Devon County Council

Quality Assurance & Improvement Team

Service Improvement Plan

Name of Service:	
Date SIP Created:	
Date SIP Reviewed:	**Date SIP Reviewed:**
Date SIP Reviewed:	**Date SIP Reviewed:**

SAMPLE

In the event of any query about this document, please contact the Quality Assurance & Improvement Team:
qualityimprovement-mailbox@devon.gov.uk

How to complete the Service Improvement Plan

Date: the date on which the issue was identified.

Source: how the issue was identified, e.g. Internal Audit (IA), CQC Inspection (CQC), Environmental Health Officer (EHO), Fire Officer (FO) etc.

Issue: a brief description of the problem / concern / improvement required.

Risk: the risk to service users' health, safety or wellbeing; risk to safety of staff / visitors; damage to the provider's reputation; financial loss etc:

- **Low**
- **Medium**
- **High.**

The purpose of rating the risk in this way is to determine which issues need to be dealt with as the highest priority and which can be treated as less urgent.

Action Plan: a brief description of the actions that will be taken to address the problem or concern, or to make the improvement.

Who: the person responsible for taking the action (this should always be a named individual)

When: the target date by which the action will be completed.

Progress: the current position regarding progress against the target date:

- **Complete (see below)**
- **On Target** – no foreseen risk to completion by the target date
- **Behind** – identified risk to completion by the target date (use the Action Plan column to show the new target date, brief reasons for the failure to meet the original / previous target date, brief summary of work completed so far, and the plan for "next steps")

It is suggested that as each item is completed, the line is "cut and pasted" into a separate table in order to provide a record of actions taken which can be produced as evidence of an ongoing commitment to improving the quality of the service.

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Section 1: Documentation about Service Users							
(inc. care / support plans, assessments, consent documentation, daily records, etc)							
Date	**Source**	**Issue**	**Risk**	**Action Plan**	**Who**	**When**	**Progress**
09/07/15	**CQC Inspection Report**	**Care plans lack detail and are not always informed by up-to-date assessments.**	**High**	**Review and update all assessments (inc. skin integrity, nutrition, falls) for each resident.** **Update each resident's care plan to reflect any changes identified by assessment reviews.** **Ensure that each resident's care plan includes sufficient detail to ensure their needs and preferences are met safely and effectively.** **(Revised deadline 31/08/15 due to senior staff absence)**	**Team Leaders / Key Workers**	**By 09/08/15**	**On Target** **Behind** **Behind**
09/07/15	**CQC Inspection Report**	**Care plans are not person-centred and there is insufficient evidence of the person being involved in writing / reviewing their care plan.**	**Medium**	**Review each resident's care plan with the resident to ensure it reflects their choices and preferences in all aspects of care and support.** **Where residents lack capacity, involve relevant relatives in the review process, ensuring that Best Interest decisions are recorded to underpin this process.** **Ensure that the involvement of residents / relatives in the review process is evidenced (signatures etc).** **(All awaiting completion of work identified above – revised deadline 30/09/15)**	**Team Leaders / Key Workers**	**By 09/08/15**	**Behind** **Behind** **Behind**
09/07/15	**CQC Inspection Report**	**Residents' daily records fail to show that the care and support identified in the care plan is being provided.**	**Medium**	**Discuss in care staff meeting the importance of daily records evidencing the care and support that is being given.** **Team Leaders to mentor individual care staff in how to write clear, accurate and comprehensive daily records.** **Provide staff with a "prompt sheet" of things they should include when writing the daily record.**	**Manager** **Team Leaders** **Manager**	**Next staff meeting (23/07/15)** **By 09/09/15** **23/07/15**	**Completed** **On Target** **Completed**

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Section 2: How Care and Support is Provided							
(inc. staff practice, moving & handling, privacy, dignity, choice, independence, response to health issues, mealtimes, nutrition and hydration, daily life and activities, etc)							
Date	**Source**	**Issue**	**Risk**	**Action Plan**	**Who**	**When**	**Progress**
09/07/15	**CQC Inspection Report**	**Staff observed to be transferring resident AB from dining room chair to wheelchair in an unsafe way.**	**High**	**Ensure that all staff's Moving and Handling Training is "in date".** **If any staff training is out of date, arrange refresher training.** **Team Leaders to observe moving and handling techniques as part of practice observation and to demonstrate correct techniques where necessary.** **Team Leaders to discuss any perceived deficiencies in moving and handling practice in one-to-one sessions and agree targets for improvement.**	**Manager** **Manager / Clerk** **Team Leaders** **Team Leaders**	**10/07/15** **By 30/09/15** **By 31/07/15 then ongoing** **By 31/07/15 then ongoing**	**Completed** **On Target** **On Target** **On Target**
12/07/15	**Manager's Observation**	**Staff overheard discussing resident CD's healthcare needs in hearing of visitors.**	**Medium**	**Remind all staff of the importance of confidentiality regarding residents' personal information.**	**Manager**	**Next staff meeting (23/07/15)**	**Completed**
15/07/15	**Relative**	**Complaint that resident EF's glasses have been missing for two weeks which means she is unable to read or do the crossword. Relative says she told key worker on the day they went missing.**	**High**	**Instigate search for EF's missing glasses** **If not found, arrange for Optician appointment** **Remind all key workers of their responsibility to ensure that each resident's glasses are suitable, clean, and available, and to report immediately if they are broken or go missing.**	**All Staff** **Clerk** **Manager**	**15/07/15** **By 31/07/15** **At each handover**	**Completed** **N/A - found** **Good**

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Section 3: Medication Management and Administration							
(inc. medication ordering, stock control, disposal, administration, recording, "when required" (PRN) plans, etc)							
Date	**Source**	**Issue**	**Risk**	**Action Plan**	**Who**	**When**	**Progress**
09/07/15	**CQC Inspection Report**	**Missing initials and no "non-administration" code letter in several places on MAR sheets.**	**High**	**Remind all staff administering medications that initials or a non-administration code letter must be entered in the relevant box on the MAR sheet on all occasions.** **Request all staff administering medications to report immediately any blank signature boxes from the previous medication round.** **Duty Team Leader at the end of each day to check that all signatures or administration code letters are present and to report any exceptions.**	**Manager** **Manager** **Team Leaders**	**By 16/07/15** **By 16/07/15** **Immediate until further notice**	**Completed** **Completed** **Ongoing**
09/07/15	**CQC Inspection Report**	**Two residents with PRN Medication found not to have a PRN Medication Plan in place.**	**High**	**Review all residents with PRN Medications to ensure there is a PRN Medication Plan in place in every case.** **(Delayed due to Medication Lead TL workload – revised deadline 31/07/15)**	**"Medication Lead" Team Leader**	**By 16/07/15**	**Behind**
13/07/15	**Medication Audit**	**Two eye drops and one ointment found in use with no "date opened" or "discard by" label in place.**	**High**	**Remind all staff administering medications that eye drops / ointments / creams must be labelled when opened to show the date opened and the discard date.** **Dispose of all opened eye drops / ointments / creams with no label showing date opened / discard by date and replace as necessary**	**Manager** **Medication Lead TL**	**By 16/07/15** **By 20/07/15**	**Completed** **Completed**

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Section 4: General Management of the Service							
(inc. quality assurance, contingency plans, complaints procedure, safeguarding, Deprivation of Liberty Safeguards, etc)							
Date	**Source**	**Issue**	**Risk**	**Action Plan**	**Who**	**When**	**Progress**
09/07/15	**CQC Inspection Report**	**There was no evidence that Care Plans and Assessments are being reviewed on a monthly basis. Some Falls Risk Assessments, Waterlow (Skin Integrity) R/As and MUST (Nutrition) R/As have not been reviewed for over 12 months.**	**High**	**Ensure all key workers understand that carrying out a monthly review of their residents' care plans and assessments is a mandatory part of the Key Worker role.** **Develop and introduce a Care Plans and Assessments Audit Tool for Team Leaders to check that reviews are being carried out and evidenced as such.** **(Delayed due to senior staff absence – revised deadline 30/08/15)** **Team Leaders to check monthly that required reviews have been undertaken and evidenced.** **(Awaiting completion of Audit Tool – revised deadline "monthly from 9/15")**	**Manager** **Manager / Senior Team Leader** **Team Leaders**	**By 23/07/15** **By 23/07/15** **Monthly from 8/15**	**Completed** **Behind** **Behind**
09/07/15	**CQC Inspection Report**	**The Complaints Book could not be found at the time of the CQC Inspection. The Report noted lack of evidence of complaints being systematically gathered and analysed to identify any improvements.**	**Low**	**Ensure that the Complaints Book is always kept in the General Office cupboard.** **Ensure that all staff know the location of the Complaints Book.** **Check the Complaints Book monthly to identify causes of complaints and any trends which might indicate where action is needed. Evidence that this has been done.**	**All Staff** **Manager** **Manager**	**With immediate effect.** **By 30/07/15** **Monthly**	**Completed** **Completed** **Ongoing**
09/07/15	**CQC Inspection Report**	**Resident GH has bed rails in place but does not have capacity to consent to these. No Best Interest Decision was recorded or Risk Assessment in place.**	**High**	**Undertake the Best Interest Decision process for GH, involving relatives and relevant professionals, and record this appropriately.** **Undertake a risk assessment for bed rails for GH.** **Check that all other residents with bed rails have a risk assessment in place and that consent to their use is recorded. Where the resident lacks capacity, carry out a Best Interest Decision and ensure this is recorded.**	**Senior team Leader / Key Worker** **"** **"**	**By 12/07/15** **"** **By 19/07/15**	**Completed** **Completed** **Completed**

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Section 5: Premises and Equipment							
(inc. décor, condition, suitability, servicing and maintenance arrangements, etc)							
Date	**Source**	**Issue**	**Risk**	**Action Plan**	**Who**	**When**	**Progress**
17/07/15	**Report by Care Assistant**	**Window Restrictor in room 20 (first floor) found to be loose. Records show that window restrictors have not been checked for six months (NB new handyperson commenced in post three months ago)**	**High**	**Arrange for contractor to repair or replace window restrictor in room 20.** **Arrange for handyperson to check all window restrictors and record that this has been carried out.** **Ensure handyperson's job description / list of tasks includes checking window restrictors monthly and recording this.** **Monthly window restrictor checks to be undertaken and recorded, and any defects reported to Administrator.** **Arrange for repair / replacement of defective window restrictors.** **Audit that monthly checks are being carried out and defects reported.**	**Administrator** **Manager** **Manager** **Handyperson** **Administrator** **Senior Team Leader**	**17/07/15** **18/07/15** **By 25/07/15** **Monthly** **Immediate where defects found** **Bi-monthly**	**Completed** **Completed** **On Target** **Ongoing** **Ongoing** **Ongoing**
19/07/15	**Visual Inspection**	**Carpets in rooms 11, 12, 15 stained and housekeepers report this cannot be removed.**	**Low**	**Programme replacement of carpet in these rooms into refurbishment schedule, to be completed by November 2015.**	**Manager / Administrator**	**Immediate**	**On Target**
19/07/15	**Visual Inspection**	**Scoring of woodwork / paint on room 36 doorframe due to wheelchair contact.**	**Low**	**Make good and repaint damage to doorframe.** **Investigate suitability of plastic edging to protect doorframe.**	**Handyperson** **Manager / Handyperson**	**By 30/07/15** **By 31/08/15**	**On Target** **On Target**
21/07/15	**Audit of Maintenance Records**	**5-yearly inspection and test of electrical system by contractor is overdue by three months.**	**Medium**	**Contact contractor to arrange for inspection to be carried out asap.** **Contractor to carry out the inspection**	**Administrator** **Contractor**	**21/07/15** **As arranged**	**Completed** **On Target**

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Section 6: Safe Working Practices							
(inc. health and safety, hygiene and infection control, fire safety, water temperatures (scalding), Legionella prevention, environmental hazards, etc)							
Date	**Source**	**Issue**	**Risk**	**Action Plan**	**Who**	**When**	**Progress**
09/07/15	**CQC Inspection Report**	**There are no risk assessments in place for environmental and equipment hazards including safe access and egress, electrical supply and equipment, gas supply and equipment, Legionella, stairs and steps, COSHH and waste disposal.**	**Medium**	**Put risk assessments in place for all environmental and equipment hazards, drawing on good practice guidance such as HSE guidance.**	**Manager / Senior team Leader**	**By 09/10/15**	**On Target**
09/07/15	**CQC Inspection Report**	**Staff were observed emptying commodes without wearing appropriate PPE and then serving meals without changing their workwear.**	**High**	**Remind all staff that PPE (disposable gloves and aprons) must be work when carrying out personal care tasks including emptying commodes.** **Ensure the home has adequate supply of PPE and place order for any items out of stock / running low.** **Add checking of PPE stocks to task list for TL with lead responsibility for Infection Control.** **All Team Leaders to ensure good practice is followed through day-to-day observation.**	**Manager** **Senior Team Leader / Administrator** **Manager** **Team Leaders**	**Next staff meeting (23/07/15)** **Immediate** **By 16/07/15** **Ongoing**	**Completed** **Completed** **Completed** **Ongoing**
04/06/15	**Fire Officer**	**Fire Risk Assessments have not been reviewed since 2010.**	**High**	**Fire risk assessment to be reviewed and brought up to date where necessary.** **Fire risk assessment to be reviewed annually.** **Training to be arranged for handyperson in undertaking and reviewing fire risk assessments.**	**Manager / Handyperson** **Manager / Handyperson** **Administrator**	**By 04/07/15** **By 04/07/16 and ongoing** **By 04/07/14**	**Completed** **Ongoing** **On Target**
21/07/15	**Audit of Maintenance Records**	**No evidence of hot water from taps in residents' bedrooms / WCs / bathrooms being tested to ensure temperature is less than 44 degrees C.**	**High**	**Checklist to be created for handyperson to use when checking hot water temperatures.** **All hot water taps in residents' bedrooms / bathrooms / WCs to be checked monthly and temperature recorded (rolling programme).**	**Administrator** **Handyperson**	**By 28/07/15** **Monthly**	**On Target** **Ongoing**

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Section 7: Staffing

(inc. staff levels, induction, training needs, supervision, appraisal, etc)

Date	Source	Issue	Risk	Action Plan	Who	When	Progress
09/09/15	CQC Inspection Report	Insufficient staff available at lunchtime to assist residents who require help with eating and drinking.	High	Review all residents' care plans to identify who requires assistance and in what form. Revise staff rota to create overlap at lunchtime. Recruit additional staff if current staffing insufficient.	Manager / Senior TL " Manager / Administrator	By 23/07/15 By 30/07/15 By 31/08/15	Completed On Target
09/09/15	CQC Inspection Report	No evidence of 7 care assistants having received Moving & Handling training (see also section 2 above). No evidence of 5 care assistants having received MCA / DoLS training.	High	Arrange for relevant staff to receive Moving & Handling training. Affected staff are only to undertake manual handling tasks under supervision until training is completed. Once M&H training is completed, ensure the learning is embedded in practice. Arrange for relevant staff to receive MCA / DoLS training. Once DoLS / MCA training is completed, TLs to discuss in one-to-one supervision to ensure the learning is embedded in practice.	Administrator Manager / TLs Team Leaders Administrator Team Leaders	By 31/07/15 Immediate and ongoing Ongoing By 31/07/15 Follow-up to above	On Target On Target Ongoing On Target Ongoing
09/09/15	CQC Inspection Report	No records to show that staff have received regular supervision. Two staff told CQC Inspector they have never had supervision.	Medium	Remind all Team Leaders of their responsibility to ensure staff receive supervision no less than once every two months. Ensure all TLs are aware of / using the standard supervision record form. Carry out regular sample of supervision notes.	Manager Manager Manager	TL meeting 22/09/15 " By 31/07/15 and ongoing	Completed Completed Ongoing

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