Improvement Action Plan

Healthcare Improvement Scotland:

Unannounced acute hospital safe delivery of care inspection [Follow Up]

Victoria Hospital, NHS Fife 03 - 05 December 2024

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 Chair and NHS board Chief Executive 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: Patricia Kilpatrick

Date: 16.07.25

NHS board Chief Executive

Signature: _____

Full Name: Carol Potter

Date: 16.07.25

18 week progress update for inspection team

Acute internal reporting schedule: SLT 6 weekly basis first updated action plan- from 22 April

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
Recommendation 1 NHS Fife should ensure patients are assisted with hand hygiene prior to mealtimes (see page 36).					
	Implement a patient handwipe test of change in March 2025 to support effective patient hand hygiene before meals. Patients will be encouraged to wash their hands before mealtimes, and for those unable to safely access a sink, handwipes will be provided. An audit will be conducted to assess compliance, supported by a communication plan to reinforce best practices. Insights from audit and outcomes from the PDSA cycles of the trial will inform a site-wide rollout between March and May 2025, ensuring staff training, routine integration, and ongoing monitoring for sustained effectiveness.	Between 17 March 2025 and 30 May 2026	Head of Nursing (Acute) and IPC Manager	2025-04-24 Mealtime audits re-commencing with dietetics – on formic web. (tool to be attached). Testing methodology in late May with two wards for roll out June. 2025-05-30 Memorandum shared with all teams highlighting required practice.	
Requirement 1 NHS Fife must ensure all relevant staff are provided with and complete the necessary paediatric immediate life support training to safely carry out their roles (see page 21). This will support compliance with: The Code: professional standards of practice and behaviour for nurses' midwives and nursing associates (2018), relevant codes of practice of regulated healthcare professions and the Health and Care (Staffing) (Scotland) Act (2019).					
1.1	Audit current compliance with Paediatric immediate Life Support (PILS) to identify areas requiring bespoke dates.	31 May 2025	Heads of Nursing Acute Division	2025-05-30 Confirmed PPDU are able to offer a minimum of 144 PILS places over a 12-month rolling period. To clarify with Paediatrics and ED if this will meet the 80% target. 2025-06 Confirmed with Paediatrics and ED the number of places required to reach 80% minimum coverage. 2025-6-23 PPD indicated that they can accommodate Paediatrics and ED staff within the planned programme for the next 12 months to achieve 80% cover. This will include ring-fenced spaces for these teams. PPDU will revisit if this is not feasible.	
1.2	Deliver bespoke dates to ensure relevant staff have PILS (level 2) training (aim for 80% coverage).	March 2026	Head of Practice and Professional Development		
Requirement 2 NHS Fife must ensure all relevant staff fire training is up to date and recorded appropriately, all portable electrical equipment is tested to ensure safe to use within hospital setting and all fire exits are not obstructed (see page 21). This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006).					
2.1	Complete VHK site wide equipment PAT testing cycle	30 June 2025	Director of Property and Asset Management	2025-07-04 VHK PAT testing is on a three-year maximum cycle, timescales are determined by the nature of the equipment. Day to day appliances are tested annually (e.g. fridges, extension leads). IT equipment and less frequently used items are on a three-year cycle. It can be that an item slips through the net when the contractor comes on site to test. The continuous cycle is on schedule.	
2.2	Audit training compliance and support delivery of Fire Awareness training for all staff	31 March 2025	H&S Manager/Medicine and Surgical Directorate Management teams	2025-03-13 Paediatric Ward confirmed 91% as at Feb. 2025. 2025-03-15 Gynecology 74% (recently expired courses being actioned for updates). 2025-06-02 Medical Directorate 52% / Surgical Directorate 72%	
2.3	Aim for 80% staff compliance of Fire Awareness training	02 September 2025	Medicine and Surgical Directorate Management teams	Incremental monthly progress will be required in advance to September 2025. Compliance levels are monitored via directorate Performance reviews 2025-03-17 Medical directorate teams reminder issued. 2025-04-24 Learning and Development Manager engagement with SLT seeking to support core/mandatory compliance on 2025-04-22.	

2.4	Health and Safety Officers site walkround and staff engagement in local plans	30 June 2025	H&S Manager	2025-05-07 Annual process to walk round all areas (generally with the SCN)- results in a report to the SCN with recommendations. Important / high risk immediate actions discussed at the time. Review progress in the next walk round. Ad hoc follow up will occur when H&S staff are in the area. Included evidence of Fire Officers awareness raising with colleagues via SBARs (change of use / cooking equipment April 2025)	Completed and ongoing as confirmed by NHS Fife Safety Advisor
Requirement 3 NHS Fife must ensure all fire evacuation plans are updated to take into account the use of additional beds within clinical areas (see page 21). This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006).					
3.1	All teams will review their fire evacuation plans to ensure they are consistent with OPEL escalation actions (for sign off by CNMs).	End April 2025	Health and Safety Manager)/Fire Safety Advisor/Acute Clinical Nurse Managers	2025-03-4 Confirmed Fire Safety Department carry out risk assessments in the high-risk sleeping wards annually and other medium and low risk areas on a 3-to-5- year basis. As part of these assessments, the team review the fire evacuation strategies for each of the areas. Reports are kept on the NHS Fife's shared drive under two file paths on the S Drive – Fire Assessments (Acute 2024) and Fire Strategy Documents (Acute Section).	Completed and ongoing as confirmed by NHS Fife Safety Advisor
3.2	Refresh fire risk assessment of the area identified (Ward 6 & 9) in the inspection visit and address subsequent recommendations.	End April 2025	H&S Manager/Fire Safety Advisor	2025-03-06 Meeting to review and finalise. 2025-04 Criteria for patients for the area, in terms of ability to transfer to a ward 6/9 bed, reflects Fire Safety requirements. 2025-05 Fire plan updated and on the ward area noticeboard, ward training being undertaken.	
Requirement 4 NHS Fife must ensure the safe storage of patient belongings to ensure evacuation routes are not obstructed (see page 21). This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006), Health and Social Care					
4.1	Supported Discharge Unit (Ward 6 & 9) will review their fire safety arrangements with Fire officers and update storage arrangements to ensure safe evacuation routes.	07 April 2025	H&S Manager / Fire Safety Advisor	2025-03-06 SCN/CNM met with Fire Safety Officer to review SDU evacuation plans. This led to agreement regarding beds at patient transfers to ensure that under mattress fire evacuation sheets are available to patients in these areas.	April 2025
4.2	Review patient storage facilities in Phase 1 to provide effective storage.	07 April 2025	Head of Nursing Acute/Director of Property and Asset Management / Service Manager	2025-02-25 Estates and clinical colleagues asked to identify storage options. 2025-03-17 Service Manager exploring alternative storage facilities for patients. 2025-05-06 Temporary solution with lockers is functional when there are up to three patients in a bay. For two of the bays this will not work when there are 4 patients. Therefore, SBAR being developed with estates to refurbish and reinstate former wardrobes.	To be escalated
Requirement 5 NHS Fife must ensure staff follow risk assessments and selection criteria guidance for placement of patients within additional surge beds (see page 21). This will support compliance with: Health and Social Care Standards (2017) criteria 1.23, 1.4, 2.11, 2.32, 4.14 and 5.22 and Quality Assurance Framework (2022) Indicator 2.1.					
5.1	Confirm all patient placement / surge criteria and review risk assessment arrangements are recorded when any exceptions from policy are required stating appropriate safety mitigations.	05 May 2025	Service Manager Medical Directorate (Capacity & Flow)	2025-02-07 Commenced review of SDU patient placement criteria. 2025-03-17 Draft under discussion 2025-04-02 Revised placement criteria with service.	2025-04-02

Requirement 6 NHS Fife must ensure boarding policies are followed and clear documentation is in place when deviations are made and all staff are aware of policies procedures in place to support safe selection of and appropriate patient placement (see page 36). This will support compliance with: Health and Social Care Standards (2017) criteria 1.23, 1.4, 2.11, 2.32, 4.14 and 5.22 and Quality Assurance Framework (2022) Indicator 2.1.					
6.1	Facilitate development sessions with the Site Capacity team to embed risk assessment processes and boarding, Infection Prevention and Control and NHS Fife's ACCESS patient flow identification and process criteria.	~~05 May 2025~~ December 2025	Service Manager Medical Directorate (Capacity & Flow)/IPC Manager	2025-04-17 Request to Service Manager and CNM to review Boarding procedure.	
6.2	Review all associated documentation with a view to documenting each assessment rather than deviations only.	~~05 May 2025~~ December 2025	Service Manager Medical Directorate (Capacity & Flow)/IPC Manager	This is being progressed as an integral action of the above request of 2025-04-17	
Requirement 7 NHS Fife must ensure staff follow policies and procedures for the safe care of vascular access devices (see page 36). This will support compliance with: National Infection Prevention and Control Manual (2023) criteria 2.4 and 4.2; Health and Social Care Standards (2017) Criterion 1.24; and relevant codes of practice of regulated healthcare professions.					
7.1	Undertake an observational audit alongside Hand Hygiene Audit specifically looking PVC care and practice to highlight areas of compliance and improvement areas required.	05 May 2025	IPC Manager	2025-05 Audits completed in May and action plans shared with all SCNs. 2025-07-04 Final report has been drafted and is with HoN for oversight of remaining challenges. Meeting planned in July with HoN, IPCT, PPDU and Fluid management to discuss further supportive actions.	
7.2	Review awareness Vascular Access Device practice of policy and procedures, and address identified gaps to drive improvement and compliance to safe practice.	28 June 2025	IPC Manager/HoN/Fluid Improvement Nurse / Head of Nursing	2025-05-06 Action agreed to set up SLWG to consider PVC bundle and refresh out of date policy + midline practice. 2025-05 TORs completed, VAD group re-established with first meeting 2025-06-26 June (meeting 6weekly). Planned activity includes: • Promotion of Practice and Professional Development Training on; Care and Maintenance of Venous Access Devices Simulated Practice Session, Venepuncture, Peripheral Venous Cannulation, Care and Maintenance of Venous Access Devices (CVAD), and B Braun Pump Training. • Promoting Principles of Aseptic Technique e-leaning (Turas). • Relaunch of a newly updated scrub the hub campaign in final stages of development.	
Requirement 8 NHS Fife must ensure staff comply with safe management of linen policies (see page 36). This will support compliance with: National Infection Prevention and Control Manual (2023).					
8.1	Recirculate safe management of linen policy.	February 2025	IPC Manager/Laundry Manager	2025-05-28 Email from Director of Nursing to Laundry Manager seeking confirmation that the Safe management of Linen policy has been recirculated to all areas. 2025-05-29 Policy has been reviewed, with no changes and with policy group for sign off.	
8.2	All SCNs to include laundry management guidance in ward huddles for a period of 1-2 weeks to ensure all team members can discuss.	02 April 2025	Clinical Nurse Managers	2025-06-02 HoN will discuss the inclusion of the guidance in huddles with SCN in June (Medical Directorate 26/6) Linen Management is included within Safe and Clean Audit processes In accordance with Safe and Clean Care Audit protocols, monthly SICPs audits—covering linen management and the decontamination of patient-shared equipment—were conducted by clinical teams across inpatient adult wards in June 2025. The resulting audit report demonstrates a robust standard of practice: • All 17 inpatient adult wards audited, achieved a green RAG rating, indicating compliance scores of 90% and above. Significant improvements have been observed in linen handling and storage practices across inpatient adult areas at Victoria Hospital Kirkcaldy over the past six months, as further evidenced by 7 full IPC	

				(SICPs and environmental) audits carried out by the IPC Team. Where any issues were identified in cleaning of the environment and patient-shared equipment, these were promptly rectified. With re-audit affirming the clinical teams' commitment to continuous improvement. Linen Audit Key Findings • Used linen is not rinsed, shaken, or sorted upon removal from beds. • Laundry receptacles are readily available at point of use. • Linen bags are not overfilled. • Segregation protocols for used, soiled, and infectious linen are correctly followed. • Clean linen is stored appropriately, away from inappropriate areas (e.g. bathrooms). • Adequate stock levels of clean linen are maintained across wards.	
Requirement 9 NHS Fife staff including nurses, domestic and estates must ensure the appropriate monitoring and cleaning of vents and escalate any concerns in relation to this (see page 36). This will support compliance with: National Infection Prevention and Control Manual (2023).					
9.1	Review and refresh the vent cleaning schedule.	March 2025	Director of Property and Asset Management	2025-07-08 In keeping with the nationally prescribed cleaning specification, high level extract vents are dusted weekly using an electro-statically charged high dusting tool. Although this is an appropriate frequency, the findings highlight shortcomings in the execution of this task. To remedy this the QA team have been specifically tasked with focusing on the checking of vent cleaning. The findings of the QA team will both ensure that any shortcomings are attended to immediately as well as informing routine training and supervision. Any vents which cannot be cleaned using this routine method eg: may require dismantling to be thoroughly cleaned will be escalated to the relevant Estates department. Vent cleaning has been raised to the NHS Fife Ventilation Safety Group (VSG) and discussed at recent meetings to ensure regular vent cleaning is part of the pre-planned maintenance (PPM) programme for both NHS Fife Estates and PFI providers, the checks will be carried out quarterly and this frequency will be monitored and increased if required. Any concerns can be raised by staff through MICAD reporting and the VSG. EQUANS (PFI) Ward 34 has now been included in the morning walkaround, at which the vents are checked.	
9.2	Monitor schedule and revise based on learning.	March 2026	Director of Property and Asset Management	2025-07-08 A specific audit focused on vents will be conducted in early 2026.	
Requirement 10 NHS Fife must ensure all patient care equipment is in a good state of repair, including trolley mattresses within the emergency department, and is decontaminated following use and stored safely (see page 36). This will support compliance with: National Infection Prevention and Control Manual (2023).					
10.1	Recirculate Fife Management of Care Equipment Cleaning Schedule (November 2024) materials.	24 March 2025	IPC Manager	2025-03 All materials are stored centrally on the intranet. 2025-03 Request to IPCT to raise the profile and recirculate materials (in the same month materials also recirculated in relation to the bariatric equipment SOP)	
10.2	All SCNs to include management of care equipment guidance in all ward huddles for a period of 1-2 weeks to ensure all team members can discuss.	02 April 2025	Clinical Nurse Managers	Linked to email above – to follow up IPCT email with request to SCNs. Cleaning & Management of Patient Equipment The following standards and practices are audited to ensure NHS Fife adheres to: • Reusable equipment is cleaned between each patient use, and in accordance with scheduled intervals. • Reusable patient equipment—such as commodes, beds, raised toilet seats, drip stands, IV pumps, moving and handling equipment and monitoring devices—are visibly clean and reviewed routinely. • Equipment is cleaned following exposure to blood or bodily fluids. • Mattresses are inspected regularly, cleaned thoroughly (inside & out), and included in a formal audit programme. • Appropriate cleaning materials are consistently available across clinical settings.	
Requirement 11 NHS Fife must ensure alcohol based hand rub is available for use by staff and visitors (see page 36). This will support compliance with: National Infection Prevention and Control Manual (2023).					

11.1	Review and revise replenishment arrangements in all areas	24 March 2025	Clinical Nurse managers	2025/03/19– Clarified that this sits with ward teams not domestic services. 2025/05/28 - Email from director of Nursing (acute) to all SCNs/CNMs requesting support with checking and replenishing. Compliance will be spot checked during care assurance walk rounds	
Requirement 12 NHS Fife must ensure that there are suitable arrangements for real-time staffing assessment and escalation of risk for all clinical professions (see page 39). This will support their compliance with: Health and Care (Staffing) (Scotland) Act (2019).					
12.1	Work with CNMs to support consistent recording of acuity within wards/services	06 March 2025	HoN Acute	2025-01-16 HoN emailed teams with detailed instruction, to remind everyone of their role in completing all sections to support accurate assessment and response.	Completed
12.2	Each profession to develop processes to gather data to inform their daily workforce assessment and adopt a tool like nursing's to provide a consistent whole site assessment. *(Noting that Medicine and AHPs do not have the national Realtime baseline numbers that nursing have)*	31 August 2025	Service leads	2025-05-06 Deputy Medical Director engaging with neighbouring Boards to explore learning/practice elsewhere 2025-05-06 General Manager for WCCS engaging with AHP SLT and Associate AHP Director (Pharmacy and Labs have similar processes in place) 2025-06-12 – Medical colleagues exploring tools in use in NHS E.	
2023 Continued requirement 2 NHS Fife must ensure all sharps boxes' temporary closure lids are in place and hazardous cleaning products are securely stored.					
23.2.1	Review and promote best practice and review Safe and Clean monthly audits.	28/04/2025	IPC Manager/Acute Clinical Nurse Managers	2025-04-24 The Pan Fife Infection Control group is now receiving audit reports and therefore also receiving escalation of any issues that are identified. This matter is also being reviewed through the Care Assurance Group Infection control walk rounds on a monthly basis.	
23.2.2	Review practice with domestic supervisors and Senior Charge Nurses to consider where the current process for storing cleaning products could be refined to underpin staff training.	28/04/2025	Support Services Manager/ Clinical Nurse Managers	2025-05-28 Agreed that a memorandum be circulated to nursing teams to ask for local review, and to reinforce the principles behind best practice and domestic team placing a poster in DSRs to reinforce safe storage. 2025-06-02 Memo circulated	
23.2.3	As an immediate interim measure all domestic staff will be reminded of the requirement to store cleaning products within the locked cupboards provided within each DSR.	10/03/2025	Support Services Manager	2025-06-02 Domestic teams are trained in the secure storage of chemicals and information relating to this is held in the Domestic folders at ward level. A copy of the nursing team memo to be placed in each DSR as an aid memoir.	
2023 Continued requirement 3. NHS Fife must ensure accurate assessment and recording of patients' care needs.					
23.3.1	Care Assurance is evolving and will follow the national approach, Quality of Care (QoC) reviews has been rolled out from January 2025, with soft launch and testing and national feedback already undertaken supported by Excellence in Care and NHS Fife Head of Nursing.	01 July 2025	HoN Acute	2025-05 18-month schedule in place, SBAR shared with NHS Fife Clinical Governance Committee.	
23.3.2	Utilise Care assurance documentation audit data to target development support to ensure effective recording of daily care plans.	01 July 2025	Clinical Nurse Managers/Heads of Nursing	2025-05 Incremental updates on progress with focused improvements targets in advance of planned achieved date are in place.	Ongoing process in place
2023 Continued requirement 5 NHS Fife must ensure that all staff and volunteers perform hand hygiene at the correct times.					
23.5.1	Review all hand hygiene training materials to ensure compliance.	06 March 2025	Clinical Nurse Managers/Head of Nursing	2025-03 Hand hygiene audits are mandatory – sample size of 20 per month and then review with required action plan if needed. Compliance is monitored during walking rounds, with action plans when required.	
23.5.2	Implement enhanced communication campaign to reinforce the necessity of hand hygiene	05 May 2025	HoN Acute/IPC Manager	2025-04 Bare Below the Elbow campaign live from April 2025 and National Hand Hygiene Week in May 2025. Leaflets across VHK and stall in main throughfare 2025-05-02.	

2023 continued requirement 6 NHS Fife must ensure the healthcare-built environment is effectively maintained to ensure a safe and clean environment where risks to patient and staff safety are effectively identified and mitigated.					
23.6.1	NHS Fife will continue to advocate for capital investment to enable bed-based care to be delivered in fit for purpose modern accommodation out with Phase 1 of VHK.	Dec 2025	Director of Property and Asset Management	Dermatology department, VHK upgrade is on NHS Fife Capital plan. Progress dependent upon capital allocation.	
2023 continued requirement 13 NHS Fife must ensure the dignity of patients is maintained within the older part of the hospital due to reduced availability of shower facilities.					
23.13.1	NHS Fife will enhance the cleaning regime within the Supported Discharge Unit, to support access to showering facilities. NHS Fife will continue to work to enhance the ways of working to optimise space within the area and the fabric of Phase One.	April 2025 Dec 2025	Support Services Manager Director of Nursing Acute/Director of Property and Asset Management	2025-03-19 Domestic Services and Ward team will test a system to request additional shower cleans when required to enable access from 2025-04-01 2025-04-22 Support Services Manager and SCN agreed that the routine shower cleaning in Wards 6 and 9 continues and that if the nursing team feel that an additional clean of the shower is required at any point, this request is made directly to the Domestic on duty that day or, where there is no Domestic present on the ward, a request is made via a phone call to the Domestic Supervisor on ext 27969 who will arrange to action the request. This will enable the frequency of additional request to be monitored over the next 3 -4 months to assess how frequently these requests are being made If any patient or relative should highlight to the clinical team that they have any concerns with regard to the cleanliness of the shower facilities action will be arranged at the time The current Domestic Assistant hours that Wards 6&9 are resourced for, should support Requirement 13 and if the wards in Phase 1 are ever reconfigured in future to add additional shower facilities within the wards further resourcing will be considered at that point.	2025/04/22