HIW FEEDBACK ACTION PLAN April 2014					
Care Plans	Patient A, Risk Assessment Care Plan had not been reviewed since its development in August 2013 and no care plan in place for his current requirement to have blood tests for his Lithium Therapy. Discharge Care Plan needed to be in place.	Care Plan to be reviewed Immediately and new care plan created	Hospital Manager, Senior Nurses,	Mar-14	Care Plan Reviewed by Named Nurse. New Care Plan in place for Lithium Therapy and also regular blood monitoring. CTP being developed with his care coordinators in relation to discharge.
	Patient B. Needs a care plan in relation to his tissue viability. Needs to be seen by his GP or the Practice Nurse. Needs to have proper Analgesia in place after an assessment of pain done by the GP.	GP, has been to see the patient and has carried out a full physical examination in relation to tissue viability and also any required pain relief	GP, Practice Nurse and Members of Staff	18th March 2014	Full Physical Health Review Completed by the GP and Staff. Care plan in place regarding tissue viability. Review carried out regarding pain relief and the GP has been back to reassess.
	Patient **C, General discussion regarding his 1-1 observation levels and the recording of this on** the monitoring forms	Agreed that the current monitoring forms would be reviewed to ensure that there was proper recording and appropriate information.	Hospital Manager and Senior Nurses	Apr-30th 2014	All Observation Recording Documentation has been reviewed in line with policy requirements and was sent out to the MDT for consultation and agreement. These new forms are now in use.
CLINIC ROOM	Controlled Drugs Book to be used only for recording Controlled Drugs and should not include Benzodiazepines. This was picked up in a recent audit of the clinic room by Speeds Pharmacy.	Copy of Speeds Pharmacy Audit Report to be sent to HIW when it is received. Discussion With Staff regarding changing this practice and Protocols to be put in place.	Hospital Manager Senior Nurses Lead Pharmacist	Apr-14	New Protocols have been developed for Recording Benzodiazepines and this practice has now stopped. All staff have been trained in this process.

	Staff Recording signatures on the medicine charts and then putting comments in afterwards such as patient has refused medication.	This practice to stop immediately and staff only to sign the book when the medication has been taken by the patient.	Hospital Manager Senior Nurses Staff Nurses	Immediate	Memo sent to all qualified staff regarding this and their need to adhere to the standards on administration of medication. Audit checks being carried out by senior staff and also visual checks during medication rounds.
	SOAD, C03 Form for patient E was unclear in section 4:2:1 and needs amending.	SOAD who completed the form has been contacted and the form amended for clarification	MHA Administrator RC	31st March 2014	Soad contacted and asked for clarification on the form and a new form supplied.
	Patient C, medication was transcribed from a fax document onto a medicine chart following his admission the previous day and this had not been signed by a doctor.	Discussed this with the stream manager and RC and this will not happen again. Any new patient coming to the hospital will have a medicine chart signed by the RC or in his absence by the on call consultant.	Stream Manager Hosital Manager RC Senior Nurses	Immediate	Memo sent to all staff regarding the new changes and also that they adhere to the administration policy to ensure that they are in compliance with their registration requirements.
	Recording of the receipt of medication on the correct form and filing this away in the Speeds Folder was not done in February as this was completed by an agency nurse. This recording is required by our medication policy.	All trained staff to receive refresher training from Speeds on ordering, requisitioning and documenting receipt of medication.	Hospital Manager Senior Nurses Lead Pharmacist	Apr-31st 2014	Memo sent to all staff to ensure that they adhere to the recording and stock control requirements. Random spot checks to be made by the senior nurses. Only regular staff to accept and store away medication orders. Refresher training to be supplied by Speeds Pharmacy staff.
MHA DOCUMENTATION	Medical Scrutiny of forms needs to improve as this appeared to be lacking on some forms	Process to be reviewed and action implemented	MHA Administrator RC	Apr-31st 2014	All documents have been scrutinised by the RC from New Hall Hospital and are date stamped to this effect.

	All patients need to have a Consent To Treatment Assessment which is documented and recorded in their files and the Medicine File as evidence. Any that cannot consent in relation to capacity needs to have a SOAD statement.	All patients to have a Capacity Assessment with Consent to Treatment form completed.	MHA Administrator RC Nurses	Apr-31st	Full Audit completed on this and all patients have an up to date consent form or a SOAD form on file and along with their medicine chart.
	One C02 form for a patient had no medical Scrutiny or assessment of Capacity.	This has now been rectified by the RC and the C02 form amended and an Assessment of Capacity completed	MHA Administrator RC	Immediate	Completed and rectified by RC and MHA Administrator
Staff Supervision	Inspection found that there were some staff that had not received supervision and appeared to be slipping through the net. Supervision is required to be more consistent across the board.	The supervision policy has been reviewed and the current supervision tree for staff amended. An audit has been carried out to see why some staff are not having supervision. All reports on supervision will be copied to the manager and will be part of the Clinical Governance Reviews on a monthly basis.	Hospital Manager Senior Nurses Support Services Manager Occupational Therapist	ongoing	All staff reminded that they require supervision. A new supervision tree with clearly defined responsibility has been re-drafted and given to all staff. The Hospital Manager and the Senior Nurses will drive this through with audit and reflection at the Clinical Governance review meetings. The stats on this have improved greatly but there is still an ongoing drive to improve further.

Environment	While HIW were very pleased and saw the current plans for the Refurbishment of the building they felt that the current state of the building needs addressing for the benefit of patients welfare.	Current plans for the refurbishment to be processed and datelines given where possible. Finances have been agreed. Continue as at present with the upgrading and cleaning of all rooms and facilities while we await the implementation of the refurbishment plans	Stream Manager Hospital Manager Support Services Manager Project Lead	Ongoing	A recent meeting on the 21st May looked to finalise plans and phasing of the refurbishment of the hospital. Funding and finances have been discussed and will be agreed soon. Meanwhile the work to the outside of the building has been completed. We are ensuring that we keep all staff, patients, relatives and significant others aware of developments and progress.
Observation Forms	A newly admitted patient was on 1-1 observation level. HIW reported that they were concerned that the current recording form actually documented less information that those on 15 minute observations.	We have looked at the current observation forms and also the observation policy and agree that this needs renewing to record more detail for those on 1-1 observation	Hospital Manager Senior Nurses Clinical Lead Registered Individual	31st April 2014	A new hourly observation form has been created to record and document every 15 minutes on how the patient is doing and anything of significance. This form is now in use and will be audited after a two month trial period in relation to its effectiveness.