Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Cefn Carnau Uchaf
Thornhill
Caerphilly
CF83 1LY

Inspection Report 2010-2011

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Introduction

Independent healthcare providers in Wales must be registered with Healthcare Inspectorate Wales (HIW). HIW acts as the regulator of healthcare services in Wales on behalf of the Welsh Ministers who, by virtue of the Government of Wales Act 2006, are designated as the registration authority.

To register, they need to demonstrate compliance with the Care Standards Act 2000 and associated regulations. HIW tests providers' compliance by assessing each registered establishment and agency against a set of '*National Minimum Standards,'* which were published by the Welsh Assembly Government and set out the minimum standards for different types of independent health services. Further information about the standards and regulations can be found on our website at: **www.hiw.org.uk**

Readers must be aware that this report is intended to reflect the findings of the inspection episode. Readers should not conclude that the circumstances of the service will be the same at all times.

Background and Main Findings

An unannounced inspection was undertaken to Cefn Carnau Uchaf on 29 March 2011 by an inspection manager, two independent healthcare reviewers and one Mental Health Act reviewer. The hospital was first registered in June 1999 and is currently registered to accommodate 22 patients within two distinct wards. Sylfaen ward is registered to accommodate eight female patients over the age of 18 years who have a primary diagnosis of learning disability and who may be liable to be detained under the Mental Health Act 1983. In addition, Bryntirion ward is registered for a maximum of fourteen male adults over the age of 18 years

diagnosed with a primary diagnosis of learning disability, who may be liable to be detained under the Mental Health Act 1983. The hospital is owned by Craegmoor Hospitals Limited.

As part of the inspection process the registered provider submitted a completed self-assessment form and an extensive range of supporting documentation to demonstrate how they meet the National Minimum Standards for Private and Voluntary Healthcare Services. The inspection focused upon the analysis of a range of documentation including the examination of patient records and discussion with the newly appointed manager, the business manager and a range of staff employed at the hospital. In addition, a number of patients were also interviewed and feedback obtained from both patients and staff has been used within this report.

In respect of the main inspection findings, the registered provider had in place:

- A statement of purpose and patient guide, however both these documents required updating to accurately reflect the organisational structure and the range of treatment and other services provided at the establishment.
- A system of care documentation that included: admission details and various assessments, a risk assessment and management plan and a range of care plans. However a significant number of the care plans were not signed by the multi-disciplinary team and the documentation in relation to annual health checks was not complete for one patient. There was also a lack of review dates for some of the care plans. In addition, for one patient the admission checklist was in relation to a different hospital and clearly when the patient was admitted to Cefn Carnau a new checklist should have been completed. There was also a lack of evidence that patients' views about their care and treatment were taken into account including the medication regime and known side effects and risks being fully recorded and explained to patients. Given the areas identified above a thorough audit of the range of patient documentation is required.

- A range of policies and procedures with the date of formulation and review. However, there was evidence that a significant number of staff had not signed to state that they had read and understood the policies and procedures relevant to their area of work.
- A staff training programme was in place and this covered a range of topics including: infection control, positive behaviour support, manual handling, violence and aggression, autism awareness, personality disorder, medical gases and venupuncture and the Protection of Vulnerable Adults (PoVA). However, a significant number of staff had not attended training in child protection, what constitutes a complaint and the procedures for dealing with complaints. In addition, staff had not attended recent training in restraint and physical intervention techniques.
- Some activities/therapies were on offer including: arts and crafts, cooking, literacy, music, budgeting, information technology, independent life skills, relationship and family awareness, walking and shopping. The building that had previously accommodated the swimming pool had been extensively altered and refurbished to provide a very extensive range of activity/therapy rooms including a gym, information technology suite, relaxation room and a fully equipped kitchen. However, on the day of the inspection visit there was very little evidence that patients were actually using this area.
- A number of areas had been subject to audit including; medication, health and safety, resuscitation, and the area of risk management, As part of the risk management process a ligature risk assessment had been undertaken. A number of areas had been identified following the assessment and it was unclear from the document supplied which of the areas identified had been addressed. In addition, it could not be established that the audit programmes included; monitoring of multi-professional working in mental health teams, monitoring multi-professional contributions to clinical records, the extent and quality of direct staff-patient contact, the use of comparative information on clinical outcomes and evaluation against research findings and evidence based practice.

Patient surveys were undertaken on an annual basis and an analysis of the results was available.

There was clear evidence that the management of specific patient conditions took account of the National Institute for Health and Clinical Excellence (NICE) guidelines.

In respect of the other inspection findings, feedback from patients was very positive in relation to the attitude and support received from the staff group. Feedback also indicated that patients felt safe and secure and there was clearly a good rapport between patients and staff.

At the start of the unannounced visit the staffing levels at the hospital were inadequate, as there was only one registered nurse and the newly appointed manager on duty. Given the fact that the manager had only recently commenced employment it was disappointing to note that the manager was being utilised to take charge of a ward in the absence of registered nurses. There also appeared to be a lack of psychology, occupational therapy and social work input for the patients at the establishment.

In terms of patient restraint and physical interventions these were documented and there was provision on the forms for the manager to sign to confirm that they had undertaken an initial audit of the incident. However, a significant number of the forms had not been signed by the manager.

An advocacy service was available and an advocate visited the hospital on a frequent basis and details of the service were displayed on the wards. In relation to the area of complaints the procedure was displayed on the various wards. The registered provider had kept a full and detailed log of complaints that detailed the nature of the complaint and the outcome.

Patient information leaflets were available on the rights of patients who were detained under the Mental Health Act 1983 and in addition a range of leaflets were available regarding the range of the service offered at the establishment.

The catering service for patients provided a choice and variety of meals and there was a menu cycle. Fruit and hot drinks were available throughout the day and a number of water coolers were available. However, these water coolers were located within the ward kitchens, these were locked and no plastic cups were available. Therefore, access to fresh water was restricted. Patients used the food comment book on each of the wards and could speak directly to catering staff if there were any issues.

In relation to the area of medicines management a brief overview of the ordering, storage, use and disposal of medicines was undertaken. A limited supply of *'Controlled Drugs'* were stocked at the establishment and a British National Formulary (BNF) dated March 2011 was available as a relevant reference source. A medication record was maintained for each of the patients however, the entries were not signed by the prescriber. During the inspection visit the medication trolley on Sylfaen ward was not attached to the wall. There was a comprehensive range of policies and procedures in relation to the area of medicines management available at the establishment.

In relation to the area of blood borne viruses it could not be established if all staff had received appropriate vaccination in relation to Hepatitis B.

A range of emergency equipment was available and staff had been trained in the use of the defibrillator and use of medical gases.

In relation to the environment, there were three distinct wards, one for the female patients and two for the male patients. The wards generally lacked space for patients and this was a particular issue on the first floor ward. In addition, the wards continued to require a degree of redecoration and refurbishment and a review of the window restrictors were required to ensure their suitability. The bedrooms were personalised but a number of fittings were not anti-ligature. In addition, there were also a number of significant ligature risk areas within the bathrooms and whilst the area of risk was documented within the ligature risk assessment, the risks had not been adequately addressed. The extractor fans in a number of toilets were also not working and there was a noticeable unpleasant odour within these areas. The

television on the first floor lounge was broken and had been for a number of days, therefore patients had not had access to a television. The inspection manager was informed that a replacement could not be provided until this had been agreed by a senior manager with the organisation who was on annual leave. The building that had previously accommodated the swimming pool had been extensively altered and refurbished to provide a very extensive range of activity/therapy rooms. However, there were no window restrictors fitted to the windows located in this building. The outside garden area was very pleasant with a number of distinct areas for patients use; however, this did not provide a secure area that is required to meet the standards for low secure accommodation.

The inspection manager would like to thank the business manager, hospital manager, staff and patients for their time and co-operation during the inspection visit.

Achievements and Compliance

Within the previous inspection report eight regulatory requirements had been identified, an action plan had been received and five of the regulatory requirement had been addressed. The outstanding requirements were in relation to care documentation, which must be reviewed and evidence of patient and family involvement must be documented. Many areas of the establishment required refurbishment, redecoration and repair and an urgent review of bedroom window handles and other ligature points was required throughout the hospital

In relation to achievements the building that had previously accommodated the swimming pool had been extensively altered and refurbished to provide a very extensive range of activity/therapy rooms including a gym, information technology suite, relaxation room and a fully equipped kitchen.

Registration Types

This registration is granted according to the type of service provided. This report is for the following type of service:

Description
An independent hospital with overnight beds providing medical treatment for mental health (including patients detained under the Mental Health Act 1983).

Conditions of Registration

This registration is subject to the following conditions. Each condition is inspected for compliance. The judgement is described as Compliant, Not Compliant or Insufficient Assurance.

Condition Number	Condition of Registration	Judgement
1.	The number of persons accommodated in the establishment at any one time must not exceed 22 (twenty two) as specified below: a) **Sylfaen Unit** A low secure service for a maximum 8 (eight) female adults over the age of 18 years diagnosed with a primary diagnosis of learning disability and who may be liable to be detained under the Mental Health Act 1983. b) **Bryntirion Unit** A low secure service for a maximum 14 (fourteen) male adults over the age of 18 years diagnosed with a primary diagnosis of learning disability who may be liable to be detained under the Mental Health Act 1983.	Compliant

Condition Number	Condition of Registration	Judgement
2.	The registered person must not admit or accommodate the following categories of patients: c) Persons under the age of 18 years. d) Persons who do not require care and treatment for their learning disability / mental disorder in a secure hospital environment. e) Persons who require care and treatment in conditions of medium or high security. f) Persons whose primary diagnosis is drug or alcohol misuse. g) Persons with a major physical illness or disability including those who require a wheelchair.	Compliant
3.	The minimum staffing levels for the establishment will be provided as specified in the Statement of Purpose (version 4) approved by Julian Spurling dated August 2008. Additional staffing must be provided as required in such numbers as are appropriate for the health and welfare of the patients.	Not Compliant Staffing levels for the establishment were **not** provided as specified in the most recent statement of purpose version 6 dated October 2010.
4.	A registered nurse (Registered Nurse Mental Health or Registered Nurse Learning Disabilities with the Nursing and Midwifery Council) must be present on each of the units at all times when patients are present.	Compliant
5.	The registered persons must ensure that there is a suitably experienced senior Registered Nurse (Mental Health or Learning Disabilities with the Nursing and Midwifery Council) appointed to the position of lead nurse. The role of the *'Lead Nurse'* will be to provide clinical and professional advice to the Registered Manager and nursing staff at the establishment.	Compliant
6.	The Registered Manager and Lead Nurse must be supernumerary and not included in the minimum staffing levels for the establishment.	Compliant

Action required where a condition is judged as either not complied with or there is insufficient assurance to make that judgement.

Condition number	Findings and Action Required	Time Scale
3.	**Findings:** Staffing levels for the establishment were **not** provided as specified in the most recent statement of purpose version 6 dated October 2010. **Action Required** The registered provider must ensure that the staffing levels for the establishment were provided as specified in the most recent statement of purpose version 6, dated October 2010.	Immediate and on-going.

Assessments

Healthcare Inspectorate Wales carries out on site inspections to make assessments of standards. If we identify areas where the provider is not meeting the minimum standards or complying with regulations or we do not have sufficient evidence that the required level of performance is being achieved, the registered person is advised of this through this inspection report. There may also be occasions when more serious or urgent failures are identified and the registered person may additionally have been informed by letter of the findings and action to be taken but those issues will also be reflected in this inspection report. Healthcare Inspectorate Wales makes a judgment about the frequency and need to inspect the establishment based on information received from and about the provider, since the last inspection was carried out. Before undertaking an inspection, Healthcare Inspectorate Wales will consider the information it has about a registered person. This might include: a self-assessment against the standards, the previous inspection report findings and any action plan submitted, provider visits reports, the Statement of Purpose for the establishment or agency and any complaints or concerning information about the registered person and services.

In assessing each standard we use four outcome statements:

Standard met	No shortfalls: achieving the required levels of performance.
Standard almost met	Minor shortfalls: no major deficiencies and required levels of performance seem achievable without extensive extra activity.
Standard not met	Major shortfalls: significant action is needed to achieve the required levels of performance.
Standard not inspected	This is either because the standard was not applicable, or because, following an assessment of the information received from and about the establishment or agency, no risks were identified and therefore it was decided that there was no need for the standard to be further checked at this inspection.

Assessments and Requirements

The assessments are grouped under the following headings and each standard shows its reference number:

- Core Standards
- Service Specific Standards

Standards Abbreviations:

C = Core standards

A = Acute standards

MH = Mental health standards

H = Hospice standards

MC = Maternity standards

TP = Termination of pregnancy standards

P = Prescribed techniques and technology standards

PD = Private doctors' standards

If the registered person has not fully met any of the standards below, at the end of the report, we have set out our findings and what action the registered person must undertake to comply with the specific regulation. Failure to comply with a regulation may be an offence. Readers must be aware that the report is intended to reflect the findings of the inspector at the particular inspection episode. Readers should not conclude that the circumstances of the service will be the same at all times; sometimes services improve and conversely sometimes they deteriorate.

Core Standards

Number	Standard Topic	Assessment
C1	Patients receive clear and accurate information about their treatment.	Standard almost met
C2	The treatment and care provided are patient – centred.	Standard almost met
C3	Treatment provided to patients is in line with relevant clinical guidelines.	Standard met
C4	Patients are assured that monitoring of the quality of treatment and care takes place.	Standard almost met
C5	The terminal care and death of patients is handled appropriately and sensitively.	Standard not inspected
C6	Patients views are obtained by the establishment and used to inform the provision of treatment and care and prospective patients.	Standard met
C7	Appropriate policies and procedures are in place to help ensure the quality of treatment and services.	Standard almost met
C8	Patients are assured that the establishment or agency is run by a fit person/organisation and that there is a clear line of accountability for the delivery of services.	Standard met
C9	Patients receive care from appropriately recruited, trained and qualified staff.	Standard almost met
C10	Patients receive care from appropriately registered nurses who have the relevant skills knowledge and expertise to deliver patient care safely and effectively.	Standard met
C11	Patients receive treatment from appropriately recruited, trained and qualified practitioners.	Standard not inspected
C12	Patients are treated by healthcare professionals who comply with their professional codes of practice.	Standard not inspected
C13	Patients and personnel are not infected with blood borne viruses.	Standard almost met
C14	Children receiving treatment are protected effectively from abuse.	Standard not inspected
C15	Adults receiving care are protected effectively from abuse.	Standard met

Number	Standard Topic	Assessment
C16	Patients have access to an effective complaints process.	Standard almost met
C17	Patients receive appropriate information about how to make a complaint.	Standard met
C18	Staff and personnel have a duty to express concerns about questionable or poor practice.	Standard met
C19	Patients receive treatment in premises that are safe and appropriate for that treatment. Where children are admitted or attend for treatment, it is to a child friendly environment.	Standard almost met
C20	Patients receive treatment using equipment and supplies that are safe and in good condition.	Standard met
C21	Patients receive appropriate catering services.	Standard met
C22	Patients, staff and anyone visiting the registered premises are assured that all risks connected with the establishment, treatment and services are identified, assessed and managed appropriately.	Standard almost met
C23	The appropriate health and safety measures are in place.	Standard not inspected
C24	Measures are in place to ensure the safe management and secure handling of medicines.	Standard met
C25	Medicines, dressings and medical gases are handled in a safe and secure manner.	Standard met
C26	Controlled drugs are stored, administered and destroyed appropriately.	Standard met
C27	The risk of patients, staff and visitors acquiring a hospital acquired infection is minimised.	Standard met
C28	Patients are not treated with contaminated medical devices.	Standard met
C29	Patients are resuscitated appropriately and effectively.	Standard met
C30	Contracts ensure that patients receive goods and services of the appropriate quality.	Standard met
C31	Records are created, maintained and stored to standards which meet legal and regulatory compliance and professional practice recommendations.	Standard met
C32	Patients are assured of appropriately competed health records.	Standard met
C33	Patients are assured that all information is managed within the regulated body to ensure patient confidentiality.	Standard not inspected
C34	Any research conducted in the establishment/agency is carried out with appropriate consent and authorisation from any patients involved, in line with published guidance on the conduct of research projects.	Standard not inspected

Service Specific Standards- these are specific to the type of establishment inspected

Number	Mental Health Hospital Standards	Assessment
M1	Working with the Mental Health National Service Framework.	Standard met
M2	Communication between staff.	Standard met
M3	Patient confidentiality.	Standard met
M4	Clinical audit.	Standard almost met
M5	Staff numbers and skill Mix.	Standard almost met
M6	Staff training.	Standard almost met
M7	Risk assessment and management.	Standard almost met
M8	Suicide prevention.	Standard almost met
M9	Resuscitation procedures.	Standard met
M10	Responsibility for pharmaceutical services.	Standard met
M11	The Care Programme Approach/Care Management.	Standard met
M12	Admission and assessment.	Standard almost met
M13	Care programme approach: Care planning and review.	Standard met
M14	Information for patients on their treatment.	Standard almost met
M15	Patients with developmental disabilities.	Standard almost met
M16	Electro-Convulsive Therapy (ECT).	Standard not inspected
M17	Administration of medicines.	Standard almost met
M18	Self administration of medicines.	Standard not inspected
M19	Treatment for addictions.	Standard met
M20	Transfer of patients.	Standard met
M21	Patient discharge.	Standard met

M22	Patients' records.	Standard met
M23	Empowerment.	Standard met
M24	Arrangements for visiting.	Standard met
M25	Working with carers and family members.	Standard not inspected
M26	Anti-discriminatory practice.	Standard met
M27	Quality of life for patients.	Standard almost met
M28	Patients' money.	Standard met
M29	Restrictions and security for patients.	Standard met
M30	Levels of observation.	Standard met
M31	Managing disturbed behaviour.	Standard met
M32	Management of serious/untoward incidents.	Standard met
M33	Unexpected patient death.	Standard not inspected
M34	Patients absconding.	Standard almost met
M35	Patient restraint and physical interventions.	Standard almost met
M41	Establishments in which treatment is provided for persons liable to be detained - information for staff.	Standard met
M42	The rights of patients under the Mental Health Act.	Standard met
M43	Seclusion of patients.	Standard not inspected
M44	Section 17 leave.	Standard met
M45	Absent without Leave under Section 18.	Standard almost met
M46	Discharge of detained patients.	Standard met
M47	Staff training on the Mental Health Act.	Standard met

Schedules of Information

The schedules of information set out the details of what information the registered person must provided, retain or record, in relation to specific records.

Schedule	Detail	Assessment
1	Information to be included in the Statement of Purpose.	Met
2	Information required in respect of persons seeking to carry on, manage or work at an establishment.	Met
3 (Part I)	Period for which medical records must be retained.	Met
3 (Part II)	Record to be maintained for inspection.	Met
4 (Part I)	Details to be recorded in respect of patients receiving obstetric services.	Not applicable
4 (Part II)	Details to be recorded in respect of a child born at an independent hospital.	Not applicable

Requirements

The requirements below address any non-compliance with The Private and Voluntary Health Care (Wales) Regulations 2002 that were found as a result of assessing the standards shown in the left column and other information which we have received from and about the provider. Requirements are the responsibility of the *'registered person'* who, as set out in the legislation, may be either the registered provider or registered manager for the establishment or agency. Healthcare Inspectorate Wales will request the registered person to provide an *'action plan'* confirming how they intend to put right the required actions and will, if necessary, take enforcement action to ensure compliance with the regulation shown.

Standard	Regulation	Requirement	Time scale
C1	5 & 6	**Findings** The statement of purpose and service users' guide required updating to accurately reflect the organisational structure and the range of treatments and other services provided at the establishment.	Within 28 days of receipt of this report.

Standard	Regulation	Requirement	Time scale
		Action Required The registered provider is required to produce a statement of purpose and patients' guide that accurately reflects the organisational structure and the range of treatments and other services provided at the establishment.	
C2, M7, M14	15 (1) & (3)	**Findings** There was a lack of review dates for some care plans and these plans were also not signed by the multi-disciplinary team. In addition, there was a lack of evidence that patients' views about their care and treatment were taken into account including the medication regime and known side effect and risks being fully recorded and explained to patients. **Action Required** The registered person is required to ensure that all care plans have a review date and are signed by the multi-disciplinary team. In addition, the registered person is required to ensure that patients' views about their care and treatment were taken into account.	Within 28 days of receipt of this report.
C4 & M4	16 (1)	**Findings** The audit programmes did not include; monitoring of multi-professional working in mental health teams, monitoring multi-professional contributions to clinical records, the extent and quality of direct staff-patient contact, the use of comparative information on clinical outcomes and evaluation against research findings and evidence based practice.	Within three months of receiving this report.

Standard	Regulation	Requirement	Time scale
		Action Required The registered person is required to ensure that the audit programmes include; monitoring of multi-professional working in mental health teams, monitoring multi-professional contributions to clinical records, the extent and quality of direct staff-patient contact, the use of comparative information on clinical outcomes and evaluation against research findings and evidence based practice.	
C16, M5, M6 & M35.	17 (2) (a)	**Findings** A significant number of staff had not attended training in child protection, what constitutes a complaint and the procedures for dealing with complaints**.** In addition, staff had not attended recent training in restraint and physical intervention techniques. **Action Required** The registered person is required to ensure all staff receive training in child protection, what constitutes a complaint and the procedures for dealing with complaints. In addition, staff must attend recent training in restraint and physical intervention techniques.	Within 28 days of receiving this report.
C19 & M8	24 (2) (a) & (b)	**Findings** The wards generally lacked space for patients and this was a particular issue on the first floor ward. In addition, many areas of the establishment required refurbishment, redecoration and repair and window restrictors were not in place in the newly refurbished activity area. Also the window restrictors throughout the hospital need to be reviewed to ensure their suitability.	An action plan of how this area will be addressed must be received by HIW within 28 days of the date of this report and this plan must be fully implemented by 31

Standard	Regulation	Requirement	Time scale
		Action Required The registered person is required to ensure the provision of adequate space is available throughout the wards and that the premises are kept in a good state of repair internally. In addition, window restrictors were required in the newly refurbished activity area and restrictors in place required review to ensure that they were suitable.	December 2011.
C19	24 (2) (a)	**Findings** The extractor fans in a number of toilets were not working and there was a noticeable unpleasant odour within these areas**.** **Action Required** The registered person is required to ensure that the premises are kept in a good state of repair internally. Therefore extractor fans must be in good working order.	Within 28 days of the date of this report
C22, M7 & M8	24 (2) (d)	**Findings** An urgent review of bedroom window handles and other ligature points was required throughout the hospital and this included the newly refurbished activity area. **Action Required** The registered person is required to ensure all parts of the establishment to which patients have access are so far as reasonably practicable free from hazards to their safety. Therefore a risk assessment and action plan with specific timescales must be formulated in relation to the management of the risk identified and the provision of anti-ligature fittings throughout the hospital must be achieved.	An action plan of how this area will be addressed must be received by HIW within 14 days of the date of this report and anti-ligature fittings must be provided throughout the hospital by 31 December 2011.

Standard	Regulation	Requirement	Time scale
C22	24 (2) (d)	**Findings** The medication trolley on Sylfaen ward was not attached to the wall. **Action Required** The registered person is required to ensure that all parts of the establishment are so far as reasonably practicable free from hazards.	Immediate and on-going.
M5	17 (1) (a)	**Findings** At the start of the unannounced visit the staffing levels at the hospital were inadequate, as there was only one registered nurse and the newly appointed manager on duty. Given the fact that the manager had only recently commenced employment it was disappointing to note that the manager was being utilised to take charge of a ward in the absence of registered nurses. There also appeared to be a lack of psychology, occupational therapy and social work input for the patients at the establishment. **Action Required** The registered person must ensure that there are adequate staff numbers as are appropriate for the health and welfare of patients.	Immediate and on-going.
M12 & M15	15 (1)	**Findings** The documentation in relation to annual health checks was not complete for one patient**.** **Action Required** The registered person must ensure that the establishment is conducted so as to promote and make proper provision for the welfare of patients.	Immediate and on-going.

Standard	Regulation	Requirement	Time scale
M34	24 (2) (d)	**Findings** The outside garden area did not provide a secure area that is required to meet the standards for low secure accommodation. **Action Required** The registered person must ensure that the secure garden area meets the appropriate standards for low secure accommodation.	An action plan of how this area will be addressed must be received by HIW within 28 days of the date of this report and this plan must be fully implemented by 31 December 2011.

Recommendations

Recommendations may relate to aspects of the standards or to national guidance.

They are for registered persons to consider but they are not generally enforced

Standard	Recommendation
C7, C9 & M45	All staff including medical practitioners, to read the policies and procedures relevant to their area of work and sign a statement to this effect.
C13	All staff should be vaccinated against blood borne viruses.
M17	The prescriber should sign all entries within the medication records.
M27	Patients should have open access to the water coolers.
M35	The patient restraint/physical intervention forms should be signed by the manager to confirm that an initial review has been undertaken.