

**Dignity and Essential Care
Inspection (unannounced)
Hywel Dda University Health
Board – Prince Philip Hospital
– General Medicine: Ward 4**

24 June 2014

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1. Introduction

Healthcare Inspectorate Wales (HIW) completed an unannounced Dignity and Essential Care Inspection in Ward 4, Prince Philip Hospital, part of the Hywel Dda University Health Board on 24 June 2014.

Our inspection considers the following issues:

- Quality of Patient Experience.
- The Delivery of the Fundamentals of Care
- Quality of Staffing, Management and Leadership
- Delivery of a Safe and Effective Service

2. Methodology

HIW's 'Dignity and Essential Care Inspections', review the way patients' dignity is maintained within a hospital ward/ unit / department and the fundamental, basic nursing care that patients receive.

We review documentation and information from a number of sources including

- Information held to date by Healthcare Inspectorate Wales (HIW)
- Conversations with patients, relatives and interviews with staff
- Discussions with senior management within the Health Board
- Examination of a sample of patient medical records
- Scrutiny of policies and procedures which underpin patient care
- General observation of the environment of care and care practice.

These inspections capture a snapshot of the standards of care patients receive. These inspections may point to wider issues about the quality and safety of essential care and dignity.

3. Context

Hywel Dda University Health Board was established in October 2009 following the NHS Reform Programme 2008-2009, which introduced integrated healthcare for Wales. The Health Board is responsible for the health and wellbeing of the population across Carmarthenshire, Ceredigion and Pembrokeshire, it provides a range of services for the residents of south Gwynedd and Powys. The Health Board covers a quarter of the landmass in Wales, with a population of approximately 375,061 people.

Our community and secondary care services are delivered through:

- four hospitals; Bronglais Hospital in Aberystwyth, Glangwili Hospital in Carmarthen, Prince Philip Hospital in Llanelli and Withybush Hospital in Haverfordwest,
- eight community hospitals,
- eleven health centres.

Prince Philip Hospital, Llanelli is an acute hospital which opened in 1990. There are approximately 225 inpatient beds that support acute and elective services for General Medicine; General Surgery ;Orthopaedic; Urology ; Acute Stroke and Rehabilitation which are outlined as follows :

- Clinical Decisions Unit
- Ward 1 – General Medicine/Elderly Medicine
- Ward 3 – General Medicine/Respiratory
- Ward 4 – General Medicine/Cardiology/Gastroenterology
- Ward 5 – General Medicine/Diabetology
- Ward 6 – Elective Orthopaedic
- Ward 7 – Elective Surgical Ward

The Hospital's Acute Critical Illness facilities include a level II Emergency Department; Coronary Care Unit and Critical Care Unit.

Other hospital services include a Surgical Day Case unit; an Endoscopy Unit; and Radiology and Pathology Departments. There is also a Hospice facility on site which provides an Inpatient Palliative Care Service and Day Outpatient Treatment Centre.

The main Outpatient Department provides consultation clinics for a range of specialities which support diagnostic and therapeutic interventions.

Ward 4: General Medicine/Cardiology/Gastroenterology

Ward 4 is a very busy clinical area which has 22 inpatient beds for the provision of acute general medical services and specializes in Cardiology and Gastroenterology. There are six beds with cardiac monitoring telemetry facilities that are utilised for patients with a wide range of cardiac problems. As part of the Gastroenterology Service the ward has been designated as Eating Disorder Specialist Area. The patient acuity and dependency on this ward is high and the workload is acute and intense reflecting patients with multiple conditions.

Summary

Overall, we were met by a friendly, approachable and organised staff team working within a busy ward environment, striving at all times to try and ensure that the patient experience was as positive as possible. Feedback from patients and relatives indicated overwhelming support for the care given on Ward 4.

Patients can be confident that the service, at the time of the inspection, was noted to be well run and there was attention to maintaining professional standards of care. We witnessed that patients received information about their care in a manner which was sensitive to their needs. This was not, however, always confidential because some medical staff did not always close curtains to maintain privacy. On the whole nursing staff were seen to maintain privacy, dignity and respect whilst sharing information with patients. Despite the busy and unpredictable nature of the ward, the staff, who were led by an enthusiastic ward manager and her deputy, appeared to function well as a team to ensure the seamless provision of quality care.

Several areas of noteworthy practice were observed;

- the use of a designated ward Nutrition Nurse who liaises with Hotel Services with regard to special dietary needs.
- the ward, in collaboration with a patient and relative had compiled a nutritional advice folder which covered many different dietary needs and offered further contact information for discharge home.
- nurses work on a rotation when undertaking one to one care of patients to maintain concentration and reduce fatigue.
- the ward evidenced they were listening to patients views because we noted that all patients were given a questionnaire on discharge from the ward. The findings were translated into outcomes and the actions were on the wall for patients and visitors to read.

Notwithstanding the good practice observed above, we identified a number of areas for improvement within the four domains. Broadly the areas for improvement

included; fragmented and cumbersome documentation which was not always fully completed; the under use of available communal area; the development of a supportive environment for patients with cognitive deficits and finally unclear accountability in documentation with some medical staff. Details of the areas for improvement and our requirements are set out within Appendix A.

Findings

Quality of Patient Experience

During the inspection we identified **one** area which required improvement in the area of patient experience. Our requirements in this respect are detailed within Appendix A.

Overall, we observed that staff were professional, friendly and respectful in their manner, with all aspects of patient care being undertaken in a discrete and sensitive way.

We observed that although the ward did not use privacy signage, nursing staff always ensured that curtains were drawn around the bed when care was being given. We heard patients being spoken to discreetly, with staff ensuring that conversations regarding personal care and medical conditions could not be overheard. We witnessed two very different ward rounds, with one team of doctors closing all curtains to maintain privacy, dignity and confidentiality and the other team standing more central to the ward and speaking to patients from the bottom of the bed with curtains mainly open. We saw doctors raising voices appropriately and speaking slowly with one patient who had difficulty with understanding the English language.

We also observed that on the whole, staff spoke with patients and other members of the ward team in a calm, professional and courteous manner, with patients being called by their preferred name, which was clearly recorded above their bed.

There was evidence that the ward had communication aids such as the loop system for people with hearing problems and relatives were brought in to assist on other occasions, such as overseas patients with limited English. However patients stated that their care had been discussed with them and we saw evidence of this is in the patients' notes.

Patients stated that the response to nurse call bells was excellent and that there was not always a need to use the call bell because staff were always visible. We noted that very few call bells were heard during our time on the ward and when they were used, the response was immediate.

Conversations with patients indicated that food was generally good and on the day it looked appetising with appropriate portion size. We observed a mealtime and found that it was busy with some areas of the ward having more staff support than others. We saw that all staff, irrespective of their grade, assisted with ensuring food was given to patients in a timely manner. Although "Protected Mealtimes" was observed, relatives were able to visit to assist with feeding if they wished. Patients ate their meals sitting in or by their beds, which did not provide an environment of rehabilitation or preparation for discharge home.

It was noted that there was no day room available. Discussion with the ward manager indicated that the discharge lounge, which was adjacent to the ward, could be utilised after 5 pm and on weekends and although some patients were aware of this, it was not generally recognised as part of the ward. The room could, at times, be used as a functional day room / visiting room where television, radio, reading material or an opportunity to socialise could be provided, to improve the experience for the patient.

We observed that all staff wore uniforms in accordance with the All-Wales dress code and could therefore be recognised by their uniforms or name badges.

Patients looked cared for and well groomed and stated that although they were encouraged to be as independent as possible, those who required any assistance were offered it in a sensitive and dignified manner.

There was overwhelming support for the staff, at all grades, from patients and relatives and this was confirmed in the Thank You notice board which indicated the gratitude from patients and also relatives for support offered at times of sadness and stress.

Recommendation:

- Staff need to promote the use of the discharge lounge when available to encourage socializing, rehabilitation and meaningful activities.

Delivery of The Fundamentals of Care

During the inspection we identified **six** areas which require improvement concerning the delivery of the Fundamentals of Care. Our requirements in this respect are detailed within Appendix A.

Communication and Information

People must receive full information about their care in a language and manner sensitive to their needs.

We observed interaction between staff and patients/relatives in accordance with the standard required by the 'Fundamentals of Care'. The majority of patients and relatives we spoke with during the inspection confirmed that they felt adequately informed about their care management and treatment.

We witnessed that patients received information about their care in a language and manner which was sensitive to their needs because medical and nursing staff were talking with patients in a considerate, unhurried manner.

The patient notes contained the relevant personal information, although they were not easy to navigate and documents were not filed in a systematic format. Assessments were undertaken however care plans, evaluations and outcomes for patients were difficult to find and did not seem to be set out in any organised system. In one patients notes the Fundamentals of Care had not been completed although the patient had been on the ward for a week. We spoke with the staff and this was dealt with immediately. In another instance the "This is me"¹ and "Butterfly"² documents were in the patients file but had not been completed. Finally we noted that, where there was evidence

¹ This is me is a simple and practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests

² The Butterfly Scheme allows people whose memory is permanently affected by dementia to make this clear to hospital staff and provides staff with a simple, practical strategy for meeting their needs.

of care plans, they were generic not patient centred and one was not signed and dated.

We also noted that in the inspected patients notes there were detailed initial assessments undertaken on admission to the ward, however the nursing documentation commenced with a copy of the medical teams' admission notes. Of the nine care files examined none had care plans for every risk identified. Again, there was no consistent evidence of planned care, its implementation or the evaluation of any interventions to ensure care given was effective. This also meant that neither permanent or bank staff were provided with a clear guide as to how to provide care and support to each patient in accordance with their needs, wishes and preferences. Discussion with senior staff indicated that this was the new Health Board documentation and was not individual to the ward. Subsequently we could not be assured that patients health, personal and social care needs were always assessed and set out in a regularly reviewed plan of care. We did however see detailed written and verbal handover between staff and there was a "ward round book" which captured changes made by the doctors.

We noted in the patients hospital notes there were many instances where the medical doctors had recorded information, had signed but had not printed their name or designation. Good practice would evidence doctors signing and then printing their name and designation. This will clarify who is making the record, decisions or agreeing the decisions. This is a requirement in the Good Medical Practice³ guidance: Domain 1 sec 21.

There was very little pictorial signage to assist patients living with a cognitive impairment, which is the lack of ability to process information, except on toilet doors and these only served to confuse as they were broken. Discussion with the ward manager indicated that they had already been referred to the maintenance team. There were no large print signs, clocks or Welsh translation seen on the ward. These would benefit patients with identified

³ *Good Medical Practice* is the guidance on duties of a doctor registered with the General Medical Council

communication needs and senior nurses indicated that this was on the long term improvement planning for the hospital.

There was guidance on the wall of the corridor on the way in to the ward explaining how to make a complaint, however discussion with the patients and relatives indicated that they were unsure of the process, although no one expressed any concerns.

Recommendations:

- The documentation needs to be completed appropriately and in a timely manner.
- The documentation needs to identify nursing needs, outline interventions and evaluate effectiveness of treatment. This needs to be set out in an user friendly format
- Doctors need to sign, print and state their designation when making recordings in patients' notes.

Respecting people

Basic human rights to dignity, privacy and informed choice must be protected at all times, and the care provided must take account of the individual's needs, abilities and wishes.

During the inspection we observed the efforts being made by staff to protect patient's basic human rights to dignity, privacy and choice. We also found that the care provided on the ward took into account patients abilities and wishes in this regard. This is because there was evidence that staff preserved privacy and dignity by closing doors and curtains before undertaking any personal care. We did not see the use of privacy signage on the curtains around the beds, however we did not observe any staff entering, other than to assist with care, when the curtains were closed. Staff stated that confidentiality was maintained by discussing any personal matters at quieter times or by speaking discreetly behind bed curtains.

We noted that people were called by their preferred name and were encouraged to make decisions i.e. what they would like to eat or drink, whether they wanted to go back in to bed or if they wanted a shower or bath. Staff were seen to demonstrate patience and understanding towards the patients in their care throughout the unannounced inspection.

We learned that there was no private area for patients and relatives to share time or for staff to break bad news. This had to be undertaken in the ward managers office which wasn't always conducive for confidential and private conversations.

Recommendation:

- The ward needs to ensure that there are privacy pegs available.

Promoting Independence

The care provided must respect the person's choices in making the most of their ability and desire to care for themselves.

To a limited extent we witnessed patients being supported to be as physically independent as they were able, because we saw patients receiving therapy from the Physiotherapist, another was being assisted by the nutritional nurse, and another by the cardiology nurse. However, there was no evidence of any encouragement for patients with cognitive deficits (such as confusion or dementia) through the use of specific initiatives.

Although staff promoted the "pyjamas not prescribed" ethic, all the patients observed on the day were sitting in bed or in chairs by the side of the bed. Patients stated that they were not encouraged to wear day clothes and there was little point in getting dressed to go back to bed again.

There was a daily trolley which brought newspapers, toiletries and confectionary for the patients to purchase.

There were no activities, library or games available to promote independence however there was a television in each bay but they were not prominent and barely watched. Patients seemed to have concerns regarding availability and quality of the head phones for the radio.

Relationships

People must be encouraged to maintain their involvement with their family and friends and develop relationships with others according to their wishes.

Staff stated that patients were encouraged to maintain involvement with their family, although there was no private area for them to speak confidentially with relatives. We noted that it was difficult to develop new relationships with others patients because they were either sitting in or by their beds throughout the day.

There were excellent relationships between patients / relatives and staff and family and friends were encouraged to visit within structured times, although more flexible times were possible by arrangement with the ward manager.

There was no relative's room available however the ward manager stated that when there was a need for relatives to stay overnight the patient would usually be moved to a cubicle and the relatives were made as comfortable as possible and offered food and drink.

Rest, Sleep and Activity

Consideration is given to people's environment and comfort so that they may rest and sleep.

We saw that consideration was given to the patients' environment and comfort so that they could rest and sleep. There were adequate amounts of pillows and blankets available and we observed staff asking if patients were comfortable. Not enough blankets had been picked up in the last annual audit and therefore staff were asking if patients needed more. We saw that the linen trolley had

ample stock. This was an example of good practice whereby patients and relatives' comments had been listened to and actioned.

The ward has a policy for rest between 1:30 pm and 3 pm where visitors are discouraged to visit. This again is an example of good practice allowing patients time to rest and recover without any interruptions.

From the patients spoken with and their notes inspected only one was receiving night sedation to assist with sleep. This was administered appropriately and good effects were noted.

Ensuring Comfort, Alleviating Pain

People must be helped to be as comfortable and pain free as their circumstances allow.

Patients were helped to be as comfortable and pain-free as their condition and circumstances allowed and we noted that the patients we spoke with did not display any signs of discomfort. However when we looked at the documentation, although there were pain score charts available it was difficult to evidence measurement of outcomes in the care plans / notes.

We spoke with one patient who stated that he was unable to eat his lunch because he was in discomfort after a medical intervention which had been undertaken just prior to lunch being served. Staff need to ensure that patients have adequate pain relief, when required, pre and post receiving medical interventions.

Recommendation:

- Staff need to ensure that the effectiveness of medication is recorded.

Personal Hygiene, Appearance and Foot Care

People must be supported to be as independent as possible in taking care of their personal hygiene, appearance and feet.

Patients told us that they were encouraged to be as independent as possible with washing and dressing. Assistance was given if required, especially for the male patients with shaving. Patients were seen to be clean and well groomed.

Eating and Drinking

People must be offered a choice of food and drink that meets their nutritional and personal requirements and provided with any assistance that they need to eat and drink.

We observed that patients were offered a choice of food and drink that met their nutritional and personal requirements and saw that they were provided with assistance to eat when required. All staff regardless of their grade assisted with distributing and ensuring that food was eaten in a timely manner. Patients who required pureed food were assisted to eat in an unhurried, patient and respectful manner. We also saw that fluids were offered throughout the day, with water jugs being replenished regularly. The ward team were using a recognised nutritional tool to assess patient's needs. Examination of a number of patient's records revealed that the All Wales food and fluid charts were being completed appropriately and there was evidence of referrals to the Nutritional Specialist Nurse and Speech Therapy. The ward also had a Nutritional link nurse who liaised with Hotel Services to ensure appropriate special diets were catered for. This is an example of good practice as it ensures that patient's nutritional needs are adequately met to promote their well being.

There was a clear sign in the corridor into the ward, which indicated that mealtimes were protected. We noted that this was adhered to with only one relative visiting the ward to assist with his wife's feeding.

The ward utilised the red tray system⁴ but this did not include the water jugs. This system identified who required assistance. We noted that Hotel Services staff did not take these trays until a record had been made of the food eaten. This was undertaken systematically using food measurement charts. Patients did not have a dining room to eat their meals and therefore food was brought to their bedsides. Meals were available throughout the day and snacks were stored in the ward kitchen for anyone requiring something to eat in the night.

Oral health and hygiene

Appropriate, discreet and prompt assistance must be provided when necessary, taking into account any specific needs and privacy.

It was evident that patients were supported to maintain healthy, comfortable mouths and pain-free teeth and gums, enabling them to eat well and prevent related problems. The All Wales Oral Health and Hygiene bundle was seen in the notes and staff had recently attended a dental hygiene course. One patient stated that he had brought his own electric toothbrush in with him and although patients did not know that toothbrushes were available on the Ward, staff confirmed that there were stock available. One patient stated that there had been a concern regarding denture containers but that had been resolved.

Toilet needs

Appropriate, discreet and prompt assistance must be provided when necessary, taking into account any specific needs and privacy.

We observed appropriate, discreet and prompt assistance being provided to patients when accessing toilets or commodes. Call bells were hardly heard and when used they were answered in a timely manner. Patients stated there was no need to use call bells because staff were always visible.

There were single gender toilets, a multi use bathroom and a separate shower. All were clean but there was mould on the shower room

⁴ The Red Tray system helps to reduce nutritional risk in hospitals by providing a signal that vulnerable patients need help and support from staff, or has a poor dietary intake.

ceiling. All doors locked but the engaged sign wasn't working in several of the rooms.

There was evidence of continence pads in the store room, however we did not see any continence assessments recorded in patient notes. Staff stated that they used their professional judgement when deciding on which pads to use. There was no record seen of any referrals to the Continence Nurse Specialist. The above findings may mean that some patient's continence needs are not being fully met.

Recommendation:

- Staff need to undertake continence assessments to ensure the correct continence products are being offered to individuals

Preventing Pressure Sores

People must be helped to look after their skin and every effort made to prevent them developing pressure sores.

Patients were helped to look after their skin and every effort made to prevent the development of pressure sores with the ward using the Waterlow⁵ tool as part of an initial assessment on admission. Where necessary SKIN⁶ bundles and charts were also adopted. These had been completed and reviewed as required.

Staff stated that access to pressure relieving mattresses was not a problem and we saw mattresses being delivered on the day. Referrals to the Tissue Viability Nurse Specialist were seen

⁵ The Waterlow is a pressure ulcer risk assessment/prevention policy tool.

⁶ If a patient is deemed to be at risk of developing a pressure ulcer, the SKIN bundle requires documented nursing intervention in specific areas at least every two hours to reduce the likelihood of damage

Quality of Staffing, Management and Leadership

During the inspection there were no areas which require improvement concerning the Quality of Staffing, Management and Leadership

Overall, patients can be confident that the service, at the time of the inspection, was noted to be well run with clear attention to maintaining professional standards of care.

There was a Ward manager and her deputy, who worked effectively and efficiently together sharing management responsibilities but maintaining clear lines of accountability. They promoted an open and transparent management style where staff were able to voice concerns and suggest new ways of working. Both ward managers were visible on the ward and were approachable and supportive to the patients, relatives and staff. It was evident that they had worked tirelessly to promote a cohesive and well engaged staff team.

Annual audits were embedded into the ward culture and the outcomes were utilised to inform and improve standards for the patients receiving care. However there was no dedicated time for staff meetings to communicate these findings and any changes were cascaded to staff during the handover time.

Staff spoken with suggested that the ward would benefit from an extra qualified nurse on an afternoon shift. Discussions with the ward manager explained that over the last six months there had been a number of staff on sick leave, subsequently the ward had been relying on the use of internal bank staff. In the last month, however, staff were returning from maternity leave and the ward was settling back into its usual routine. She stated that to maintain consistency and continuity for both staff and patients they had requested the same bank staff.

Due to this staffing situation it was difficult to inspect the training schedule, however the ward manager indicated that there had been a discrepancy when

the electronic e-rota system commenced and subsequently there were gaps in some mandatory training. She was working towards resolving the issue. We noted that one Healthcare Support Worker was attending a short course on dementia care that afternoon.

We spoke with a student nurse who confirmed that she had received excellent supervision by her mentor during her placement on the ward. This facilitates the consolidation of theoretical learning to promote a skilled and knowledgeable work force for the future.

Delivery of a Safe and Effective Service

People's health, safety and welfare must be actively promoted and protected. Risks must be identified, monitored and where possible, reduced or prevented.

During this inspection we have made one finding which required improvement in this area. Our requirement is detailed within Appendix A.

Overall, the ward environment was clean, fresh and standards of hygiene appeared to be maintained. Conversations with patients indicated that they were satisfied with the cleanliness in their area and discussion with a member of the domestic staff revealed that they had received appropriate training to assist them in their role.

Patients were able to find their way around the ward environment despite the lack of clear signage. Conversations with a senior nurse highlighted that improving the patient experience especially for patients with cognitive deficits, by enhancing the ward environment, is a priority.

Patients informed us that they feel safe receiving care during the day and night. We also observed that nursing and care staff wore uniforms in accordance with the All-Wales dress code with clear name badges, to assist patients in identifying their role. The Ward also used the Named Nurse system so that patients could identify the nurse looking after their care on a particular shift.

We were told by a patient about an incident that had occurred on the ward over the weekend. This had not been recorded on the Datix system. We highlighted this to the Ward Manager who addressed the issue immediately.

The ward had an Infection Control link nurse who was responsible for maintaining standards and undertaking the hand washing audit. We saw

evidence of good hand washing techniques during one ward round with the Consultant washing his hands in between consultations with patients.⁷

The Emergency Resuscitation trolley had been maintained and checked as required.

Staff were familiar with practice and worked safely within current policies and guidelines. We questioned staff regarding Safeguarding and the Deprivation of Liberty Standards and were advised that they would be able to identify problems but would refer to the ward managers in order to escalate any specific issues in this regard.

We noted that there could be a possible breach to confidentiality because we saw patient information being recorded on a white board in the main thoroughfare of the Ward. It would be best practice to record initials or Patient Identification numbers rather than names.

There was a well organised treatment room where all cupboards were labelled clearly. The medicine fridge was not locked because the fridge had been condemned and a new one was on order. Therefore there was a potential risk of unauthorised persons accessing the fridge. Controlled drugs were stored in a locked cupboard and were checked daily by evening staff. Medication was administered by nurses wearing red tabards so that they would not be disturbed. We observed patients wearing identification wrist bands which were checked prior to administering any medication. Drugs trolleys were not left unattended at any time and there was no evidence of drugs being left for patients to take later. Medication administration charts had been completed appropriately. The health board medication policy was available in the ward office, this included the policy for self administration. There were locked drawers available for patients able to self administer their medication.

⁷ DATIX software is a tool used within the NHS used to record, investigate, analyse causes of adverse events and near misses.

Recommendation:

- General identifying information needs to be kept confidential.

Next Steps

The Health Board is required to complete an Improvement Plan (Appendix A) to address the key findings from the inspection and submit their Improvement Plan to HIW within two weeks of the publication of this report.

The Health Board Improvement Plan should clearly state when and how the findings identified within the Accident and Emergency Department at the university Hospital for W will be addressed, including timescales. The Health Board should ensure that the findings from this inspection are not systemic across other departments/ units of the Health Board.

The Health Boards Improvement Plan, once agreed, will be published on Health Inspectorate Wales website and will be evaluated as part of the ongoing Dignity and Essential Care inspection process.

Appendix A

Dignity and Essential Care: Improvement Plan
Hospital: Prince Philip Hospital
Ward/ Department: Ward 4
Date of inspection:

Finding	Health Board Action	Responsible Officer	Timescale
Fundamentals of Care			
We noted on the patients hospital notes that there were many instances where the medical doctors had recorded information, had signed but had not printed their name or designation.			
In one patients notes the Fundamentals of Care had not been completed although the patient had been on the ward for a week. In another instance the "This is me" and "Butterfly" documents were in the patients file but had not been completed. Finally we noted that, where there was evidence of care plans, they were generic not patient centred and one was not signed and dated.			
We could not be assured that patients health, personal and social care needs were always assessed and set out in a regularly reviewed			

plan of care.			
We did not see the use of privacy signage on the curtains around the beds.			
Although there were pain score charts available it was difficult to evidence measurement of outcomes in the care plans / notes.			
We did not see any continence assessments recorded in patient notes. Staff stated that they used their professional judgement when deciding on which pads to use.			
Management and Leadership			
We noted that there could be a possible breach to confidentiality because we saw patient information being recorded on a white board in the main thoroughfare of the Ward.			
It was noted that there was no day room available.			