Priory Church Village HIW action plan.

Hospital: Priory Church Village

Date of inspection: 2nd 3rd and 4th September 2014

Date of Action Plan: 25th September 2014 (updated 14/11/14)

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)							
1. Regulation 15 (1) (a) (b) (c) & (d)	**Four Sets of Care Notes were examined.** Many issues were raised regarding the admission process, due to 3 admissions in two weeks. Care plans lacked detail and direction. Review on occasion was brief and not in sufficient detail. Patients who had recently sustained injury did not have relevant care plans i.e. pain management. Patient who had	• Audit of care plans to be conducted weekly by nursing team to identify issues and also to develop the junior nursing team to understand level of detail required based on training provided by the QIL.	Audit undertaken and presented to CG. Action plan to be discussed in nurse meeting.	Clinical Services Manager. CSM		28/11/14	
		• Care planning to be included in supervision with nursing team with individual coaching from the WM, CSM and QIL.	Care planning was included in the nurse group supervision day. Coaching to continue and progress reviewed by SMT.	CSM		01/12/14	
		• CSM to lead qualified meetings monthly.	Occurred for October, November has been arranged.	CSM		01/12/14	

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	toe nail removal did not have care plan regarding this. .	• Care plan audits to be presented monthly to clinical governance meetings.		CSM		01/01/15	
2. Regulation 20 (2) (a)	**Supervision not in place for majority of staff.**	• CSM to ensure supervision is being carried out and to keep a log on the FFg system.	Log is kept on FFG, Supervision is being carried out and is logged.	CSM		30/10/14	30/10/14
		• Supervision to be audited monthly and taken to clinical governance meetings to monitor performance.	This was taken to November CG. All supervisions that have been carried out have been logged.	CSM		01/01/15	14/11/14
3. Regulation 20 (1) (a) & (2) (a)	**A number of staff had not received MVA training.**	3.0 MVA to be above 90% compliant and to monitor compliance via clinical governance meetings.	Both MVA train the trainers are undertaking the refresher course the week beginning 10/11/14. Currently ay 90.9% need to maintain.	HD		30/11/14	
4. Regulation 19 (2) (c) (i)	**A number of staff said that there was a lack of debrief.**	4.0 Debriefs to occur following all incidents of restraint.	Debriefs have commenced for incidents involving restraint. To review forms at December CG.	CSM		30/11/14	
		4.1 Debrief records be filed in incident record book.	Debriefs are being recorded on the incident reporting system.	CSM		30/11/14	
		5.0 Debrief records to be reviewed at clinical governance.	To be reviewed at December CG.	CSM		01/01/15	
5. Regulation 15 (1) (b) & (c)	**A number of staff had no access to the shared drive system.**	• HD to ensure staff have access to appropriate IT facilities.	All staff have access to facilities and a sheet is available for those to state if passwords are lost etc.	HD		31/10/14	31/10/14
6. Regulation 15 (1) (a) (b) and (c)	**There was no information at ward level in**	6.0 Activity Coordinator to be recruited and to lead on this.	Activity coordinator recruited and has information that will be displayed on the ward.	HD		15/11/14	14/11/14

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	relation to community activities for patients.	6.1 SMT to review access to community activities for patients.		HD/CSM		01/12/14	
		6.2 Activities offered to be advertised to all patients and information available on ward.	Activities are now available on the ward.	CSM		01/12/14	
7. Regulation 15 (1) (a) (b) & (c) and 19 (1) (a) and (b)	**Some decisions taken were arbitrary and a blanket approach –** this related to limiting amount of DVD's in patients bedrooms.	• SMT to review arbitrary decision making on site and take to clinical governance.	Have Priory Secure Services restrictive practice tool and will be reviewing onsite activities. Feedback to December CG.	HD/CSM		01/12/14	
		• To complete a self-assessment of restricted practices with a staff group.	As above.	HD/CSM		01/01/15	
8. Regulation 15 (5) (a) and (b)	• **One error on drug administration chart found.** • **No label on a cream opened in the medication room.** • **Error in a medication that was transcribed on the medication chart.**	• Ward Manager and CSM to continue to address Ashtons audit issues.	Ashtons audits are completed by ward manager.	CSM		30/11/14	01/11/14
		• Raise Ashtons audit issues in clinical governance and qualified meetings.	Completed for October CG and was discussed in November. Downward trend noted in medication issues.	CSM		01/12/14	01/11/14
9. Mental Health Act.	**Mental health act audits were well completed however an**	9.0 Ensure action plan is kept on same file as audit (action plan was available but not filed in same place and was provided to	Separate audit file now kept (previously on CG file) for ease of access to audits and their action plans.	HD/CSM		15/10/14	01/11/14

Outcome/ Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
	action plan in response to audits was not always available.	HIW)					