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28 April 2014

Dear Mr Torrington,

Re: Visit undertaken to The Priory, Church Village Hospital on the 15, 16 and 17 April 2014

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to the Priory Church Village independent hospital on the evening of 15 and all day on the 16 and 17 April 2014. Our visit highlighted areas that are noteworthy and include:

- The good rapport we observed between patients and staff.
- The environment was clean and on-going maintenance of the hospital was evident.
- All staff had an appraisal for the year.
- The food was generally commented upon favourably by staff and patients. Menus were varied with seasonal variations and had dietary input from a dietician.
- The Mental Health Act (MHA) documentation was all kept in a file in date order.
- Feedback indicated that the new manager was having a positive effect on the morale and general running of the hospital.

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Our visit also highlighted a number of issues. We provided a verbal overview of our concerns to your registered manager at the end of our visit on 17 April 2014. A summary of these, which include regulatory breaches is set out below:

Issue of concern	Regulation
1. A review of the clinic/treatment room identified the following: a. A range of drugs were being stored and treated as Controlled Drugs when they were not. b. Patient A was prescribed 25mgs of promethazine. The instructions stated take one or two tablets, however there was no instructions to accompany and inform the decision making process of how many tablets to administer to the patient. c. Patient B was prescribed lactulose but this was not in stock. Medication prescribed for patients must be available. d. Patient B was prescribed procyclidine 5mgs. The instructions stated take half a tablet, (2.5mgs) at 20:00hours however there was no specific stock. e. Patient C was prescribed Felodipine. The dose of the medication had been altered to 10mgs. This should have been re-written. f. Ferrous Sulphate 200mgs was prescribed for patient C. This medication was not in stock and it was unclear if it had been discontinued. g. Ventolin medication for patient C was kept under the sink. This should be kept in a locked cupboard. h. Patient C was prescribed paracetamol 1 or 2 tablets four times a day. However, there was no instructions to accompany and inform the decision making process of how many tablets to administer to the patient. i. Patient C was prescribed Procyclidine 5mgs tablets. The notes stated they were to be given with an intramuscular injection (IM), but it was not clear which IM injection because the patient was prescribed more that 1. j. Procyclidine 5mgs for patient C stated take one daily, but the prescriber had crossed out daily and there was no further instruction on the prescription sheet. k. The responsible clinician (RC) was not signing for all medication on the prescription sheets.	Regulation 15 (5) (a) & (b) & 26 (2) (a)

All areas identified must be addressed and an urgent pharmacy audit must be undertaken.	
2. A review of care plan documentation identified the following issues: a. There was no discharge plans in place for patients D, E, A and F. (Notice has been served for patient F) b. For patient D, there was no evidence of MDT input into the care planning process. c. There was no risk management plan for within eyesight monitoring of patient D. It was more of a limited evaluation. d. Risk assessments for patient D identified there was a current risk of absconding, non adherence with treatment and inappropriate sexual behaviour, however no care plans were in place for these areas. e. Patient D was subject to restraint but no specific care plan had been developed. f. Patient F had no risk management plan in place for within arms length observational levels. g. There was little evidence of MDT input into care plans for patient F. h. The word “restricting” was inappropriate in a care plan for patient F. i. There was no risk management plan for within eyesight monitoring of patient E. j. There was little evidence of MDT input into care plans for patient E. k. The care plan on wound care for patient E lacked detail. There was no description of the wound, size and/or colour. l. Patient E did not have access to podiatry services and their toe nails desperately required cutting. m. Patient E had seen her GP regarding leg pain and was prescribed pain relief, however there was no care plan or pain relief assessment in place. n. The care plan on diabetes for patient A was not specific in terms of blood glucose levels and being weighed regularly. The plan did not state how often regularly is. o. Patient A did not have her blood glucose levels monitored for 4 days due to no strips for testing being available. p. A care plan for patient A stated that feet and	Regulation 15 (1) (a) (b) & (c)

legs are to be checked weekly for changes. The last recorded check was dated 13 December 2013. q. The risk management plan on general observations was not complete for patient A. r. It was difficult to ascertain the level of discussions and agreement of care plans for patient A due to key areas being left blank. All areas identified must be addressed.	
3. Positive Behaviour Support (PBS) plans must be introduced and staff must receive appropriate training in this area.	Regulation 15 (1) (a) (b) & (c)
4. The role and function of the Multi Disciplinary Team (MDT) must be improved. The MDT was not functioning effectively. There was evidence of broken relationships, an inability to understand and value each others roles and a lack of involvement in the care planning process.	Regulation 15 (1) (a) (b) & (c) & 18 (2) (a) & (b)
5. A review of staff files was undertaken and the following observations were made: a. There was lots of historical information contained on files relating to previous organisations including Craegmoor and Independent Community Living that could be archived. b. Files contained duplication of information such as 2 or 3 copies of the same reference. c. There was inconsistency across the files reviewed, specifically in areas such as appointment information, interview notes etc. d. The mandatory training records reviewed highlighted that 2 out of the 10 employees we examined did not have current/valid Managing Violence and Aggression (MVA) training in place. Areas identified must be addressed.	Regulation 20 (2) (a) & (c) & Regulation 21 (2) (d)
6. A review of the use of bank staff is required in order to develop strategies for a permanent solution to any staffing deficiencies.	Regulation 15 (1) (a) (b) (c) & 20 (1) (b)
7. A review of community activities is required to ensure they are increased. There was a lack of meaningful links with the community, such as voluntary work, attending college courses and group	Regulation 15 (1) (a) (b) & (c)

outings to social settings, for example bowling.	
8. Patient G was being administered medication without appropriate authorisation under Part 4 of the Act, no authorisation (either s58 or s62) was in place for medication whilst awaiting the assessment and authorisation of a Second Opinion Appointed Doctor (SOAD). All medication must be authorised as set out in part 4 of the Act.	Regulation 15 (1) (a) (b) & (c)
9. 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.	Regulation 28 (2) (a) (b) (c) & (3) & (4) (a) (b) (c) & (5) (a) (b) & (c)

You are required to submit a detailed action plan to HIW by **20th May 2014** setting out the action you intend to take to address each of the above issues. The action plan should set out timescales and details of who will be responsible for taking the action forward. When the plan has been agreed by HIW as being appropriate you will be required to provide monthly progress updates.

On receipt of this letter the Registered Provider is required to comment on the factual accuracy of the issues detailed and on receipt of your action plan, a copy of this management letter, accompanied by your action plan will be published on our website.

We may undertake a further visit to ensure that the above issues have been properly addressed and we will undertake more frequent visits if we have concerns that necessary action is not being taken forward in a timely manner.

Please do not hesitate to contact me should you wish to discuss the content of this letter.

A copy of this letter is being sent to Mr Dean Harries, Manager at the Priory Church Village Hospital.

Yours sincerely

Mr John Powell
Head of Regulation

cc – Mr Dean Harries, Priory Church Village, Church Road, Tonteg, Pontypridd CF38 1HE