Belfast Health and Social Care Trust
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Action plan arising from RQIA Inspection of Shannon Clinic (14 - 17 December 2020)

Version number	2.6	**Version Date:**	18/06/2021

Directorate:	Specialist Hospitals and Women's Health
Lead Director Name:	DIRECTOR
Current Status Grading:	

RAG Rating

	Action missed or will not make the deadline
	Action on track to be complete by deadline
	Action Complete

Collective Leadership Team (CLT) refers to: Division Chair / Co-Director / Divisional Nurse / Divisional Social Worker

No.	Issue	Recommendation/Action	Responsible Lead(s)	Timescale for Completion	Evidence of Progress / Completion	Current Status
4.0 Governance and Quality Improvement						
4.2	No trends analysis in relation to incidents, complaints etc	Consideration to be given to the employment of patient data officer to assist in the formation of data/reports in terms of adverse incidents, complaints, physical interventions, safeguarding referrals etc and the analysis and identification of trends.	Co-Director	February 2021	Passed scrutiny February 2021. Recruitment process in place.	G
		Bench marking exercise to be undertaken with similar MSU. NHS Benchmarking Network to be extended into Shannon Clinic.	Co-Director	March 2021	Shannon data has been part of NHS benchmarking for the past 2 years. Next round commenced February 2021	G
5.0 Safeguarding Arrangements						
5.1	Staff do not have adequate working knowledge and understanding of safeguarding	Learning from previous BHSCT ASG reports from Muckamore and Meadowlands to be disseminated and specific actions to be identified for Shannon Clinic	Divisional Social Worker	February 2021	Notice boards adapted from MAH learning (June 2020) insitu and updated monthly.	G

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	arrangements including completion and screening of forms and documentation				Meadowlands report reviewed. (Nil further to add following review.)	
		Audit to be undertaken in relation to safeguarding process in Shannon Clinic. Audit should include: - • Staff's working knowledge of safeguarding arrangements • Consistent reporting of incidents subject to safeguarding • Adult safeguarding training compliance • Quality of completion of APP 1 forms by staff • Screening of APP 1 by ward managers • Quality of protection plans, recording and sharing of same • Cross referencing adult safeguarding forms to incident forms and progress notes to ensure that incident has been recorded in all places • Recording of referrals to DAPO	Divisional Social Worker	February 2021	Questionnaire regarding staff knowledge of ASG 29.01.21 with a return date of 08.01.21 ASG training continues and compliance monitored. Rag rated database collated with staff training information Currently weekly meetings to discuss ASG / Datix Weekly update included as part of evidence log.	G
		Action plan to be developed to address any issues identified from above audit. Action plan should include a repeat audit of the above within three months of original audit. Repeat audit should then take place every six months thereafter.	Divisional Social Worker	March 2021	Feedback from audits completed and presented May 2021	G
		Adult safeguarding training to be provided to all staff appropriate to their role and responsibilities.	Divisional Social Worker	February / March 2021	ASG training continues and compliance monitored.	G

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					Rag rated database collated with staff training information	
		Adult Protection Policy and Procedures to be recirculated to all staff. Staff to sign signatory sheet to evidence that they have read and understood same.	Service Manager / Clinical Director	January 2021	Complete	G
		Aide memoire to be developed to assist staff in the completion of APP1s	Divisional Social Worker	February 2021		G
		Weekly adult safeguarding meeting between Senior Social Worker and ASMH within Shannon Clinic to be recommenced.	Divisional Social Worker /Assistant Service Manager	January 2021	Commenced w/c 1.02.21	G
		Adult safeguarding to become a standing agenda item at weekly ward managers meeting, MDT and monthly governance meeting.	Service Manager / Clinical Director	January 2021	28.01.21 Governance dates and agenda/minutes to be added evidence log Standing item on weekly safety brief.	G
5.2	One member of staff currently covering both the IO and DAPO roles under adult safeguarding.	One person covering both roles to cease	Divisional Social Worker	Complete	A member of social work staff within Mental Health Services has been identified to cover the role of DAPO.	G
5.3	ASP5 forms being commenced by nursing staff	ASP5 forms to be commenced by IO Audit to be completed on a monthly basis for compliance	Divisional Social Worker	Immediate	Complete	G

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5.4	ASP 1 forms are not being screened by ward managers in a timely fashion	All ASG referrals sitting on PARIS duty desk to be addressed immediately.	Assistant Services Manager Senior Nurse Manager Ward Managers	February 2021	In progress. All current ASG referrals screened in timely manner and reviewed by DAPO with monitoring template.	G
5.5	Adult safeguarding data is not reviewed to establish trends to glean learning leading to service improvement and to inform MDT, live governance etc. Referrals are considered on a stand-alone basis.	ASG data to be reviewed on a monthly basis to establish trends and shared with Governance Lead, ASM, Social Work Lead for Shannon Clinic (DAPO) and Band 8a Safeguarding Lead within the programme.	Divisional Social Worker	February 2021	ASG monitoring template in place Referrals also discussed at weekly safety brief Tracker document completed for February. & March Review of both to facilitate identification of any trends. Feedback at Governance 24/05/2021	G
		ASG investigations to identify learning for discussion at relevant meetings.	Divisional Social Worker	February / March 2021	As above	G
		ASG referrals are to be cumulatively reviewed and triangulated against the safeguarding incidents in relation to specific patients, wards and/or staff members	Divisional Social Worker	February / March 2021	As above	G

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5.6	The identification of a lead safeguarding person within Shannon	Safe guarding Champion for Shannon to be identified	Divisional Social Worker	February / March 2021	Divisional Social worker liaising with SM regarding nomination from nursing colleagues as champion Training underway to facilitate Band 6 champion from within Nursing team.	G
6.0 Incident Reporting						
6.1	No consistent approach to completion or grading of incidents	Adverse incident forms completed by Shannon Clinic during past six months to be reviewed against agreed standards to ascertain quality of completion by staff, quality assurance by approver and follow up. Audit to be repeated six monthly.	Governance Manager / Clinical Governance lead	February 2021	Audit completed. Feedback to CLT 31/05/21 Feedback to team Governance meeting 28/06/21	G
		Staff survey to be completed to ascertain staff's confidence in completing/quality assuring an adverse incident form on DATIX.	Governance Manager / Clinical Governance lead	February 2021	Included as part of overall audit	G
		Action plan to be developed from audit and staff survey findings.	Governance Manager / Clinical Governance lead	February 2021	Commenced 19/04/21	G
		Calendar of audit of incident forms to be developed.	Governance Manager / Clinical Governance lead	March 2021	Quarterly audit schedule implemented	G
		Visual aide to be developed for staff in relation to completion of forms.	Governance Manager / Clinical Governance lead	January 2021	Grading template available on wards – liaison ongoing with Corp Standardised template for completion of Datix web form supplied.	G

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6.2	No programme of regular training for staff in relation to incident reporting	All staff to complete refresher e-learning training on adverse incidents	Service Manager / Clinical Lead	February / March 2021		G
		Training/refresher training to be facilitated for approvers.	Service Manager / Clinical Lead	February / March 2021		G
6.3	No analysis or identification of trends in relation to incidents. Weekly physical intervention reports are reviewed in isolation and there is no analysis of this data over a longer period of time.	Consideration to be given to the employment of patient data officer to assist in the formation of data/reports in terms of adverse incidents, complaints, physical interventions, safeguarding referrals etc and the analysis and identification of trends. Data to be benchmarked.	Co-Director	April 2021	Passed scrutiny process February 2021 Recruitment process in place	G
		Reports to allow for analysis of data to be included in identification of suite of reports to developed to enhance governance arrangements.	Service Manager / Clinical Lead / Governance Manager / Clinical Governance Lead	February 2021	As per Divisional Governance	G
		The use of the SAI process is to be reviewed and to include the ability to allow appropriate learning from these within Shannon	CLT / Governance Manager	Immediate	Established as part of Governance meetings and safety briefs	G