Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Focussed Independent Mental Health Service Inspection (Unannounced)

Regis Healthcare Limited

Brenin Ward

Inspection date: 9 – 11 December 2018

Publication date: 12 March 2019

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@gov.wales**

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

Digital ISBN 978-183876-013-7

Contents

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

Our purpose

To check that people in Wales receive good quality healthcare.

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

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 focussed independent mental health inspection of Regis Ebbw Vale on the evening of 9 December 2018 and following days of 10 and 11 December.

This is the fifth inspection of this service since March 2018 with significant concerns being identified in all previous inspections. Following the inspection in September 2018 a Notice of Proposal to cancel the registration of Regis Healthcare was issued on 26 September 2018. In line with the legal process, Regis Healthcare sent written representations to HIW on 23 October 2018.

The purpose of this inspection therefore was to evaluate the written representations made by Regis Healthcare and to assess progress with recommendations made in the inspections conducted during 2018.

The following sites and wards were visited during this inspection:

- Brenin Ward – Low Secure Child and Adolescent Mental Health Service

Our team, for the inspection comprised of one HIW inspector and two clinical peer reviewers. The inspection was led by a HIW inspection manager.

2. Summary of our inspection

The registered provider had completed recruitment of registered mental health nurses and healthcare support workers which eliminated the requirement to use agency staff to fulfil staffing rotas. We observed professional and caring interactions between staff members and patients.

However, significant improvements are still required in the completion of clinical documentation to correctly record the care provided at the hospital.

Given the areas for improvement still required, we are not fully assured that Regis Healthcare is providing safe and clinically effective care.

HIW require assurance that issues fundamental to patient care and safety are addressed at pace. The registered provider must ensure that actions are sustainable and maintained through established governance arrangements.

This is what we found the service did well:

- The recruitment of a consistent workforce
- The completion of mandatory training
- The recording of PRN[1] medication
- The Recording of section 17 leave.

[1] PRN (pro re nata) medication is administered “as needed” as opposed to medication given at regular intervals.

This is what we recommend the service could improve:

- Clinical recordkeeping
- The completion of care planning documentation
- The completion of de-escalation and restraint documentation
- The completion of contemporaneous patient records

We identified regulatory breaches during this inspection regarding the matters listed above, further details can be found in Appendix A.

HIW will now use the findings of this inspection and the provider's response along with the representations made in response to the Notice of Proposal to cancel registration to inform the decision on whether HIW upholds the Notice of Proposal to cancel and issues a Notice of Decision to cancel, or it accepts the representations submitted by Regis Healthcare.

In the meantime Regis Healthcare remains under the highest level of scrutiny and HIW will be monitoring the service closely and is in regular contact with the commissioners of patients at the hospital.

3. Background of the service

Regis Healthcare Limited is an Independent Hospital for Children and Adolescent Mental Health (CAMHS) at Ebbw Vale Hospital, Hillside, Gwent NP23 5YA.

The service has two wards, Ebbw and Brenin, both have 12 beds and offer care to people under the age of 18 years. At the time of the inspection Ebbw was closed.

The service was first registered on 15 January 2014.

The service employs a staff team which included a Managing Director, Hospital Director, HR Director, Finance Director, Medical Director, Ward Doctor, Ward Manager, Deputy Ward Manager, registered nurses (RMNs and RGN), Senior Support Workers and Support Workers.

The multi-disciplinary team includes psychiatrists, psychologist, assistant psychologists, occupational therapists, technical assistants, teachers and activities co-ordinators. There was also a large administrative team which supported the clinical teams in the daily running of the hospital.

Delivery of safe and effective care

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

The care documentation and other associated records at the hospital were paper based. As identified in previous inspections the hospital had numerous files for each individual patient. The records were disorganised and fragmented which meant that both hospital staff and HIW's inspection team found it very difficult to navigate and track information contained within the records. It was not possible to read a patient's file and easily identify the care required and being given to that patient.

Whilst we observed there to be a few up to date and well written care planning documents held within some patients' records, a large proportion of documentation was out of date. There were significant inconsistencies in the information recorded, with some documentation not clearly recording the action required, the responsible person, timeframe and review date. Care plans did not always refer to or reflect national professional guidance such as, National Institute for Health and Care Excellence (NICE) and Nursing & Midwifery Council 'The Code'.

The registered provider had not ratified a specific care plan template at the hospital, therefore there were a number of different formats which further complicated the review of care provision.

Improvement needed

The registered provider must ensure that patient records are organised and hold the most up to date information.

The registered provider must ensure that there is an agreed care plan format at the hospital and that this is used.

We reviewed the patient records and care planning documentation in detail for three patients.

For Patient A there were two well written care plans in place; these were for physical health and electro compulsive therapy (ECT). Both care plans had a clear format and documented the needs identified, goals, interventions and evaluation. However, the care plans did not document who wrote them or any review dates. Older care plans for this patient e.g. anti-ligature clothing and

bathroom access, whilst these had review dates, they were less detailed and more difficult to follow. The patient's records included documentation relating to diet restricting behaviours, nasogastric (NG) tube feeding and weight management. However, these pieces of information were disjointed and written in isolation; they did not provide care plan formulation that incorporated these elements of patient care or show reference to any NICE guidelines.

It was positive to note, through reading the Patient A's records and speaking to staff members, that there was a person centred approach to the patient's care that included the views and wishes of relevant family member.

For Patient B there was a risk reduction care plan in place that was of completed to a satisfactory standard which also considered the patient's preferences as to the method of restraint to be used if required. Whilst this care plan had been completed on 12 October 2018 and signed by the patient, it was due to be reviewed by 13 November; there was no evidence to confirm that this had been completed.

For Patient C there was a detailed flashback care plan in place that was dated the 10 December 2018. However this information was not reflected in a positive behavioural support (PBS) plan. There were inconsistencies with the management and recording of nutrition and diet for this patient. Within the patient's physical health file (maintained separately by the registered provider's practice nurse) there was a "meal plan" that provided actions around the patient's nutrition. There were also 24-hour observation forms in place for this patient which included recording the patient's food and fluid intake. This information should have translated in to a specific care plan but this was not in place.

Improvement needed

The registered provider must ensure that all patients have up to date care plans to manage their individualised risks and needs.

The registered provider must ensure that all care plans are specific, measurable, achievable, realistic and, timely (SMART).

The registered provider must ensure that all care plans are regularly reviewed and updated.

In addition we noted that the 9 December food and fluid intake section of the 24-hour observation form for Patient C was blank whilst the patient's contemporaneous notes simply stated that the patient "maintained adequate diet and fluid" in reference to their nutrition and diet for that day.

This prompted the inspection team to review a further four patients' 24-hour observation records for that date; these were incomplete with regards to the food and fluid intake, with a maximum of two entries on the daily food and fluid form and the remainder being left blank. Therefore it was not clear whether the patients had not consumed food or drink at these other times or whether staff had omitted to complete the form. If food or fluid is not consumed then this should be clearly documented and not left blank. Similarly any dietary intake must also be detailed.

For Patient C we reviewed the 24-hour observation forms for the period of 1 October 2018 through to 28 November 2018. The observation forms for the period of 25 October to 5 November were not available for review, therefore we cannot be assured that these were completed.

Improvement needed

The registered provider must ensure that all documentation is completed in full to reflect the patient's food and fluid intake.

The registered provider must ensure that all 24-hour observation forms are correctly filed.

On 19 November 2018 the registered provider had commenced a multi-disciplinary team (MDT) daily handover process as part of reviewing changes and developments of the individual care needs of the patients at the hospital. On 23 November it had been identified and agreed that patients at the hospital need to be provided with a sexual health clinic, education and knowledge and this should be developed in a care plan for each patient; this had not commenced at the time of our inspection.

Improvement needed

The registered provider must ensure that there is an up-to-date care plan in place for each patient regarding sexual health.

The registered provider must ensure that there are governance processes in place to check that actions agreed by the MDT are completed in a timely fashion.

We reviewed the registered provider's Use of Restrictive Physical Intervention Policy October 2018. This document was not reflective of the current practice in place at the hospital or its status as independent health care provider. Throughout the policy it referred to "health board" and included details of health

board structures and processes, such as the “NHS Putting Things Right” complaints process. The policy also referred in places to patients as adults and referenced the Deprivation of Liberty Safeguards (DoLS) which is not applicable to persons aged under 18 years.

The policy also referred to prone floor restraint despite assurances from the registered provider, during this and previous inspections, that this type of restraint is not used at the hospital.

Improvement needed

The registered provider must ensure that its Use of Restrictive Physical Intervention Policy reflects current practice in place at the hospital as an independent health care provider.

The registered provider must ensure that its Use of Restrictive Physical Intervention Policy is written for providing care to persons aged under 18 years.

We reviewed a large sample of de-escalation and restraint records spanning the previous two months; we identified inconsistencies in staff practice and regular poor standards of record keeping.

De-escalation and restraint records were completed and maintained as paper records, these were held within file(s) for the month in which they occurred. However, there was no systematic filing system in each of the monthly files nor were de-escalation and restraint records numbered/catalogued. This meant it was not possible to easily review the completed forms and be assured that they were all present and all episodes of de-escalation and restraint were accounted for. There was an entry in one patient’s contemporaneous record of “safe hand hold” but the corresponding restraint form was not present; therefore this was either not completed or it had been mislaid.

Improvement needed

The registered provider must ensure that there are systematic filing and cataloguing arrangements in place for de-escalation and restraint records so that all records are stored and readily available.

The registered provider must ensure that all instances of de-escalation and restraint are recorded on the associated paperwork as well as the contemporaneous record.

The registered provider had introduced a “Stop the Clock” practice with regards to restraint; where staff, if safe to do so, would not restrain a patient for more than 9 minutes.

However, some staff were documenting with the use of body maps each nine minute period of restraint on the form, even if there was no release from the restraint. Other staff were documenting the full period of restraint on one body map to reflect the actual time that the patient and staff were in that position. There was no consistency within the hospital as to which method should be used for documenting the period of restraint.

As part of the “Stop the Clock” practice we were informed that there was a decision of whether staff should disengage from the restraint if safe to do so or to continue. However, there was no record of this decision process, therefore it was not evident of how staff had come to the decision to disengage or continue the restraint.

Improvement needed

The registered provider must ensure that staff consistently complete the restraint form body map to record the accurate period of restraint.

The registered provider must ensure that staff document the decision whether it’s safe to disengage or to continue a restraint as part of the “Stop the Clock” practice and detailed in the associated policy.

Restraint forms did not clearly state that floor restraint was in the supine (face-up) position as opposed to prone (face-down). This needs to be included so that the registered provider can be assured that prone restraint is not used.

Improvement needed

The registered provider must ensure that restraint forms clearly document that a floor restraint was in the supine (face-up) position.

We reviewed the daily contemporaneous records of four patients. Whilst there were a number of detailed entries that were completed to a high professional standard, on the whole entries were of poor quality and did not reflect the NMC professional standards of practice and behaviours for nurses, midwives and nursing associates. Often entries in to contemporaneous record were brief and did not fully reflect the patient’s presentation or the care provided. Not all entries

in the contemporaneous records included the staff member's name signature and profession.

Following a previous inspection where we identified failings in the completion of contemporaneous records the registered provider had implemented a monthly audit of these records, however this audit process ceased in October 2018. This needs to be re-established to identify and address the poor completion of contemporaneous records at the hospital.

Improvement needed

The registered provider must ensure that contemporaneous records are completed comprehensively and in line with professional standards for record keeping.

The registered provider must re-established the audit of contemporaneous records.

As stated earlier, the de-escalation and restraint forms were not numbered; therefore it was difficult to reconcile individual forms to the entries within the contemporaneous record. In addition, where there were entries within the contemporaneous records these did not specify the times when the de-escalation or restraint occurred. Instead, only the time of the entry in to the record was recorded.

When cross-referencing de-escalation and restraint forms to the contemporaneous records there were numerous occasions when the contemporaneous record did not include details of all episodes of de-escalation or restraint that had occurred that day. On some days no instances of de-escalation or restraint were recorded in the contemporaneous records despite a de-escalation and restraint form being completed.

In addition, there were entries for restraint within the contemporaneous record that stated the restraint lasted for a significantly shorter period than the restraint form. One entry stated that restraint had lasted "for about 30 minutes" where the restraint form documented the restraint lasted 68 minutes. Another contemporaneous record stated that a restraint lasted for 5 minutes however the restraint form documented the restraint lasted for 27 minutes.

Therefore, the contemporaneous records did not accurately reflect what had occurred in the provision of care for patients, particularly in regards to de-escalation and restraint. Furthermore, the majority of entries in the contemporaneous records did not meet the standards set out by the Nursing & Midwifery Council 'The Code'.

Improvement needed

The registered provider must ensure that each instance of de-escalation and restraint is accurately recorded in the patient's contemporaneous record, including the time and duration of restraint.

We reviewed the documenting of PRN medication within the contemporaneous records as previously this was a failing of the registered provider. From the sample of PRN medication records we reviewed we were able to confirm that all were clearly and correctly recorded within the contemporaneous records.

We reviewed a samples of Section 17 Leave[2] authorisation forms, these were also fully completed as required.

[2] Section 17 Leave authorises a patient detained under the Mental Health Act leave from the hospital.

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 Independent Health Care Regulations and National Minimum Standards.

Since our inspection in September 2018 a new Hospital Director had been appointed. There was a newly appointed Managing Director in place who was in the process of applying to HIW to be the Registered Manager. The Finance Director was in the process of applying to HIW to be the Responsible Individual. Also a new Clinical Lead and Ward Manager had been appointed since the recent departure of the previous employees in those roles.

The registered provider had undertaken and was continuing recruitment of registered mental health nurses and healthcare support workers. In the week preceding the inspection the registered provider had recruited registered nurses, some of whom were being used via an agency, to be directly employed and managed by the hospital. Therefore at the time of the inspection the registered provider was not reliant on the use of agency staff to fulfil staffing rotas.

The registered provider had recently introduced a revised induction process for all staff that we were informed would be more in depth than the previous induction. At the time of the inspection no staff had completed this, therefore we were unable to evaluate the induction process at this time.

It was positive that throughout the inspection we observed staff interacting and engaging with patients appropriately, and treating patients with dignity and respect.

The staff mandatory training statistics provided evidenced very high compliance. Where training was due to elapse these were highlighted and monitored to ensure that staff completed their training in a timely manner.

The newly appointed Managing Director had implemented new governance processes and reporting for the hospital. Due to these processes only been established in the preceding two months further time is required to evaluate the impact these changes will have on the management, leadership and governance of the hospital. Reviewing the minutes of various governance meeting that had been held to date, not all actions had been given a specific timescale or designated to a responsible person(s) to implement.

Improvement needed

The registered provider must ensure that actions are specific, measurable, achievable, realistic and, timely (SMART) and identify a responsible person(s) to implement.

4. What next?

Where we have identified improvements during this inspection which require the service to take action the provider is required to complete the improvement plan at Appendix A. When completing the improvement plan the registered provider should:

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.

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

With regards to Regis Healthcare Limited's continued registration HIW will now consider, in conjunction with the written representations made by the provider to HIW's Notice of Proposal to cancel the registration, the findings of this inspection and the registered provider's response. This will then be used to determine whether HIW upholds the Notice of Proposal and issues a Notice of Decision to cancel the registration or whether the representations are accepted and the Notice of Proposal is revoked.

In the meantime, as stated earlier, Regis Healthcare remains under the highest level of scrutiny; HIW will be monitoring the service closely and is in regular contact with the commissioners of patients at the hospital

5. How we inspect independent mental health services

Our inspections of independent mental health services 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.

HIW inspections of independent mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent mental health services.

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

Appendix A – Improvement plan

Service: Regis Healthcare Ltd

Wards: Brenin

Date of inspection: 9 – 11 December 2018

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	Regulation/ Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The registered provider must ensure that patient records are organised and hold the most up to date information.	15(1), 19(1)(a) & (b)	At the time of responding to this item, Hillview Hospital is in the process of migrating to electronic records (Care Notes).	Steven Dyton-Thomas Finance Director / Information Governance Lead	Target Installation Date 28 Feb 2019 Target Implementation Date 31 Mar 2019
The registered provider must ensure that there is an agreed care plan format at the hospital and that this is used.	19(1)(a) & (b)	Based on verbal feedback from the unannounced inspection, a care plan format was agreed and implemented.	Angela Mason Ward Manager	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that all patients have up to date care plans to manage their individualised risks and needs.	15(1), 19(1)(a) & (b)	We are constantly updating and reviewing our care plans on the basis of clinical need, and/or on a monthly basis.	Angela Mason Ward Manager	Monthly or when needs change Ongoing
The registered provider must ensure that all care plans are specific, measurable, achievable, realistic and, timely (SMART).	15(1), 19(1)(a) & (b)	This was introduced following the unannounced inspection. The team has been abiding by SMART objectives way of doing things.	Angela Mason Ward Manager	Monthly or when needs change Ongoing
The registered provider must ensure that all care plans are regularly reviewed and updated.	15(1), 19(1)(a) & (b)	This was introduced following the unannounced inspection. The team has been abiding by SMART objectives way of doing things.	Angela Mason Ward Manager	Monthly or when needs change Ongoing
The registered provider must ensure that all documentation is completed in full to reflect the patient's food and fluid intake.	15(1), 19(1)(a) & (b)	We have engaged a dietitian and now all patients had a food and fluid intake chart. These charts have been updated to comply with regulations.	Senior Support Workers	Daily Ongoing
The registered provider must ensure that all 24-hour observation forms are correctly filed	15(1), 19(1)(a) & (b)	The Nurse in Charge is responsible for ensuring that the observation forms are completed accurately and filed in the nurses handover file.	Angela Mason Ward Manager	Daily Ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that there is an up-to-date care plan in place for each patient regarding sexual health.	15(1), 19(1)(a) & (b)	A number of patients have identified as having sexual health needs. For each of these patients a care plan is in place. When a patient presents with sexual health needs, a care plan will be written.	Vicky Jones Registered General Nurse	Monthly or when needs change Ongoing
The registered provider must ensure that there are governance processes in place to check that actions agreed by the MDT are completed in a timely fashion.	15(1), 19(1)(a)	With a new ward manager in post, a new template which captures daily. Weekly and monthly audits have been designed to ensure that agreed actions by the multi-disciplinary team are completed in a timely manner.	Angela Mason Ward Manager	Daily Ongoing
The registered provider must ensure that its Use of Restrictive Physical Intervention Policy reflects current practice in place at the hospital as an independent health care provider.	15(1), 16(2)(b), 19(1)(a) & (b)	Following our inspection, we have updated our Use of Restrictive Physical Intervention Policy.	Dr Clair Wright Hospital Director Angela Mason Ward Manager	Daily Ongoing
The registered provider must ensure that its Use of Restrictive Physical Intervention Policy is written for providing care to persons aged under 18 years.	15(1), 16(2)(b), 19(1)(a) & (b)	Following our inspection, we have updated our Use of Restrictive Physical Intervention Policy.	Enock Mhindurwa Managing Director Steven Dyton-Thomas Finance Director	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that there are systematic filing and cataloguing arrangements in place for de-escalation and restraint records so that all records are stored and readily available.	15(1), 16(2)(b), 19(1)(a) & (b)	Up until this feedback, restraint records were filed together in files relating to a particular month. A separate files will now be created for each young person with the restraint and de-escalation documentation being stored in separate file sections for each month of the year. At the time of writing this action plan, Hillview Hospital is in the process of migrating from paper documentation to electronic record system (Care Notes / Datix).	Dr Clair Wright Hospital Director	To be completed by 1 Feb 2019
The registered provider must ensure that all instances of de-escalation and restraint are recorded on the associated paperwork as well as the contemporaneous record.	15(1), 16(2)(b), 19(1)(a) & (b)	Following verbal feedback from the December 2018 unannounced inspection, a new cataloguing system was introduced. Each form is now given a reference number. After each incident a form is completed and the details are recorded in the contemporaneous notes, quoting the form reference number by the person who has completed the form.	Dr Clair Wright Hospital Director	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that staff consistently complete the restraint form body map to record the accurate period of restraint.	15(1), 16(2)(b), 19(1)(a) & (b), 23(1)(a)(i)	Following verbal feedback from the December 2018 unannounced inspection it was clarified that on the restraint documentation a new body map is to be completed each time hands are taken off to ensure consistent practice.	Dr Clair Wright Hospital Director	Completed
The registered provider must ensure that staff document the decision whether it's safe to disengage or to continue a restraint as part of the "Stop the Clock" practice and detailed in the associated policy.	15(1), 16(2)(b), 19(1)(a) & (b), 23(1)(a)(i)	A section will be added to the restraint forms requiring documentation of to disengage or continue a restraint.	Dr Clair Wright Hospital Director	To be completed by 1 Feb 2019
The registered provider must ensure that restraint forms clearly document that a floor restraint was in the supine (face-up) position.	15(1), 16(2)(b), 19(1)(a) & (b)	Following the unannounced inspection in December 2018 and the verbal feedback given, all incident forms were amended to specify that all floor restraints are to be conducted using a supine position.	Dr Clair Wright Hospital Director	Completed
The registered provider must ensure that contemporaneous records are completed comprehensively and in line with professional standards for record keeping	15(1), 19(1)(a), 23(1)(a)(i)	Following the inspection, we have intensified our process in ensuring our compliance with the regulatory standards by robust auditing of	Angela Mason Ward Manager Dr Clair Wright Hospital Director	Daily Ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		contemporaneous notes and all written records.	Enock Mhindurwa Managing Director	
The registered provider must re-established the audit of contemporaneous records.	15(1), 19(1)(a), 23(1)(a)(i)	Contemporaneous Notes Audit Tool in place.	Angela Mason Ward Manager	Weekly Ongoing
The registered provider must ensure that each instance of de-escalation and restraint is accurately recorded in the patient's contemporaneous record, including the time and duration of restraint.	15(1), 19(1)(a), 23(1)(a)(i)	Following verbal feedback from the unannounced inspection in December, we introduced a system whereby the staff member completing the de-escalation and restraint documentation makes an entry in to the contemporaneous record summarising the incident. Moving forward, we will ensure this includes the time and duration of restraint. A qualified nurse then countersigns this entry.	Angela Mason Ward Manager	Daily Ongoing
Quality of management and leadership				
The registered provider must ensure that actions are specific, measurable, achievable, realistic and, timely (SMART) and identify a responsible person(s) to implement.	15(1), 19(1)(a) & (b)	The service provider is aware that previous documentation was not SMART enough. All clinical documentation is now reflecting this.	Steven Dyton-Thomas	Monthly Ongoing

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): **Enock Mhindurwa**

Job role: **Managing Director**

Date: **31 January 2019**