[HIW Regulatory Action Plan]

Hospital: **Priory Hospital Cefn Carnau**

Date of inspection: **8-10/4/14**

Date of Action Plan: **15/5/14** **update 05/8/14**

Hospital Director: **Carla Rawlinson**

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

Outcome/ Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
Outcome/Standard – (insert outcome/standard)							
Regulation 28 (2) (a) (b) (c) & (3) & (4) (a) (b) (c) & (5) (a) (b) (c)	Under Regulation 28 of the Independent Health Care (Wales) Regulations 2011, the registered provider must provide a written report on the areas listed, within Regulation 28, to HIW on a 6 monthly basis. The reports sighted during our visit did not provide sufficient assurance on analysis of complaints and interviews with patients and staff and no reports had been submitted to HIW.	1. A biannual responsible individual visit will take place and a report will be forwarded to HIW as required.	Agreement between Responsible Individual Trevor Torrington and Operations Director Steve Conway that Steve Conway will conduct these visits and forward a biannual report to HIW Steve Conway has agreed to conduct and forward the first report by 30th June 2014 Steve Conway has conducted his visit to Cefn Carnau with a view to discussing this at a meeting planned with HIW.	Ops Director		30.06.14	

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Outcome/Standard (insert Outcome/standard)							
Regulation 26 (2) (a) (b) & (c) We reviewed the environment and the following observations were made:	Complete refurbishment and redecoration of the bathrooms and WCs are required on Sylfaen ward. The flooring, china ware and walls were marked and need replacing.	1. Continue with current refurbishment plan and report progress monthly to the Clinical Governance Committee	Project manager has been allocated and advised to source quotes with a view to work commencing in June 2014 Meeting took place between Estates Manager, project consultant and HD on 10/6/14 to review planned works and quotations - a number of other quotations have been sought since that meeting Meeting took place between Estates Manager, Project Consultant, Interior Designer and HD on 29.7.14 to finalise plans and discuss colour schemes, etc. Work on the exterior of the building has now started.	Hospital Director/ Estates		30.10.14	
	On Sylfaen ward a bathroom/WC was not clean. The bin was overflowing and the WC was full of toilet paper. A robust process for checking and cleaning bathrooms/WCs must be introduced.	2. Bathrooms will be monitored hourly by an allocated staff member with a record kept of these checks	Process in place.	Ward Staff to check		30.04.14	22.04.14
	The flooring in the WCs on Bryntirion ward	3. Continue with current refurbishment plan and report progress monthly to the Clinical Governance	Project manager has been allocated and advised to source quotes with a view to work	Hospital Director		30.10.14	

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	was marked and stained. Replacement of the flooring is required.	Committee	commencing in June 2014 Flooring quotes have been re-checked following meeting on 10th of June 2014 Flooring materials and colours have been selected with service user involvement				
	Refurbishment of patient bedrooms is required to facilitate adequate storage, reduce trip hazards and provide a more pleasant environment.	4. Additional furniture to be provided patient bedrooms 5. A process set up to ensure redecoration to commence as patients move on and new are patient are admitted to the property	E-mail sent to Priory Interior Designer for information regarding new furniture – response received, furniture identified, currently in the process of measuring space prior to ordering Date for new furniture changed to coincide with other refurbishment works following discussion with interior designer	Hospital Director		30.10.14	
Regulation 15 (1) (a) (b) & (c)	Patient A is morbidly obese and there was no record of him being weighed since May 2013. A care plan on health promotion cannot be effectively evaluated without knowing the weight of patient A.	6. To ensure that patients are weighed as per their care plans. 7. To source weighing scales appropriate for obese patients. 8. Add to the Documentation Quality Walk Round monitoring of completion of weights as a site specific issue.	Advice and quotes in the process of being sought. Dderwen – Clients have a care plan relating to weight monitoring and advised all recordings to be recorded on care notes with a title of health observations and an explanation for weight loss or gain. Bryntirion– Physical observations monitored on a monthly basis which includes their weight and records them in a file, on care notes and in the specified are of the care notes. We are still awaiting adequate	Ward Manager		30.06.14	Confirmed by Clinical Services Manager (CSM) 17.06.14

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			equipment to weigh bariatric patients. I have been advised that they have been ordered – we are just awaiting delivery. Bariatric scales are now on site Sylfaen - Service users are offered weekly physical observation monitoring and recorded on the ward. This has been in the diary to complete every weekend.				28.7.14
	A drug and alcohol plan was in place for patient A and had recently been evaluated. However, this was not and never has been an issue for the patient.	9. Ensure that for any irrelevant care plans under the My Shared Pathway headings there is simply a statement to say this is not an issue for this individual and the monthly review will state – there is still no issue 10. Add to the Documentation Quality Walk Round monitoring as a site specific issue	We have considered how the care plan system works and this monitors all review dates monthly. We have also reviewed how the care plans are devised i.e. using My Shared Pathway headings Bryntirion – This care plan has now been discontinued and staff have been advised for the future.	Primary Nurse under supervision of the ward manager		30.06.14	Confirmed by CSM 17.06.14
	The risk management plan sighted for patient A was no more than a review of the risk areas. The capacity and consent form for patient B was not	11. Review risk management plans for all patients 12. RC to complete the consent documentation.	Primary nurse is currently working on the management plan for review by MDT of the patient identified during the inspection Bryntirion – all patients have an up to date and in-depth risk management plans. Record of capacity & consent to	Primary Nurses RC		30.06.14	Confirmed by CSM 17.06.14

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	completed apart from the first page. This would need to be re-done by the current responsible clinician (RC) and this could not be found.	13. To be added as a site specific issue to monitor via the Documentation Quality Walk Round	treatment DP Form 11 now completed.			30.04.14	11.04.14
	The Care plan on drug and alcohol misuse for patient B contradicted itself in terms of historical usage.	14. Review care plan and ensure it is robust and fit for purpose with feedback provided to the nurse.	Dderwen – Care plans have been amended to highlight previous issues and the importance of ensuring patients are educated around the dangers of substance misuse. Bryntirion – care plan amended and reviewed.	Primary Nurse		13.04.14	Confirmed by CSM 17.06.14
Regulation 15 (1) (a) (b) & (c)	There was no positive behavioural support plans (PBS) in place. We were informed this was due to a lack of training. PBS plans must be introduced for the patient group.	1. Training for staff in relation to PBS to provided by the Quality Improvement Lead 2. Utilise PBS plans that patients are admitted with under supervision of the Clinical Psychologist. 3. When sufficient staff are trained PBS plans will be developed for patients for whom it is deemed clinically appropriate /necessary by the hospital and community MDTs	Programme being developed. Training date selected, additionally Priory are exploring the possibility of an e-learning module to support face to face training Quality Improvement Lead has attended and provided input and support to the MDT, further dates planned	HD		15.12.14	
Regulation 15 (9) (a) & (b)	Patients complained about the varying quality, portions and variety of food provided	1. To set up a food forum at the site as part of an internal ongoing quality improvement programme	This is in progress	HD		31.12.14	
		2. A taster menu day is planned for patients	This has taken place with positive feedback from all	Catering Manager			23.04.14

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		3. Change the 3 week rolling menu to 4 week to add variety and introduce theme days.	This is now in place	Catering Manager		30.04.14	10.04.14
		4. Senior managers to visit ward at mealtimes to gain feedback	This is now happening regularly.	HD and CSM		31.05.14	14.05.14
		5. Redistribute the food section of the patient's satisfaction survey	Food survey have been re-issued as planned and show much improved feedback, some suggestions acted on immediately e.g. one service user asked for duck on his birthday on 31st of July, same purchased and prepared	HD		30.06.14	04.07.14
Regulation 15 (1) (a) (b) & (c)	The dining experience for patients must be improved. On Sylfaen and Dderwen wards the tables were not set, there was no water with meals and staff did not eat with patients in an attempt to enhance the experience.	**6.** Source new dining furniture of Sylfaen	New dining furniture is now in place for Sylfaen	HD			1.05.14
		7. Paint Dining Room and change pictures	Date changed to reflect the overall refurbishment schedule	Hospital Director/ Estates		30.10.14	
		8. Staff to sit down with patients at mealtimes even when the staff are not eating.	Discussed and recorded in staff meeting minutes. Dderwen Staff endeavor to sit with clients at meal times if there is space; however kitchen is not big enough for another table. Staff will socialize with clients at meal times. In relation to the laying up of tables, clients wanted to take this role on and a timetable was drawn up and implemented regarding kitchen duties. However if they decline	HD and CSM			5.06.14 Confirmed by CSM 17.06.14

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			this task, staff will organize the tables to be laid and ensure refreshments are offered. Sylfaen - New materials identified to make meal times an improved experience. This has been approved and will be purchased this working week. New furniture in place since recent HIW inspection.				
Regulation 20 (2) (a)	. A robust and reliable system is required to ensure monitoring of staff supervision is taking place.	**1.** Review current compliance with Priory Supervision Policy for managerial and clinical supervision	Supervision matrix in place for line management supervision for all clinical staff.	Hospital Director (HD)/ Clinical Services Managers (CSM)		31.07.14	Confirmed by CSM 17.06.14
		2. Reallocate all permanent staff supervisors	Line management supervision re-allocated for all clinical staff	HD/CSM		31.07.14	Confirmed by CSM 17.06.14
		3. Allocate individual to co-ordinate and monitor a supervision log	Member of admin staff identified to manually log supervision on receipt of documentation, local log for same created.	HD/CSM		31.07.14	10.06.14
		4. Utilise the FFG system as a checking measure for compliance	Supervision stats were reviewed and had improved month on month since April when checked on FfG as part of the monthly benchmarking process, 83.1% April, 84.1% in May, 87.1% in June	HD/CSM		31.07.14	8.7.14

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Regulation 20 (1) (a) & (2) (a)	Two areas of mandatory training need to be improved. 26% of staff were late or had expired for the Managing of violence and aggression (MVA) and 15% were late or had expired for break away training. The registered provider must ensure that training for all staff is up to date	**5.** Identify staff who require MVA and Breakaway Training	Print out from e-learning system to identify training requirements	HD		29.08.14	14.5.14
		6. Plan monthly MVA training as a rolling programme	Discussion with MVA instructors with Reception as a booking Trying to arrange training for June July training days booked	HD		29.08.14	
Regulation 15 (1) (a) & (b)	MHA forms not fully completed	7. Ensure MHA forms are fully completed and monitored via MHA Administrator	Signed and dated CO3 now in place	HD		15.06.14	13.05.14
Regulation 15 (1) (a) (b) & (c)	Advanced decisions need to be reviewed in line with Priory policy	8. Full MDT review of all service user advanced decisions to ensure that these have not been completed in isolation and that they reflect the patients views in their language and have been completed in a way that recognises/reflects individuals levels of understanding – record to be made of review. With a further review when Section is renewed or at CPA	HIW feedback shared with MDT members regarding their views on this issue Following discussion with the MDT and the Quality Improvement Lead for the area who also liaised with other Priory colleagues a decision has been made to discontinue these directives and only use them when someone is approaching the end of their life			15.12.14	 1.08.14
Regulation 19 (1) (a) & (b)	The Mental Health Act files on the ward must	Include Mental Health Act Documentation as a bespoke issue to review during Priory	Files were checked and updated following the inspection and documents identified as	CSM		30.04.14	10.04.14

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	hold a complete set of legal documents and must contain all the appropriate detention paperwork.	Healthcare Quality Walk Round Standard Operating Procedure	missing were replaced Dderwen – Recently complete audit of paperwork with MHA Administrator and all files are up to date and no missing paperwork. Bryntirion – awaiting MHA audit. Sylfaen - Arranged with Anyce for Audit for this week and update all files on Sylfaen this week.				Confirmed by CSM 17.06.14
		1. MHA Coordinator to re-provide MHA face to face training regarding documentation and rolling programme set up.	Training plan submitted by Anyce Gentle MHA Co-ordinator in relation to timescales, contents on 19.06.14 – training dates now to be planned	MHA Coordinator		31.08.14	