Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

# Improvement Action Plan

## Healthcare Improvement Scotland:

## Unannounced acute hospital safe delivery of care inspection

Dumfries & Galloway Royal Infirmary, NHS Dumfries & Galloway

20 –22 March 2023

### Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

**NHS board Chair**

Signature: _____

Full Name: Mr Nick Morris

**NHS board Chief Executive**

Signature: _____

Full Name: Mr Jeff Ace

Date: 13/06/2023 Date: 13/06/2023

| Ref: | Action Planned | Timescale to meet action | Responsibility for taking action | Progress | Date Completed |
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| Rec – 1 | - Take through Unscheduled Care Group to define requirement and input from a site point of view | 3 months | Unscheduled Care Leads | June '23 - Attendance already in place<br>- AHP service Manager<br>- Ward Areas<br>- Senior Managers<br>- AMD<br>- Radiology Service Manager | |
| Req – 1 | - Undertake Review of current Risk Assessments in place for double room occupancy | 1 month for RAs | Callum Ambridge | Aug 23 – discussed with IPCT – meeting to be arranged to discuss, MDT approach<br>Sep 23 – meeting arranged for Oct with IPC, Resus team, HSE, Support Services, Capacity and risk team – this is to ensure wider representation and inclusion of risks, ensuring to | |

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| | | | | incorporate updated relevant guidance | |
| Req – 1 | Review and audit selection criteria for double room occupancy | 3 months for audit cycle | Vicki Nicoll/Andrew Russell | Aug 23 – updated version of double up criteria sent for comment. Consider capacity manager participation in activating care plan when agree to DU.<br>Sep 23 – further discussion arranged for 9/10 to finalise criteria with IPC and linked to Risk Assessments | |
| Req – 2 | - Ensure adequate number of screens available for areas for patient privacy and dignity | 1 month | Vicki Nicoll | Complete – 2 Screens per ward area purchased and available in the bed store | June ‘23 |
| Req – 2 | - Consent gained and recorded for patients placed in double occupancy rooms | 1 months | Vicki Nicoll/Andrew Russell | Section for consent added to criteria with prompt for entry in to clinical note. | Aug ‘23 |
| Req – 3 | - Develop and implement enhanced observation guideline | 4 months | Vicki Nicoll | Aug 23 - Version 1 created, VN and SW to review<br>Sep 23 – review of version 1, additional detail required, version 2 review in Oct 23 | |
| Req – 4 | - CCTV Risk Assessment to be completed for use in Mental Health Circumstances<br>- CCTV SOP and protocol for use by Mental | 1 Month | Jena Davies/Vicki Nicoll | Immediate Action taken surrounding awareness and use of camera in room with | Oct ‘23 |

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| | Health Team and awareness from ED staff | | | all ED staff. Signage and cover over screen at ED desk immediately implemented, this remains in place at all times.<br><br>Aug 23 – Agreed with MHT to remove CCTV. Request sent to SERCO to remove. System currently switched off.<br><br>Oct '23 – Camera has been physically removed. | |
| Req – 5 | - Review MEG audit<br>- Review SIP around occupational exposure<br>- Educate at SCN huddle | 2 months – To complete audit cycle. | Vicki Nicoll | SIPS audit was complete in April '23. The areas which have submitted were at 100%, areas who did not submit will be required to submit additional audit in June '23.<br><br>July 23 – MEG updated to reflect safe disposal of waste question. Discussed at SCN meeting. | July '23 |
| Req – 6 | - Levels of care under review<br>- Recording of levels of care on site huddle | 3 months | Vicki Nicoll | Original levels of care are in place however review on acuity and dependency underway | |

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| | | | | Aug 23 – version 2 of level of care created. To be sent for comment within senior team. Level of care dashboard created on Qlikview.<br><br>Oct 23 – Implement final version by end of Oct 23 | |
| Req – 7 | - Undertake review of Fire Evacuation Policy | 1 month | David Bryson | Review complete and signed off by Board Fire and Security Group. No material change procedure. | |
| Req – 7 | - Complete 'Fire Safety Walk Talk Orientation' for each staff member and ward area | 1 month | Callum Ambridge | Document circulated to ward areas for completion and walks undertaken with the fire officer around areas and also lecture theatre update session for SCNs, Ops management from the Fire Officer. | Sep 23 |
| Req – 7 | - Updated mandatory training course to be completed | 6 weeks | Callum Ambridge | Mandatory Training Course live 1st June with deadline of 6 weeks for completion<br><br>Sept '23 – 91.93% compliance with Fire training. | Sep 23 |

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| Req – 7 | - A&D meeting with Fire Warden | 2 weeks | Ashley Carmichael | Completed on 24th May with attendees from across the hospital | 24th May 2023 |
| Req – 7 | - Inclusion of Fire and evacuation plan on daily ward checklist<br>- Audit to be undertaken in 4 weeks | 6 weeks | Vicki Nicoll/Callum Ambridge | Checklist complete and circulated<br>Audit to take place W/C 3rd July ’23<br>Oct 23 – SCN and CNM to continue to audit on monthly basis | |