Advocate is aware of any referrals made for the person and we will record information we pass to the relatives etc 3. We will seek out training on how to use the AMT4 assessment upon admission 4. We will use the AMT4 assessment upon admission 5. We will request , where the person has an AMT4 score of <4 , that the GP or ANP undertake a 4AT delirium screen 6. We will ensure that all people's records are complete re POA, where appropriate (an invoked POA) we will request copy of it from the POA, or via the CMAHT 7. We will link into work being undertake regionally relating to MDT meeting notes and how people get their own copy of this to reflect upon agreements and decisions made with them	February and ongoing	JSwan , Medical, AHP and nursing team at Thornhill Hospital

Standard 6 - Medicine				
Standard number	Standard	Improvement Actions	By when	Who is responsible
6.1 6.2 6.7 6.16	Patients receive analgesia in a time scale that is acceptable to them. 80% Patients or where appropriate the patients relatives/carers/ power of attorney understand the reason why medicines are being administered. 60% All patients have a wrist band in situ which includes their full name and CHI number. 60% Staff receive appropriate training relating to medicines administration	1. We will ensure that all our RN's are be signed up to PGD Symptomatic Relief process 2. We will ensure PRN analgesia is prescribed in anticipation where necessary through good communication with GP and / or ANP 3. We will develop a medicines administration action plan, this will include ensuring all patients have wrist bands on and that they are checked at every administration of medication against the P MAR 4. We will also ensure that wrist bands are checked for integrity at admission; transfer and administration of medication, changing the band if is it not clear.	February 2018 and ongoing	JSwan , Medical, AHP and nursing team at Thornhill Hospital

Standard 7 – Discharge and Transfer				
Standard number	Standard	Improvement to be implemented	By when	Who is responsible
7.1	There is written evidence within the patient records that the patient or where appropriate Power of Attorney / Guardian/ Family have been included in decision/ discussions regarding discharge/ transfer. Staff are aware of how to organise rapid discharge for patients who wish to die in a homely setting. To also think about: Advice and information on Advocacy service given Care home choice guidelines given	1. We will ensure that we involve the relevant POA/ Guardian/ Advocate of the person in discussions pertaining to discharge, we will record these discussions 2. We will link into work being undertake regionally relating to MDT meeting notes and how people get their own copy of this to reflect upon agreements and decisions made with them 3. We will offer advocacy services to people where appropriate 4. We will know how to contact the advocacy service for people 5. When a person is being discharge to a residential placement we will ensure that with our SW colleagues the person and their advocate receives a copy of the Choice Guidelines.		

Managing and Developing the Performance of the Team **Standard 8 - Staff and Skill Mix**			
Standard number Improvement Standard	Improvement to be implemented	By when	Who is responsible
EKSF compliance is only 77%	1. SCN Swan will ensure that each HCSW has a Registered Nurse Allocated on EKSF any emerging system to undertake their ADR 2. SCN Swan will NOT attempt to undertake all staff's ADR's, rather allocated RN's to take on junior RN's. 3. Mhairi Hastings will discuss the Catering Staffs need for ADR's (under line management of JSwan) with Alison Solley Locality Manager – highlighting need for a hotel services manager to undertake these	March 2018	J Swann
Apologies to SCN meeting: 50% attendance	1. JS will aim to met all SCN meetings unless on leave. Clinical need will always take priority.		
Identification of the Nurse In Charge	1. We will on every shift write on the white board in the hospital who the Nurse in charge is for that shift 2. We will order and wear the Nurse in Charge badge		
Student to mentor ratio's	1. When we have recruited to the two current RN vacancies and inducted those staff to the team, we will consider release of other team members to mentorship training	September 2018	
All staff are aware of the quality improvement projects occurring within their ward and can show evidence of this work	1. We will widely share this action plan and we will put it on display in the staff area 2. We will encourage one another and remind one another of the improvements we want to make for our patients 3. We will aim to have run charts for some of the work		

	contained in this action plan to evidence our improvement work		

Standard 9 – Infection Control				
Standard number	Standard		By when	Who is responsible
		No improvement work required at this time We will maintain our achievements from our current work!		