# Dementia & Cognitive Impairment

## Inpatient CQC Compliance and Assurance Action Plan -Updated 22/01/14

| Regulation/Issue | Action | Lead (s) | Deliverables | Due Date | Progress |
|---|---|---|---|---|---|
| 9.a.Legal rights of detained patients not ensured:<br><br>i Capacity Assessments and Best Interest Decisions. | 1. Agree standard process for DCI inpatient units on Capacity Assessments & Best Interests processes relating to decisions re:<br>• Consent to admission<br>• Consent to Treatment<br>• Consent to care plans | Ian Morton & Jonathon Hare | 1a.Written standard process on MCA produced, agreed and circulated.<br><br>1b. Consent to admission and treatment capacity assessments on RiO for all new patients<br><br>1c Completed training needs survey of for all staff with an identified role in above process. | 31/12/13<br><br>12/12/13<br><br>31/12/13 | Complete. Agreed at ISIG. IM has met with Ward managers and service managers for all 4 units re implementation.<br><br>Complete. All wards ensuring and auditing for all new admissions since 01/01/14. IM has discussed need for capactiy assessments prior to admission with Liaison team (NMH & BGH 13/01/14). Meetings and training being arranged with 3 CMHTs in February to ensure capacity assessments carried out before admission.<br><br>Formal survey not undertaken as clearly indicated that all inpatient nursingstaff require further input on MCA and DoLS. |
| | 2. Ensure relevant staff identified and competent to carry out their role in this process | | 2. Evidence of additional training being delivered | 31/01/14 | On-going..<br><br>Ten Band 6 & 7 Staff attended LBE "train the trainers" for MCA/DoLS on 17/12/13.<br><br>Agreed training programme starting with all qualified nursing staff in January 2014. Sessions delivered to all wards before the end of January. Staff being assessed on writing up capacity assessments and then followed up individually to ensure competence<br><br>Dr Mandal ensuring junior Oaks doctors competent in addressing and recording capacity. |
| | 3. Agree audit procedure for each ward to ensure standard process adhered to. | | 3. Clearly stated audit procedure for each ward to ensure capacity assessments and best interest decisions carried out. | 31/12/13 | Complete. Each ward has own audit procedure prior to all items being incorporated into monthly Quality Assurance process (currently being arranged by Clara Wessinger) |

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| 9.a Legal rights of detained patients not ensured<br><br>ii. DoLS | 1. Ensure screening of non MHA patients who lack capacity re do they need DoLS authorisation.<br><br>2. Ensure relevant staff identified and competent to carry out their role in this process<br><br>3. Agree audit procedure for each ward to ensure standard process adhered to. | Ian Morton & Jonathon Hare | 1. Each of non MHA patient who lacks capacity to consent to admission has evidence of screening for DoLS recorded in Progress Notes.<br><br>2.All registered nurses trained in recognising potential DoLS.<br><br>3. Clearly stated audit procedure for each ward to ensure DoLS screening taking place. | 12/12/13<br><br>31/3/14<br><br>2/12/13 | Complete. All wards making entry in progress notes of DoLS Screen for patients within first week of admission. Current patients being reviewed - DoLS authorisations applied for relating to 1 Silver Birches patient and another pending for each of SB and CV.<br><br>On-going – Sessions on DoLS included in Round 3 of DCI Inpatient Staff Development Programme in Feb/March. 10 Band 6 & 7 Staff attended LBE "train the trainers" for MCA/DoLS on 17/12/13<br><br>Complete. Each ward has own audit procedure prior to all items being incorporated into monthly Quality Assurance process (currently being arranged by Clara Wessinger) |
| 9.b. Blanket Restrictions | 1. Inform patients and family carers that bedrooms routinely locked to safeguard patient's possessions but that rooms can be accessed on request.<br><br>2. Ensure that in mild weather access to garden | Ward Managers | 1a Written material on notice boards etc explaning policy.<br><br>1b. Paragraph in ward leaftets for patients and carers explaning policy.<br><br>1c. Evidence of discussion and agreement with patients / carers at initial meetings / CPA<br><br>2. Addition of this point to daily | 18/12/13<br><br>31/03/14<br><br>31/01/14<br><br>18/12/13 | Complete. Each ward has a notice in place explaining default position of keeping bedrooms locked to protect their property from confused patients who may go into their room but **not a blanket policy** as can be opened / kept open on request. All Cornwall Villa family members have been written to re above.<br><br>On-going – not all wards have leaflets yet but para will be in place in all newly produced / reprinted leaflets<br><br>On-going. All Cornwall Villa family members have been written to re above.<br><br>Complete |

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| | areas is possible for patients and visitors. | | environmental checklist. | | |
| 15.a. Items stored in toilets and bathrooms . . . may be trip hazards | 1. Ensure removal of all identified trip hazards from toilets and bathrooms. | Nina Wright & Edna Ezifuela | 1a. Absence of trip hazards in toilet and bathroom areas on Silver Birches.<br>1b. Addition of trip hazards to daily environmental checklist | 18/12/13 | Complete<br>Complete |
| 15. b. Identified ligature risks not removed (BTH) | 1. Re-assess ligature risks with head of non-clinical risk<br>2. Ensure removal of all identified ligature risks | Sue Pond & Siva Ramalingam | 1. Description of all identified risks requiring attention and prioritisation for removal.<br>2. Absence of identified ligature risks on Bay Tree House | 18/12/13<br>31/01/14 | Complete. Risk assessment has taken place and priorities identified.<br>On-going. All identified potential ligature points have been shortened sufficiently to neutralise risk. Estates indicate complete removal and replacement within 2 weeks |
| 20.a. Gaps in the daily records. | 1. Agree acceptable standard frequency of entries in progress notes.<br>2. Ensure all relevant staff are made aware of required frequency of recording in progress notes<br>3. Establish audit process to ensure agreed standard is being met. | ISIG<br>Ward Managers<br>Ward Managers | 1. Clear standard statement re minimum levels of recording<br>2. Evidence of emails to staff, minutes of team meetings etc communicating standard<br>3. Audit records | 18/12/13<br>31/1/14<br>31/1/14 | Complete. Agreed at ISIG on 13/11/13 – minimum of once per shift for assessment and MHA patients and once per 24 hours for rest.<br>On-going – will have been addressed at all 4 team meetings before end of January<br>Complete. Each ward has own audit procedure prior to all items being incorporated into monthly Quality Assurance process (currently being arranged by Clara Wessinger) |
| 20.b. Incomplete recording of restraint. | 1. Ensure all nursing staff have access to template restraint record, are able to use it and are aware of requirement to use it.<br>2. Establish audit process to ensure agreed | Ward Managers<br>Ward Managers | 1. Evidence of emails to staff, minutes of team meetings etc communicating standard.<br>2. Audit records | 18/12/13<br>31/1/14 | Complete. Template distributed to Ward Managers and forwarded on to all staff.<br>Complete. Each ward has own audit procedure prior to all items being incorporated into monthly Quality Assurance process (currently being arranged by Clara Wessinger |

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| | standard is being met. | | | | |
| 20.c. Out of date Risk Assessments | 1. Establish required frequency for updating of risk assessments<br>2. Ensure all relevant staff are made aware of required frequency for updating risk assessments.<br>3 Establish audit process to ensure agreed standard is being met. | ISIG<br>Ward Managers<br>Ward Managers | 1. Statement re agreed frequency for updating risk assments<br>2. Evidence of emails to staff, minutes of team meetings etc communicating standard<br>3. Audit records | 18/12/13<br>31/1/14<br>31/1/14 | Complete agreed at ISIG on 27/11/13 –<br>On-going – will have been addressed at all 4 team meetings before end of January<br>Complete. Each ward has own audit procedure prior to all items being incorporated into monthly Quality Assurance process (currently being arranged by Clara Wessinger) |
| 20.c. Out of date Care plans | 1. Establish required frequency for updating of care plans<br>2. Ensure all relevant staff are made aware of required frequency for updating care plans.<br>3. Establish audit process to ensure agreed standard is being met. | ISIG<br>Ward Managers<br>Ward Managers | 1. Statement re agreed frequency for updating care plans<br>2. Evidence of emails to staff, minutes of team meetings etc communicating standard<br>3. Audit records | 18/12/13<br>31/1/14<br>31/1/14 | Complete agreed at ISIG on 27/11/13 –<br>On-going – will have been addressed at all 4 team meetings before end of January<br>Complete. Each ward has own audit procedure prior to all items being incorporated into monthly Quality Assurance process (currently being arranged by Clara Wessinger) |
| 10. Risks previously identified not addressed across the service. | 1. Establish multi-disciplinary Inpatient Services Improvement Group (ISIG)<br>2.Implement 'Lean' methodology (Kanban and Task Management Boards) on all four inpatient areas to support continuous improvement and leader standard work. | Alan Beaton / Ian Morton | 1. Minutes of meetings showing attendance from management, nursing, medical and OT colleagues.<br>2. Task Management Boards x4, Records of Improvement meetings x 4. Evidence of leader standard work. | 13/11/13<br>01/04/14 | Complete. Group commenced meeting in November 13. Currently meeting 2 weekly before moving to monthly. Addressing compliance actions (i.e. this action plan) initially.<br>On-going. All 4 areas implementing task management boards and holding regular Improvement Group meetings. |

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| | 3. Expand current audit and peer review processes to cover issues identified above | | 3. Revised audit and peer review records incorporating all elements referred to above. Records of Dementia Care Mapping | 31/01/14 | On-going. Monthly (QA) audit process currently being revised to incorporate elements from this action plan. Further clarity needed re future arrangements for Peer Review |
| | 4. Each consultant psychiatrist provides clinical leadership to Improvement work at ward level. | | 4. Minutes of Ward Improvement meetings | 31/03/14 | On-going. Initial discussions held with consultants x 2 on 11/12/13 re short Improvement work sessions attached to Ward Rounds. Further work needed (Job plans) if consultants to have necessary time to attend. |