Quality and Effectiveness Safety Trigger Tool Escalation Procedure

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Partners in Care

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Document Information

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The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership. The Trust is committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy.			

Amendment History

Issue	Status	Date	Reason for Change	Authorised
2	Draft	01.11.14	Addition of key responsibility for monitoring monthly QUESTT completion	Care and Clinical Policy Group
3	Ratified	26.08.16	Revised	Care and Clinical Policy Group

Contents

1 Introduction

1.1 This protocol provides a framework that will enable Managers and Clinical Leaders to monitor and escalate concerns, when teams are experiencing difficulties managing quality safety and effectiveness normally identified using the Quality Safety and Effectiveness Trigger Tool (QUESTT).

2 Statement/Objective

2.1 The QUESTT will monitor key performance indicators to provide an early warning if essential characteristics of a well performing team, working within an environment that will support quality and safety, are absent or at risk. It is recognised that the presenting issues are often the symptoms of deeper, more significant managerial and practice issues and/or demands. It is a supportive tool that will support teams and individuals within them to provide safe and effective care, it is recognised that often factors external to the team and/or organisation have a significant impact upon a team's essential characteristics.

2.2 As we strive to ensure efficiency and quality of care, we must ensure that we have the level of support for teams to thrive. This process is designed to achieve this.

2.3 Action plans developed by Managers/Team Leaders should be supportive in nature and not intended to apportion blame.

3 Roles & Responsibilities

3.1 The Team Leader or Service Manager is responsible for ensuring the monthly completion of the Tool for their team. A nominated person must be established for the purposes of completion of the tool; this should be determined at a local level. It is essential that there is contingency built in to support annual leave and other factors.

3.2 It is the responsibility of General Managers and Heads of Service/Profession to ensure their teams have completed the monthly QUESTT by monitoring and responding to automated email reminders.

3.3 The Chief Nurse and Chief Operating Officer hold joint responsibility for the monitoring and escalation of the QUESTT results on a monthly basis.

3.4 In the protocol below the levels of escalation provide further detail of levels of responsibility, reporting and monitoring.

3.5 This protocol will not cover all factors that may affect a team and where other concerns are present these should be managed in the appropriate way reflecting other Trust Policy.

3.6 The Chair of the meeting will be responsible for the action plan and distribution of meeting notes.

3.7 The Deputy Chief Operating Officer will be responsible for the effective completion of all managerial and operational actions and reporting to the Chief Operating Officer.

3.8 The Deputy Director of Nursing - Professional Practice will be responsible for all quality, safety and professional practice actions and reporting to the Chief Nurse .

3.9 As the improvement action plan progresses, any learning that is considered relevant for sharing should be shared as it occurs, if it is considered appropriate by the meeting members.

3.10 The meeting will be treated in confidence with information shared on a need to know basis. When learning from incidents, the information shared will be anonymsed.

4 Submission and Reporting Schedule

4.1 The QUESTTwill be completed between the 1st and 7th day of the month by all teams/wards/ services included. One reminder will be sent electronically by the perforimance team on approximately the 4th day of the month.

4.2 On the 8th day of the month the data set is released to all managers who will then review the scores of teams/ wards / services they are repsonisble for and take approprirate action as set out in section 6.

5 Training

5.1 Teams /ward/service lead manager responsible for completion of QUESTT receives face to face training which is then cascaded to 2-3 other team members to ensure each month the QUESTT can be completed in a timely fashion.

6 Monitoring, Auditing, Reviewing & Evaluation

6.1 The procedure will clarify the different escalation levels for the QUESTT results and the actions that will be required.

6.2 The QUESTT report will be presented monthly at the Quality Improvement Group and Red and purple levels will be reported to the Trust board where applicable along with the actions taken to mitigate risk.

6.3 A review of the QUESTT score will be part of the monthly managerial supervision provided between the General Manager/Service Leads and Team Leaders to allow discussion and any necessary actions to be supported; avoiding the need to implement this protocol of management escalation. It is expected that scores of 15 and less will be managed as part of regular management supervision meetings.

6.4 QUESTT scores should also be discussed at the monthly service delivery unit board meetings where required.

6.5 Where teams/services have not completed the monthly QUESTT the manager will be informed and an action requested as these teams will be considered 'at risk'.

6.6 The time frame for improvement will be dependent on the indicators triggering and the risk to quality and safety of the service. This will be decided by the members of the action plan team.

6.7 The QUESTT can be repeated at any time during the month to check for increases or decreases in escalation and inform an appropriate response.

6.8 **LEVEL 1**

6.8.1 Where Level 1 concern is raised, the Team Leader/ ward manager/service lead together with General Manager/matron or associate nurse director dependent on service leadership will meet to identify key actions. The actions will be measurable and able to demonstrate improvement. Liaison will also occur between the other aligned teams across the Trust to strive to achieve shared solutions. The General Manager/ will liaise with other areas to support team self-management.

6.8.2 The Zone Manager/AD Community Hospitals/ Service Delivery Unit (SDU) General Manager and Team Leader/matron/service manager will manage this level of concern. The Community QUESTT a score of **16-24** will act as a trigger for this level of intervention. Using the community hospital QUESTT a score of **12 -16** will act as a trigger for this level of intervention.

6.8.3 A Level 1 meeting will be held within 2 weeks of the notification.

6.8.4 Level 1 Reporting arrangements:- The action plan progress and achievement of the required improvements will be reported to the SDU General Manager

6.8.5 and Chief Nurse , Safety and Clinical Risk with monitoring undertaken at the SDU Quality Review Meeting chaired by the Chief Operating Officer with reports to the Quality Assurance Committee quarterly, as part of the regular quality report.

6.9 LEVEL 2

6.9.1 Where actions implemented at Level 1 do not achieve the required improvement or the score using the QUESTT is **25-35** (acute/community),**17-25** (community hospital), a Level 2 improvement meeting will be held.

6.9.2 Membership of this meeting will include the Team Leader, SDU General Manager/Service Lead, SDU Associate Director of Nursing (ADN) and relevant Head of Profession/s and to review the team's performance and develop an action plan with time limited objectives.

6.9.3 A Level 2 improvement meeting will be held within one week of the notification.

6.9.4 If there are any issues raised that may indicate the need, a Human Resource Manager for the area will be a member of this Level 2 improvement meeting membership.

6.9.5 Level 2 reporting arrangements:- The Action plan will be reported to and monitored by The Deputy Director of Nursing & Professional Practice with reports to the Quality Review Meetings monthly and Zone Manager/Matron/ ADN SDU General Manager operational meetings monthly as part of the regular quality report.

6.9.6 The Chief operating Officer and Chief Nurse will be informed of all Level 2 improvement meetings.

6.10 LEVEL 3

6.10.1 In cases where Level 2 interventions are not effective or where there is a Community/Acute QUESTT score of **36-46** or a community hospital QUESTT score of **26-36**, a Level 3 improvement meeting will be held **N.B. A Level 3 improvement meeting will be held within 4 working days of the notification.**

6.10.2 The improvement meetings will be led by the Chief Operating Officer and the Chief Nurse, the meeting suggested membership will be:

- General Manager/Service Lead
- Associate Director of Nursing for the SDU
- HR Manager
- Team Leader
- Head of Profession most closely linked to the team (e.g. for a Community Nursing Team, it will be the Head of Nursing)

- Deputy ChiefOperating Officer
- Deputy Ditrector of nursing – Professional practice or quality and safety
- Other professional representatives as required e.g. Pharmacist, Quality and Safety Team.

6.10.3 Conduct of meeting

- Meeting notes and action plans will be distributed to all invitees within 2 working days with a high-level briefing to the Chief Nurse and Chief Operating Officer.
- Key responsibilities will be agreed at the meeting – see meeting template in Appendix 1.
- Action review meetings will be held weekly for the initial month and then reviewed with consideration of the risks that have not been effectively managed.
- Monthly reports to the Executive Management Team will be provided by the Chief nurse and Chief Operating Officer (see responsibilities above).
- The action plan will co-exist with any other investigations being undertaken in the team e.g. HR or SIRIs with progress reports fed into each meeting.

7 De-escalation Planning

7.1 As the improvement actions are implemented and risk assessments indicate reduction in level of intervention required, a de-escalation process will be agreed by the members of the meeting with a proposal presented to the Chief Operating Officer and Chief Nurse for agreement.

7.2 As de-escalation occurs, the membership of the improvement meeting will be reviewed to ensure that the correct level of intervention continues to support the improvement journey for the team/ward.

8 Learning for the Organisation

A plan will be agreed by the improvement team to ensure that any organisational learning occurs and where appropriate, learning is shared with our partner organisation. The aim of organisational learning is to ensure lessons learnt are used when reviewing and developing services that are safe and effective.

9 References

9.1 Not applicable.

10 Equality and Diversity Exceptions

10.1 There are no equality and diversity exceptions.

11 Distribution

11.1 To All Teams, wards and Heads of service and managers across the organisation.

12 Appendices

Appendix 1 - Quality Effectiveness & Safety Trigger Tool (QUESTT)

Appendix 1

Quality Effectiveness & Safety Trigger Tool (QUESTT)		
Team	**Total Score**	
	Level 0	< 16
Month **Year**	Level 1	16-24
	Level 2	25-35
Completed by	Level 3	> 36
	Self Assessment	**Score**
Vacancy rate	0-3% / 3-10% / 10%+	0 / 2 / 4
Total sickness absence rate higher than 3.5%	No / Yes	0 / 2
Long term sickness absence rate higher than 2%	No / Yes	0 / 2
Reduction in capacity (in hours) TODAY is greater than 30%	No / Yes	0 / 2
New or no line manager in post (within last 6 months)	No / Yes	0 / 2
Monthly review of key activity, safety and quality indicators has been undertaken in the PREVIOUS MONTH	Yes / No	0 / 2
Planned annual appraisals performed in the PREVIOUS MONTH	Yes / No	0 / 2
Involvement in multi-disciplinary meetings in the PREVIOUS MONTH	Yes / No	0 / 2
Involvement in GP practice meetings in the PREVIOUS MONTH when requested to do so	Yes / No / N/A	0 / 2 / 0
Formal team meeting held during LAST 3 MONTHS	Yes / No	0 / 2
Formal feedback obtained from patients in LAST 3 MONTHS	Yes / No	0 / 2
2 or more formal complaints in the PREVIOUS MONTH	No / Yes	0 / 2
Evidence of resolution to recurring themes from incidents/complaints in the PREVIOUS MONTH	N/A / Yes / No	0 / 0 / 2
Unusual demands on service exceeding capacity to deliver in the PREVIOUS MONTH	No / Yes	0 / 2
Has the team adhered to a "Clear desk" policy in the PREVIOUS MONTH?	No / Yes	0 / 1
CURRENTLY more than 2 ongoing RCA investigations or disciplinary investigations within team/service	No / Yes	0 / 2
Do you have any medical devices overdue for review?	N/A / No / Yes	0 / 0 / 1
If you have medical devices overdue for review have you taken appropriate action?	N/A / Yes / No	0 / 0 / 1
Service specific question 1		
Service specific question 2		
Service specific question 3		
Service specific question 4		
TOTAL SCORE		

Community Hospital & MIU Quality Effectiveness & Safety Trigger Tool (QUESTT)

Total Score	
Level 0	< 11
Level 1	12-16
Level 2	17-25
Level 3	26-36

Ward or Department	**Name**	
Date of Review	**Signature**	

SECTION ONE The content of this completed tool should be used to form the basis of a monthly multi-disciplinary review of the key quality indicators within a clinical area. The assessment should be made by the team leader and then validated by the members of the review group discussing the results. The first section acts as a trigger or early warning tool, and must be assessed and completed each month.

NB - if the statement is true insert x in the box & then tab off. The score will be calculated automatically. If it is not true, leave blank.

	TRUE	SCORE
New or no line manager in post (within last 6 months)	x	1
Vacancy rate higher than 3%	x	3
Unfilled shifts is higher than 6%	x	2
Sickness absence rate higher than 3.5%	x	2
No monthly review of key quality indicators by peers (e.g. peer review or governance team meetings)	x	3
Planned annual appraisals not performed	x	2
No involvement in Trust-wide multi-disciplinary meetings	x	2
No formal feedback obtained from patients during the month (e.g. questionnaires or surveys)	x	2
2 or more formal complaints in a month (wards) or 3 or more (A&E or OPD) or 1 or more (CCU & ICU)	x	3
No evidence of resolution to recurring themes	x	3
Unusual demands on service exceeding capacity to deliver (e.g. national targets, outbreak)	x	2
Hand hygiene audits not performed	x	2
Cleanliness audits not performed	x	2
Ward/department appears untidy	x	2
No evidence of effective multidisciplinary/multi-professional team working	x	3
Ongoing investigation or disciplinary RCA investigation (including RCA's & infection control RCA's)	x	2
TOTAL SCORE		36
COMMENTS		

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Quality Impact Assessment (QIA)

	Please select			
Who may be affected by this document?	Patient / Service Users	☐	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☐	Other Statutory Agencies	☐
	Others *(please state):*			

Does this document require a service redesign, or substantial amendments to an existing process? NO	☐
If you answer yes to this question, please complete a full Quality Impact Assessment.	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity? NO	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐		
If you answer yes to any of these strands, please complete a full Quality Impact Assessment.				
If applicable, what action has been taken to mitigate any concerns?				

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☐	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☐	Other Statutory Agencies	☐
	Details *(please state):*	This is an existing policy that has been updated.		

Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

Policy Title (and number)		**Version and Date**	
Policy Author			

An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.

EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)

Age	Yes ☐ No☐	Disability	Yes ☐ No☐	Sexual Orientation	Yes ☐ No☐
Race	Yes ☐ No☐	Gender	Yes ☐ No☐	Religion/Belief (non)	Yes ☐ No☐
Gender Reassignment	Yes ☐ No☐	Pregnancy/ Maternity	Yes ☐ No☐	Marriage/ Civil Partnership	Yes ☐ No☐

Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☐

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☐ No☐
Are the services outlined in the policy/procedure fully accessible[6]?	Yes ☐ No☐
Does the policy/procedure encourage individualised and person-centered care?	Yes ☐ No☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐

If 'Yes', how will you mitigate this risk to ensure fair and equal access?

EXTERNAL FACTORS

Is the policy/procedure a result of national legislation which cannot be modified in any way?	Yes ☐ No☐

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?

ACTION PLAN: Please list all actions identified to address any impacts

Action	**Person responsible**	**Completion date**

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:
For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net
This form should be published with the policy and a signed copy sent to your relevant organisation.

[1] Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
[2] Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them
[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated
[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives
[6] Consider both physical access to services and how information/ communication in available in an accessible format
[7] Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy