Priory Church Village HIW action plan.

Hospital: Priory Church Village

Date of inspection: **15, 16 ,17th April 2014**

Date of Action Plan: **29 April 2014 (updated 18/06/14)**

Hospital Director: **Dean Harries**

RAG Rating
Green = Action Completed
Amber = Action in Progress
Red = Action Over Timescale for Completion

Outcome/ Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
Outcome/Standard – (insert outcome/standard)							
Regulation 15 (5) (a) & (b) & 26 (2)(a)	**A range of drugs were being stored and treated as controlled drugs when they were not.**	1. Drugs liable to misuse should be managed under the appropriate procedure. 2. Ashtons drug competency check list to be completed for all nurses on site.	New controlled drugs, and drugs liable to misuse all now monitored. Drug competencies now completed.	CSM		26th may 2014	26th may
	Some prescribed medication had no instruction.	3. A full check of all medication instructions on the prescription chart. 4. Site to regularly work with Ashtons pharmacy audit when in place (01.05.14)	Pharmacist from Ashtons visits this monthly.	CSM		16th of May	16th may
	Some prescribed medication was out of stock.	5. A full check on all prescribed medication and stock to take place and missing medication to be ordered.	CSM has completed this with Ashtons pharmacist. All medication is now ordered via online system and with pharmacist input.	CSM		16th May	16th may 2014
	A change was made to one medication which was not rewritten on the chart.	6. Prescriber to be informed of this error. 7. CSM to communicate with all nurses to raise this with the prescriber if this is noticed. 8. To set up a process to monitor ashtons medication audits going forward.	Ashtons now in place and monitoring this.	CSM, HD		30th May 2014	30th may 2014
	Some medication	9. Storage of medication to be reviewed and changes to be	Medication under sink has been moved. DLM's no longer in CD	CSM, HD.		6th of June 2014	6th june 2014

Outcome/ Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
	storage was not appropriate.	made. 10. Storage of medications to be checked as an additional item on the Environmental Quality Round – add as site specific issue. 11. To include storage as an aspect in the Ashtons medicine training.	cabinet. Storage of medication has been added to the walkaround document. This has been discussed with pharmacist and will form part of the medication training.				
	The RC was not signing all medication on the prescription charts.	12. RC to sign prescription charts and monitor compliance via the ashtons medication audit.	Ongoing with RC. RC has agreed to sign all physical medication and currently working through medical assessments for all patients.	CSM, HD		6th of June 2014.	
Regulation 15 (1) (a) (b) & (c)	**Patients do not have discharge plans.**	1. Discharge plans to be developed for all patients by the MDT.	All patients now have discharge care plans.	CSM		6th June 2014	
	No evidence of MDT input into care plans.	2. Care plans to be discussed at ward rounds and MDT meetings to ensure all have MDT input. 3. To be monitored via the Documentation Quality Walk Round – add to site specific issue to the tool.	75% of patients have now been reviewed in ward round. 3 patients seen every week, therefore 12 every 4 weeks. Added to walk round doc and walk round document completed.	MDT.		4th July 2014	
	No risk management plan for one patient on 'within eyesight 1:1' observations.	4. Risk management plans to be developed for all patients. 5. Training to be arranged and provided for all nurses.	Risk management plans are now in place for patients. Training from quality lead has been provided to nursing team.	CSM		June 20th 2014	6th of may 2014
	Care plans did not cover all risks highlighted in the risk assessment.	6. To audit regularly and review the risk assessment and care planning process to ensure all areas identified are addressed. 7. To review care plans to ensure that they contain appropriate language and provide feedback to nurses.	Risk assessments now have full risk management plans and all areas identified have been addressed.	CSM		13th June 2014	15th June 2014

Outcome/ Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
		8. To monitor for improvement via the Documentation Quality Walkaround.					
	Some patients who may be subject to restraint did not have a restraint care plan.	9. MVA care plans to be put in place for all patients evidencing patient involvement and making clear any advanced statements on how they would like to be helped should their behavior become unsettled.	Care plans have been developed and in place.	CSM		13th June 2014	
	Wound care plans were poor in detail and lacked direction.	10. Wound care – care plans to be put in place for the patients that require this and to ensure the correct amount of detail is included in order for staff to know how to correctly manage the wound and be able to measure the wound for improvement. 11. To develop a relationship with the local community nursing team (such as district nurse or tissue viability nurse) so that advice can be sought on wound care as required. 12. Further training to be sought and provided.	Wound care has been reviewed on site and care plans are being developed. Letter has been sent to surgery, awaiting response.	CSM		31st July 2014	
	Diabetes care on site is poor. Irregular recording of blood glucose, occasionally after food and no leg/foot checks are occurring. Weighing stated in care plan as	13. A full review of physical healthcare on site to be presented to clinical governance. 14. Training on diabetes care to be sought. 15. Care plans to be reviewed for all physical health needs ensuring that they are measurable and frequency of physical health observations are specifically	On track.	CSM		14th July 2014	

Outcome/ Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
	regularly but not sure how often regularly is.	recorded. 16. Physical care to be discussed in all qualified meetings as a regular agenda item. 17. Need to monitor that physical healthcare observations are being completed as prescribed daily – this needs to be added to the shift planner to be done by the nurse in charge before the end of each shift. 18. To ensure the relevant physical health monitoring equipment is in place such as blood glucose strips.					
	Patients did not have access to podiatry services.	19. A podiatrist to be put in place for the patients.	This is now in place.	CSM			29/04/14
	One patient stated that they are suffering with leg pain, no care plan for leg pain/pain relief in place.	20. Care plans to be put in place for all patients who feel pain for pain care/relief or to be included in the physical health care plan.	To be discussed at June MDT with new RC inline with sign off date.	CSM		14th July 2014	
	Patient, carer, relative, advocate involvement on care plans have been left blank.	21. All care plans to be reviewed for patient involvement. 22. Monitor for sustained improvement via the quality walk round. 23. Where a patient is not involved then another party should have input recorded.	This has been added to the quality walkaround. HD and CSM have met with advocate to ensure patients feel able to discuss their care plans.	CSM		14th July 2014	
	All patients should have a PBS plan.	24. To commence training of staff and support from the quality improvement lead. 25. To allocate PBS plans to staff members to complete	HD has contacted ABMU to provide PBS training to the team at Church Village. Application forms received.	HD		29th August 2014	

Outcome/ Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
		and put in place.					
Regulation 15 (1) (a) (b) & (c) & 18 (2) (1) & (b)	**The role of the MDT was not functioning effectively, evidence of broken relationships and an inability to understand each others roles.**	1. Quality lead to work with the MDT to improve outcomes for patients. 2. HD to address any further issues.	Quality lead has undertaken one visit to the MDT meetings on site.	HD		25th July 2014	
Regulation 20 (2) (a) & (c) & Regulation 21 (2) (d)	**HR files contain historical information, duplicate information and there is an inconsistency of information across the files.**	1. Administrator to review HR files. 2. Historical information to be archived. 3. A consistent approach to be taken for all files.	HD has directed administrator to meet this requirement via supervision. Will review with Administrator before 9th June.	Administrator		27th June 2014	
	Mandatory training shows some staff members have out of date training.	4. HD and CSM to address FFG compliance with all staff.	An updated FFg compliance plan has been developed. Management team are now implementing this.	CSM, HD		20th June 2014	
Regulation 15 (1) (a) (b) & (c) & 20 (1) (b)	**A review of bank staff is required to find a permanent solution to staffing.**	1. To develop a recruitment and retention plan for site. 2. To monitor progress of implementation of this plan at the clinical governance meeting.	Recruitment is taking place an ongoing to fill all vacancies and recruit beyond establishment. 4 nurses have been offered and accepted positions at the hospital. The hospital has also recruited 8 HCA's.	HD		20th June 2014	
Regulation 15 (1) (a) (b) & (c)	**There was a lack of meaningful**	1. HD to address with OT and activities coordinator to address this and build links	HD has met with OT Team and directed this as an action. HD will meet with OT to review	HD and MDT		20th June 2014	

Outcome/ Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
	links to the community such as voluntary work, attending college courses and group activities.	with the community.	this before 9th of June 2014. Reviewed at Ward round 16th of June. Will be implemented by the Activities coordinator.				
Regulation 15 (1) (a) (b) & (c)	**One patient was being administered medication without appropriate authorization under part 4 of the act.**	1. CSM to address with MHA administrator to ensure this is in place for all new admissions.	Completed, MHA administrator addressed this with patients primary nurse.	CSM, MHA administrator		16th may 2014	16th may 2014
Regulation 28 (2) (a) (b) (c) & (3) & 4 (a) (b) (c) & 5 (a) (b) & (c)	**Under Regulation 28 the registered provider must provide a written report on the regulatory areas of the site to HIW on a 6 monthly basis.**	1. HD to discuss with Ops director on how to achieve this.	Operations director has now achieved this and a visit will take place in June.	HD, ops director.		4th August 2014.	