Mental Health Act Monitoring Inspection: NHS Mental Health Service (Unannounced)

Princess of Wales Hospital/Ward 14 & Psychiatric Intensive Care Unit (PICU)/ Abertawe Bro Morgannwg University Health Board

Inspection date: 21 November 2017

Publication date: 22 February 2017

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@wales.gsi.gov.uk**

Fax: **0300 062 8387**
Website: **www.hiw.org.uk**

Digital ISBN 978-1-78903-191-1

Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced NHS Mental Health Act monitoring inspection of Princess of Wales hospital within Abertawe Bro Morgannwg University Health Board on 21 November 2017. The following wards were visited during this inspection:

- Ward 14
- Psychiatric Intensive Care Unit (PICU)

Our team, for the inspection comprised of a HIW inspector and a Mental Health Act peer reviewer.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act. We look at how the service complies with:

- Mental Health Act 1983
- Mental Health (Wales) Measure 2010
- Mental Capacity Act 2005

HIW also explored how the service met aspects of the Health and Care Standards (2015).

Further details about how we conduct NHS Mental Health Act monitoring inspections can be found in Section 5 and on our website.

2. Summary of our inspection

We found that the requirements of the Mental Health Act and Code of Practice were being met. Patient records were appropriately organised and easy to navigate and obtained relevant information. The paperwork we reviewed was detailed and there was clear accountability and evidence of how decisions relating to patient care were made.

A programme of audits, including patient files, controlled drugs and infection control ensured high standards were maintained and any actions identified were followed up. Results of audits were communicated and shared with staff.

The environment was clean and generally well maintained. We recommended some improvements on ward 14 that will ensure high standards are continued.

Through discussions with staff and observations on both wards we concluded there was good team working taking place and staff were committed to providing patient care to high standards.

We saw on ward 14 some nurse alarm call bells located on the outside of some bedrooms and we have recommended that the health board review this to ensure patients' safety is not compromised should they need assistance.

This is what we found the service did well:

- The Mental Health Act team delivered in-house, bespoke Mental Health Act training for student, qualified and general nurses and staff
- Regular audits ensured standards were maintained and any actions identified follow up
- 'Welcome Boards' provided comprehensive information in English and Welsh for visitors and patients

- The Mental Health Act team and ward staff worked together to ensure Mental Health Act paperwork was compliant with the Act and Code of Practice. Support and advice was provided to ward staff to maintain this standard regularly and when needed

This is what we recommend the service could improve:

- Review the accessibility of the nurse call alarm bells on ward 14 to ensure patient safety is not compromised by their current location
- Improve some areas on ward 14, specifically, repair the patient payphone and damaged fire door. Ensure curtains (or similar) are available in all patient bedrooms to protect patient privacy and dignity.
- Review the visiting arrangements on ward 14 to ensure that patients and visitors are given privacy to meet and talk without being overheard by others when using the dining room

3. What we found

Background of the service

The Princess of Wales hospital provides NHS mental health services at Coity Road, Bridgend, CF31 1RQ, part of Abertawe Bro Morganwwg University Health Board.

Coity Clinic is the mental health unit within the Princess of Wales Hospital site which provides assessment, therapeutic interventions and support for individuals experiencing an acute mental health episode where inpatient care is necessary.

Coity Clinic contains ward environments designed specifically to meet the needs of older people, people with dementia and younger adults as well as a Psychiatric Intensive Care Unit for people with short term complex needs.

Ward 14 is a 20-bedded, acute assessment unit for both male and female patients. At the time of our visit, there were 20 patients being accommodated, with two patients on leave.

The psychiatric intensive care unit (PICU) is an eight-bedded unit for both male and female patients. At the time of our visit, six patients were being accommodated.

Both wards had a staff team which included consultants, psychologists, occupational therapists, pharmacists, nurses, health care assistants and hotel services staff.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We observed staff treating patients respectfully and with kindness during our inspection.

Notice and welcome boards provided comprehensive information for both patients and visitors. Systems to obtain feedback from patients and visitors were in place and results were displayed. The communication and patient experience teams ensured that feedback was followed-up.

Social and leisure activities were offered and we observed patients engaged in activities during our visit.

We have recommended that the payphone on ward 14 is repaired so patients have this as a means of maintaining contact with family and friends. We also recommended that the arrangement in place on ward 14 whereby the dining room is mainly used by visitors is reviewed. This is to ensure that private and sensitive conversations cannot be overheard by other visitors when present.

During our inspection, we offered patients, staff and visitors the opportunity to speak with us. Those that we spoke with, told us that there was good care and treatment being provided and that the staff were "an awesome team".

Staying healthy

Staff told us that patients were encouraged to maintain a healthy lifestyle and we saw some healthy eating information displayed next to the kitchen serving hatch on the Psychiatric Intensive Care Unit (PICU). Patients on both wards were provided with choices of what they wanted to eat and drink and there were snacks and drinks readily available outside of set mealtimes. We observed patients receiving snacks during our visit.

Patients were able to move freely on both wards and ligature points[1] had been assessed throughout the ward environments and risks limited as appropriate for the patient groups. Both wards were suitable to accommodate anyone requiring a mobility aid.

Gardens were easily accessible on both wards, with each ward having a notice to indicate access times to these areas (open at 6am until midnight). The gardens provided some planted areas and seating to encourage the use of the outside spaces.

Ward 14 had specific male and female lounge areas and there was a large activity area. One activity room had a pool table and the other room had seating and tables whereby patients could participate in arts and crafts, games, reading and puzzles. The room had a TV and DVD player. During our visit we saw a number of patients and staff participating in activities. This meant that there were arrangements in place to ensure patients were appropriately stimulated and occupied.

A gym was situated between ward 14 and PICU. The room was well equipped, including a treadmill, bike and weights. Patients from both wards shared this facility and we were told it was well utilised.

The PICU had an open plan living/dining area. There was also a quiet lounge on the ward, so patients could spend time away from others in accordance to their wishes and preferences. Books, radios and televisions were available in these areas for patients' use.

Both wards were secured from unauthorised access by an intercom system. Access to both wards was appropriate to maintain the safety, privacy and dignity of patients on the wards.

In each ward office, there was a patient status board[2] displaying confidential information regarding each patient being cared for on the ward. There were

---

[1] A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.

[2] A board that provides staff with a quick reference to essential information about the individual patients being cared for on the ward.

facilities to hide the confidential information when the boards were not in use. This meant that the staff team were making every effort to protect patient confidentiality.

Dignified care

We observed staff on both wards interacting and engaging with patients appropriately and treating patients with dignity and respect. There was also evidence that staff addressed patients by their preferred name. In addition, the staff we spoke to, were enthusiastic about how they supported and cared for the patients.

On both wards, we observed that each bedroom had an observation panel (window) in the door and we saw that these were mainly in the open position. As patients could not operate these from within their bedroom, observation panels should be closed for privacy and only open for observation, or if the patient chooses.

On ward 14, in addition to some single occupancy bedrooms there were also some double and dormitory style bedrooms. Curtains were used as 'dividers' within these areas, but this did not promote and uphold patients' dignity and privacy for providing dignified care. During the feedback meeting, we therefore advised the health board to consider the appropriateness of these rooms in providing dignified care and that any future refurbishment plans take this into consideration.

Patient information

Welcome boards in English and Welsh on each ward provided comprehensive information for visitors. Information provided included the values and standards of care, infection control advice, visiting times, staff uniforms explained and how to submit feedback.

In addition to the welcome boards, notice boards were displayed on the wards and in the corridors of the Coity Unit. Ward 14 had patient information about specific health issues including Hepatitis B, HIV and alcohol and drug services. Activity information was located near the activity room on ward 14 and both wards displayed pictures of their staff team.

Advocacy information, results of feedback and leaflets for carers were readily available.

Communicating effectively

Through our observations of staff/patient interactions, it was evident that staff ensured that they communicated with patients effectively. Staff took time to undertake discussions using words and language suitable to the individual patient.

Staff told us that communications and patient experience teams were in place, which provided an alternative avenue for patients and visitors submitting feedback. These teams ensured that feedback was delivered to ward managers so they could make improvements to the service.

Timely care

Both wards had a multi-disciplinary team (MDT) which included a consultant, occupational therapists, psychologists and a pharmacist. Weekly multi-disciplinary meetings took place, and where applicable, community managers and home treatment staff would attend. These embedded a collaborative approach to patient centred care.

Staff told us that advocacy services attended weekly meetings on ward 14 and more regularly on PICU.

Individual care

People's rights

Legal documentation to detain patients under the Mental Health Act or restrict patients leaving the hospital, was compliant with the relevant legislation.

Patients could also utilise the Independent Mental Health Advocacy (IMHA) service and also access the Independent Mental Capacity Advocacy (IMCA) service when required.

We noted that the payphone on ward 14 was without a handset and recommended this was fixed. We were however told that patients could use the office phone and some were able to use their own mobile phones to make calls.

Staff told us that patients on ward 14 used the dining room to meet with friends and family. During the visit, we observed visitors using the dining room for this purpose. However, we considered this arrangement unsuitable because there was a lack of privacy and conversations were clearly overheard which was not appropriate due to the sensitivity of the discussions taking place. We therefore recommended that areas available to patients and their families are reviewed, this is to ensure that conversations can be held in private.

Improvement needed

The payphone on ward 14 needs to be repaired so patients can use it to maintain contact with family and friends.

A review of the visiting arrangements on ward 14 needs to take place to ensure that patients and visitors can meet in private and talk without being overheard by others

Listening and learning from feedback

Feedback forms were readily available for patients and visitors to provide feedback and were located next to a box, so that comments could be submitted anonymously.

The results from previous patient feedback were displayed, which was positive. However, staff told us that because the feedback forms were generic, some questions were not suitable for mental health patients and because of this, obscured their result. This issue was discussed during our feedback meeting. Senior managers were aware of this and were working on solutions to resolve the problem.

Staff told us that they would assist patients who provided any verbal feedback to ensure it was documented and dealt with accordingly. Any identified learning from feedback would be shared with staff, as stated.

Advocacy services were available to provide independent advice for any patient who wished to raise any concerns.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Our review of the Mental Health Act paperwork confirmed compliance with the Mental Health Act and Code of Practice. We saw comprehensive and detailed records which were easy to navigate. Regular audits ensured that the high standards observed, were maintained.

The hospital environment was clean and well maintained in general. We recommended some improvements on ward 14 to ensure this standard is upheld.

We observed some nurse call bells on ward 14 located outside the bedrooms and have recommended this is reviewed to ensure patient safety is not compromised by the location of these.

Safe care

Managing risk and promoting health and safety

There were processes in place to manage and review risks and maintain health and safety on ward 14 and PICU. Both wards provided individualised patient care that was supported by least restrictive practices, both in care planning and ward practices.

Environmentally, both wards appeared clean and PICU was maintained. However, we observed some areas on ward 14 that needed to be reviewed and improved. The fire door (leading to ward 15) was damaged and required repair to ensure patient and staff safety was not compromised. One bedroom had no curtains at the window and the wardrobe had been moved to block light within the room. We therefore advised staff of the need to ensure that curtains (or equivalent) were fitted in this room. This was to maintain patients' dignity and privacy. We were told that new seating for the male lounge had been approved, but on looking at the seating in the female and activity area, that also needed to be replaced due to the extent of wear and tear.

On ward 14, staff had access to personal alarms and we saw staff wearing these during the visit. Of the bedrooms we observed, the patient call bell was situated outside the room. Staff told us that patients with a hospital bed had an alarm attached; however, for those patients who did not require this type of bed, (but who might need to call for assistance), the location of the call bell was not conducive to safe and effective care. We therefore recommended that the health board review the locations of all patient call bells, especially in bedrooms. This is, in order to determine their accessibility and ensure that patient safety and/or dignity is not compromised by their current locations.

Both wards had sufficient space for mobility aids to be used on their wards.

Improvement needed

The following areas need to be repaired and/or improved on ward 14:

- The patient payphone needs to be repaired
- Curtains (or equivalent) need to be fitted in every bedroom to protect the privacy and dignity of patients
- The fire door needs to be repaired to ensure that staff and patient safety is not compromised
- Seating in the female lounge and activity room needs to upgraded due to wear and tear

A review of the location of patient call bells is required to ensure patient safety and dignity is not compromised due to their location

Safeguarding children and adults at risk

There were processes in place to ensure that the hospital focused on safeguarding vulnerable adults and children, with referrals being made to external agencies as and when required.

Effective care

Safe and clinically effective care

Overall, we found governance arrangements in place that helped ensure that staff on the unit provided safe and clinically effective care to patients.

A new physical health monitoring process was in place and we noted that all assessments were evidenced based which will ensure consistent clinical recommendations are made.

We noted clean clinical rooms on both wards and saw fridge temperatures were recorded daily. This meant that drugs were stored appropriately. Controlled drugs storage was also compliant with professional requirements.

Record keeping

The patient records we reviewed were paper based files and there was a 'virtual statutory folder' on the computer system which contain scanned statutory Mental Health Act paperwork. There were secure storage arrangements in place to prevent unauthorised access and breaches in confidentiality.

Of the records we reviewed, there was evidence of detailed and comprehensive record keeping. The records were well organised and easy to navigate.

Regular audits were undertaken and any actions identified were followed up to ensure patients' records were accurate, relevant and detailed.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients across two wards. The records reviewed were legally compliant within the requirements of the Mental Health Act and of a high standard, reflecting the Code of Practice[3]. The records were well arranged and all records relating to the patients detentions were present.

---

[3] The Mental Health Act 1983 Code of Practice for Wales is guidance to doctors, approved clinicians, managers and staff of hospitals, and approved mental health professionals on how they should proceed when undertaking functions and duties under the Act. It also gives guidance to doctors and other professionals about certain aspects of medical treatment for mental disorder more generally.

It is intended to be accessible to patients, carers, advocates and others who support them. The Code should also be beneficial to the Mental Health Review Tribunal for Wales, police and ambulance services, and others involved in providing services to people who are, or may become, subject to compulsion under the Act.

Of the records we reviewed, we saw clear accountability and evidence of how decisions relating to patient care were made. There were also understandable, detailed written records reflecting multi disciplinary team decisions.

The health board's mental health act administration team ensured that patients were provided with their statutory rights under the Act, including appealing against their detention. There was evidence that patients were supported by the advocacy service.

We noted that all Section 17 leave[4] had been authorised by the responsible clinician on Section 17 Leave authorisation forms. These forms were detailed and had been fully completed.

Of the records we reviewed, the detained patients on section 17 leave did not have photographs for identification on their file. It is good practice to have a photo of the patient on file as this can help with any 'absent without leave' situations.

Monitoring the Mental Health (Wales) Measure 2010

Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010[5]. We reviewed four care and treatment plans (CTP) and found that there was evidence that care co-

[4] Your responsible clinician may let you leave hospital for a certain time even though you are detained under section. This is often called 'section 17 leave', because it is section 17 of the Mental Health Act that allows this. Your leave could be: very short (e.g. for half an hour or a few hours); for a weekend (to go home, for example); for longer (up to a week). Your responsible clinician can place certain conditions on you, such as telling you where you have to stay while you are on leave. The responsible clinician can make you go back (recall you) to hospital at any time. www.mind.org.uk

[5] The Mental Health (Wales) Measure 2010 has the same legal status in Wales as other Mental Health Acts. The 2010 Measure is all about the support that should be available for people with mental health problems in Wales wherever they may be living. The Measure is intended to ensure that where mental health services are delivered, they focus more appropriately on people's individual needs. For more information: http://www.mentalhealthwales.net/mental-health-measure/

ordinators had been identified for the patients and, where appropriate, family members were involved in care planning arrangements.

We saw that advocacy services were integral to the assessment process and the advocacy referral pathway (flow chart) enabled appropriate support from the Independent Mental Health Advocacy (IMHA) service and the Independent Mental Capacity Advocacy (IMCA) service when required. There was clear evidence in the CTPs we reviewed, that advocacy services were available to all patients and information relating to these services was easily accessible.

To support patient care plans, there were an extensive range of patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them.

The plans we reviewed had clearly evidenced when a patient had refused to sign and/or agree to their CTP.

We found that Care and Treatment Plans reflected the domains of the Welsh Measure.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

Through discussions with staff and observations on both wards, we concluded there was good team working taking place. Staff were committed to providing patient care to high standards and said they felt supported by senior management.

Processes were in place for staff to receive an annual appraisal and complete mandatory training and there was a high compliance rate for these areas.

The Mental Health Act team deliver a programme of training for student, qualified and general hospital nurses and staff. This bespoke programme ensured staff had up to date knowledge and skills in this area.

The staff we spoke to were able to describe the process for reporting incidents and lessons learnt were communicated to all staff as a means of improving patient care.

Governance, leadership and accountability

We found that there were systems and processes in place to ensure that both wards focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit. The results of which are submitted to senior managers so outcomes can be monitored and clinical outcomes discussed regarding the delivery of patient care.

There was dedicated and passionate leadership from the ward managers who were supported by committed ward teams, strong multi-disciplinary teams and

senior managers who regularly attended both wards. We found that staff were committed to providing patient care to high standards.

Staff spoke positively about the leadership and support provided by the ward managers on both wards. Staff also commented that team-working on the wards was very good.

It was positive that throughout the inspection that the staff on both wards were receptive to our views, findings and recommendations.

Staff and resources

Workforce

Staff told us, and we observed that, both wards had teams that evidenced good team working and motivated individuals to provide dedicated care for patients. It was positive to hear the impact the multi disciplinary team was having on the patient groups.

We reviewed staff training and noted that there was a mandatory programme in place for all staff. Systems were in place on each ward to monitor completion rates and regular review of the information by ward manager's ensured staff remained up to date. Staff told us they could access additional and relevant training with line manager approval which was recorded on the training spreadsheet.

Discussions with staff highlighted that specific Mental Health Act training was delivered by the Mental Health Act team. There were programmes in place for student nurses, a rolling programme for qualified nurses and training sessions for general hospital staff. This bespoke training ensured that staff had up to date knowledge and skills in this area.

Staff were receiving annual, documented appraisals with completion dates recorded. Variations of formal and informal supervision were taking place, depending on what was required. Staff meetings were in place and sharing learning from incidents and/or feedback is discussed with staff.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we conduct NHS Mental Health Act monitoring inspections

Our NHS Mental Health Act monitoring inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

During our NHS Mental Health Act monitoring inspections will look at how services:

- Comply with the Mental Health Act 1983, Mental Health (Wales) Measure 2010 and Mental Capacity Act 2005
- Meet aspects of the Health and Care Standards 2015

We also consider other professional standards and guidance as applicable. These inspections capture a snapshot of the standards of care within NHS mental health services.

Further detail about how HIW inspects mental health and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection			

Appendix B – Immediate improvement plan

Service: Princess of Wales Hospital

Ward(s): Ward 14 & PICU

Date of inspection: 21 November 2017

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No immediate assurance issues identified				

Appendix C – Improvement plan

Service: Princess of Wales Hospital

Ward(s): Ward 14 & PICU

Date of inspection: 21 November 2017

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Time scale	Update
Quality of the patient experience					
The payphone on ward 14 needs to be repaired so patients can use it to maintain contact with family and friends.	6.2 People's rights	Repair previously requested, will escalate to IT lead and switchboard lead within POW for action. The ward facilitates patient's use of their own mobile phones in line with the Health Board's Mobile Communications Policy. Those patients who do not have access to a mobile phone, the ward staff	Ward Manager	31st Jan 2018	

Improvement needed	Standard	Service action	Responsible officer	Time scale	Update
		facilitate the use of a landline on Ward 14.			
A review of the visiting arrangements on ward 14 needs to take place to ensure that patients and visitors can meet in private and talk without being overheard by others	2.1 Managing risk and promoting health and safety 2.7 Safeguarding children and safeguarding adults at risk 4.1	The dining room is used as a visiting area while acknowledging it does not allow for complete privacy due to the open layout. Interview rooms are available outside the entrance to the ward and two rooms on the first floor which can be used when appropriately risk assessed. As part of patient's recovery plan patients are encouraged to leave the ward and use the public facilities within Princess of Wales Hospital for contact with their relatives and friends when deemed appropriate in line with	Ward Manager and Service Manager	31st Jan 2018	

Improvement needed	Standard	Service action	Responsible officer	Time scale	Update
	Dignified care	their risk assessment. Ward manager and service manager will meet to undertake a review of room availability both on and off the ward to improve the privacy for patients and relatives when visiting.			
Delivery of safe and effective care					
The following areas need to be repaired and/or improved on ward 14: The patient payphone needs to be repaired Curtains (or equivalent) need to be in every bedroom to protect the privacy and dignity of patients	2.1 Managing risk and promoting health and safety 2.9 Medical devices, equipment	Payphone – see above Quote has been requested by the providers. Once received will place an order for replacement curtains for the window. Previous repair requested. Has been escalate to estates manager at POW	Ward Manager Locality Manager	31st Jan 2018 31st Jan	

Improvement needed	Standard	Service action	Responsible officer	Time scale	Update
	and diagnostic systems	for urgent repair. Arrange for costs for replacing seating and submit for approval.	Ward manager / Locality Manager	2018 31st Jan 2018	
The fire door needs to be repaired to ensure that staff and patient safety is not compromised. Seating in the female lounge and activity room needs to upgraded due to wear and tear.					
A review of the location of patient call bells is required to ensure patient safety and dignity is not compromised	2.1 Managing risk	Ward manager completed review of the nurse call system within the ward. The bedrooms that have	Ward manager	complete d	

Improvement needed	Standard	Service action	Responsible officer	Time scale	Update
	and promoting health and safety 2.9 Medical devices, equipment and diagnostic systems 3.1 Safe and clinically effective care	call bells situated outside of the bedrooms are all in close proximity to the main staff areas i.e. the office / dining room / kitchen area. These rooms are designed for used for those patients who need increased observations so staff members are always within the vicinity. The rooms further away from the main staff areas have call bells within the actual rooms. The ward manager will ensure that this management plan is in place for all admissions and that all staff are aware			
Quality of management and leadership					

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Dermot Nolan**

Job role: **Locality Manager**

Date: **27/12/17**