Coed Du Hall Hospital
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No	Concern	Regulation	Action	Responsible	Action Date	Status
1	A significant number of agency nurses had no documented induction available. All agency staff must have a documented induction.	Regulation 20 (1) (b)	Review and update induction programme for agency nurses.	HM/EJ/CL	With Immediate effect	Completed
			Identify all agency nurses requiring Induction.	EJ/CL	30.06.14	Completed
			Deliver Induction pack to all agency nurses.	CL	30.06.14	Completed
			Develop tracking system for induction process.	RI/HM/EJ	30.06.14	Completed
			Review and monitor monthly for compliance.	HM	31.07.14	Completed/ Ongoing
			Deliver compliance monitoring to the RI and ensure documentation available for scrutiny and monitoring through regulation 28 visit.	HM/OD	05.09.14	Ongoing
2	There was no information available for a number of agency staff regarding their skills and experience to confirm suitable employment checks had been undertaken. All staff working at the hospital must have suitable checks undertaken and the relevant experience and training.	Regulation 21 (2) (a) b) (c) & (d)	Review existing system for recording information on agency staff, identifying shortfalls and information required.	RI/HM/EJ	30.06.14	Completed
			Coordinate meeting with Agency provider and seek agreement on information required and procedure for receiving it.	HM/EJ	15.07.14	Completed
			Develop personnel information sheet for all agency workers.	RI/HM/EJ	15.07.14	Completed/ Ongoing
			Implement and populate personnel information sheets.	EJ	31.07.14	Completed/ Ongoing
			Review and monitor documentation for compliance.	HM/EJ	31.07.14	Completed/ Ongoing
			Maintain Agency Staff personnel files for scrutiny and regulation 28 inspection visits	HM	05.09.14	Ongoing

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3	A full and comprehensive review of staffing numbers must be undertaken to ensure patients have planned leave and community access in line with their programmes of care.	Regulation 15 (1) (a) (b) & 20 (1) (a) & (b)	Review staffing complement. Document patient activity sets and leave requirements. Review and implement staffing structure to meet identified planned leave and community access. Review and monitor daily/weekly activity and maintain records indicating leave/activity taken. Review any planned leave or community access not pursued and rationale for noncompliance.	HM HM/MB OD/HM MDT MDT	14.07.14 24.07.14 31.07.14 21.07.14 21.07.14	Completed Completed Completed Completed/ Ongoing Completed/ Ongoing
4	The multi-disciplinary team (MDT) was not functioning appropriately in terms of making clear, appropriate and timely decisions and there was a lack of evidence of MDT involvement in the care planning process. The MDT must be involved in all decisions regarding patient care.	Regulation 15 (1) (a) (b) & (c)	Develop and deliver MDT attendance and audit document. Implement MDT document for populating by each professional member to evidence clear, appropriate and timely decisions. Collaborative Care files to be delivered at MDT for review and all members to input data as appropriate and sign entry to evidence MDT decision making. Comprehensive record of MDT process, involvement and decision making to be recorded and available for scrutiny and audit.	AB/BS MDT MDT MDT	07.07.14 07.07.14 07.07.14 First monthly audit 25.07.14 (shows clear evidence of MDT input to care files)	Completed Completed Completed/ Ongoing Ongoing
5	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)	Review the current process of regulation 28 visits, documentation and reporting. Develop a more comprehensive and robust system, process and reporting structure that will complement the governance arrangements and ensure sustainable quality improvements across all areas of service delivery.	RI/OD RI/OD	30.07.14 30.07.14	Completed Completed/ Ongoing

			Communicate the system and processes developed to the HIW to ensure the system and processes meet the identified need and satisfy the required standards. Deliver comprehensive reports to the RI and HIW that captures areas of good practice, identifies areas that require quality improvements and deliver actions and activity that ensure quality improvements are embedded in practise. Deliver systems and processes that review and monitor actions and activity to provide the necessary assurances that improvements have been delivered.	RI/OD RI/OD OD/HM	05.09.14 Starting 05.09.14 05.09.14	Ongoing Ongoing Ongoing
6	There was a lack of robust governance and clinical audit processes at the hospital to ensure early identification of patient issues. A robust documented governance and audit process must be introduced.	Regulation 15 (1) (a) & (b) & 19 (1) (a) & (b)	Deliver monthly governance meetings, recording all activity against identified governance domains. Develop a monthly report to RI demonstrating robust governance activity. Deliver comprehensive regulation 28 report to RI & HIW identifying governance activity and actions to identify quality improvements.	HM/MDT HM/MDT OD	All Baseline audits completed 31.07.14 27.08.14 with monthly reports to RI/OD by last working day of each month 05.09.14	Completed/ Ongoing Ongoing Ongoing Ongoing Ongoing
7	Infection control processes were inadequate. A red bag containing soiled linen was placed on top of other laundry. Infection control processes must be improved.	Regulation 9 (1) (n) & 15 (1) (b)	Review Infection Control Processes Identify Infection control lead and source enhanced infection control training for lead individual. Additional new Bin (with fitted Red lid) purchased to isolate soiled linen as a part of new procedures.	HM HM HM	07.07.14 IFC Lead Identified 16.07.14 Infection Control/	Completed Completed Completed

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			Comprehensive Infection Control training planned and implemented for all staff. Annual COSHH training programme reviewed and amended to incorporate infection control process. Put up infection control posters in the laundry and information areas for staff and patients.	HM HM	COSHH training 28 and 31.07.14 24.07.14	Completed Completed
8	We reviewed the hospital environment and the following issues were identified:	Regulation 26 (2) (a) (b) & (c) & (4) (a)				
	a) The fire door on Beech lounge was wedged open.		Check fire door on Beech lounge and remove wedge. Install automatic electronic door closer to Beech lounge fire door linked into fire alarm system. Ensure all staff attend annual update in relation to fire awareness training.	 CM-Electrician	With Immediate Effect 23.07.14 See 10 b) below	Completed Completed Completed
	b) There were cracked and missing wall tiles in the laundry room. These must be replaced.		The loose wall tiles in the laundry had been deliberately removed when two windows had recently been replaced as a part of the March 2014 environmental audit. The replacement of these 4 tiles had unfortunately been overlooked. The contractor has now refitted these.	Window contractor	08.07.14	Completed
	c) The rehabilitation kitchen units were sticky, dirty and worn. Door handles were also missing from cupboards. This area requires refurbishment.		A refurbishment of the rehabilitation kitchen has been added as an addendum to the environmental audit and this has now taken place.	Kitchen Contractor	29.07.14	Completed
	d) A pot containing sputum was very full and was left on the floor at the side of a chair on Beech ward. Any pots used for patients must be emptied and/or removed regularly.		Remove sputum bowl and dispose of appropriately. The Service user requiring sputum bowl has since been discharged from Coed Du Hall.	Nursing	With immediate effect	Completed
	An audit of the environment must be undertaken		A full environmental audit was completed on 28	RI	31.05.14	Completed

	and an action plan addressing the environmental issues must be formulated with specific timescales.		March 2014 with recommendations implemented over the subsequent months. All identified issues were completed by the end of May 2014. The additional observation from 8 c) above has been added as an addendum to this report.	RI	08.07.14 29.07.14	Completed Completed
9	An audit of 10 staff files was undertaken and the following issues were identified	Regulation 20 (2) (a) & 21 (2) (d)				
	a) There were no up-to date appraisals available.		Review appraisal status for all staff. Deliver comprehensive programme of appraisals for all staff. Document appraisals and maintain record for scrutiny.	HM HM HM	01.09.14 01.09.14 01.09.14	Ongoing Ongoing Ongoing
	b) There was conflicting start of employment dates on file. The personal portfolio had a different date to the personnel file.		Develop and deliver a comprehensive audit document. Audit all staff files for completeness. Deliver audit, outcomes and actions to RI. Develop adhesive summary label including name, DOB, address, telephone contact, DBS due date, start date, payroll number, and professional registration number and attach to all staff personnel files. Ensure all dates correspond as appropriate. Ensure comprehensive documentation available for scrutiny through Regulation 28 visits.	GN GN GN GN GN GN	16.07.14 16.07.14 18.07.14 31.07.14 31.07.14 05.09.14	Completed Completed Completed Completed Completed Ongoing
	c) There was a lack of appointment information. Some staff files contained		See 9 b) above.	GN	31.07.14	Completed

	contracts of employment and invite to interview letters whereas some files did not have the same.					
	d) Not all staff had an up to date supervision record.		Review all staff supervision records. Ensure all staff are allocated a supervisor. Deliver supervision to all staff. Populate supervision matrix. Deliver a systematic review to ensure sustainability. Ensure all documentation is available for scrutiny through Regulation 28 visits.	HM HM MDT CL HM/CL HM	21.07.14 21.07.14 July – August 2014 08.07.14 08.08.14 05.09.14	Completed Completed Ongoing Ongoing Ongoing Ongoing
	All the above areas identified must be addressed.					
10	A review of staff training was undertaken and the following issues were identified:	Regulation 21 (2) (b)				
	a) The hospital's mandatory restraint training, entitled "Respect" was poorly completed. All the Registered Nurses had not undertaken recent training and 2 registered nurses were 2 years overdue. Seventeen (17) support workers were also overdue training in this area.		Review all training requirements for all staff. Respect training to be organised and delivered to all staff who require updates. All staff to attend mandatory training as required. Update training matrix to evidence and monitor compliance. Ensure all documentation is available for regulation 28 site visit.	EJ EJ EJ CL HM	07.07.14 25.07.14 01.08.14 04.08.14 05.09.14	Completed Completed Completed/ Ongoing Ongoing Ongoing
	b) All staff was overdue with fire awareness training.		Fire Awareness training is included in the comprehensive mandatory training programme referred to in 10 a) above. Ensure availability of fire officer to deliver training promptly.	EJ/CL CM	Training commenced 16.07.2014 complete by 31.07.2014	Completed Completed

	c) The Mental Health Act (MHA) and Mental Capacity Act (MCA) were overdue for a number of staff.		MHA and MCA training diarised to ensure compliance. Enhanced training for MHA, administrators and nursing staff to be completed with PE Law Solicitors on the 8 August 2014. Record all attendance for scrutiny. Update training matrix to evidence % compliance. Ensure all documentation is available for regulation 28 site visit.	HM EJ/OD/HM CL CL/HM	28.07.14 -31.07.14 08.08.14 11.08.14 05.09.14	Completed To be completed 08.08.14 11.08.14 Ongoing
	d) The majority of staff were overdue for the mandatory Confidentiality and Complaints training.		Confidentiality and Complaints is included in the comprehensive mandatory training programme referred to in 10 a) above. Record all attendance for scrutiny.	EJ/HM CL	28.07.2014 -01.08.14 04.08.14	Completed 04.08.14
	All areas identified must be addressed as a matter of urgency.					
11	A review of 5 sets of patient documentation identified the following issues:	Regulation 15 (1) (a) (b) & (c)	Deliver a full and comprehensive review of all patient files. The comprehensive review will take place to develop an agreed approach towards care planning. BCUHB to review Review the specific detailed concerns as highlighted in 11a through to 11y. Clinical governance structure to monitor and direct compliance.	HM/MDT HM/MDT HM/MDT HM/MDT HM	Started 07.07.14 Started 07.07.14 To be agreed W/c 07.07.14 27.08.14	Ongoing Ongoing Ongoing Completed Ongoing

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			Ensure documentation available for scrutiny during regulation 28 site visit.	HM	05.09.14	Ongoing
	a) There was little evidence in nursing notes of treatment and therapeutic interventions for patients A,B,C,D and E.		Document treatment and therapeutic interventions in care plans for A,B,C,D and E.	Primary Nurses	28.07.14	Completed
	b) The discharge plan for patient A was not updated to reflect the situation and was overdue for evaluation.		Update discharge plan for A and evaluate.	HR	20.07.14	Completed
	c) The activity programme for patient A lacked detail. The programme for mornings just stated "morning routine".		A more detailed activity programme for A developed.	HR/LP	28.07.14	Completed
	d) There was a lack of patient involvement documented in support plans for patient A.		Document A involvement in support plans.	HR	25.07.14	Completed
	e) There was a lack of evidence of MDT input into the care planning/risk assessment process for patients A,C,D and E.		Document evidence of MDT input into the care planning/risk assessment process for patients A,C,D and E.	MDT	25.07.14	Completed
	f) There was no care plan on observational levels for patient A.		Develop care plan on observation levels for A	HR	20.07.14	Completed
	g) The care plan on vulnerability for patient A was not updated to reflect the current situation.		Update care plan on vulnerability to reflect current status for patient A.	HR	09.07.14	Completed
	h) The care and treatment plan for patient B was not dated and there was no indication of when a review was due.		Update and review care plan for B.	HR	29.07.14	Completed
	i) There was no mention of domestic abuse in the care plans for patient B since November 2013.		Develop domestic abuse risk assessment and care plan.	HR	20.07.14	Completed
	j) A discharge plan for patient B must be developed with full MDT input.		Develop and deliver discharge care plan for B through MDT process.	KK	20.07.14	Completed
	k) Support plans for patient C were not		Review support plans for C monthly as directed.	HR	12.07.14	Completed

	being reviewed monthly in line with the identified timescales.					
	l) There was a lack of evidence of patient involvement in the care planning process for patient C.		Evidence patient involvement in the care planning process through MDT meetings.	HR	25.07.14	Completed
	m) The risk of patient D starting a fire was very high. This was not being robustly managed.		Deliver robust risk assessment and risk management care plan for D addressing the risk of fire setting.	KK	25.07.14	Completed
	n) The risk management plan titled 'smoking in bedroom' for patient D referred to another patient, F's room.		Revise the risk management plan for D.	KK	25.07.14	Completed
	o) A documented fire check on rooms was last completed on 22/01/2014.		Deliver updated fire check on all rooms.	HM/CM	12.06.14	Completed
	p) The activity programme for patient D was not detailed.		Document and detail activity programme for D	TH	25.07.14	Completed
	q) The care and treatment plan for patient E was not signed by the patient and care coordinator.		Discussion with E regarding signature on care and treatment plan Obtain signature of care coordinator.	LB HM	25.07.14 To be advised	Completed Ongoing
	r) The risk dependency and support assessment for patient E was not dated.		Date documentation relating to risk dependency and support assessment for E.	LB	25.07.14	Completed
	s) Monthly on-going reviews of risk strategies were not undertaken for patient E.		Deliver monthly review of risk strategies for E	LB	14.07.14	Completed
	t) The risk management strategy for patient E was not signed and dated.		Sign and date risk management strategy for E	LB	14.07.14	Completed
	u) Care plan 1 on personal hygiene for patient E had writing all over it and it could not be determined if this was an evaluation of the plan.		Evaluate and update personal hygiene care plan for E, ensure typed plan in situ.	LB	14.07.14	Completed
	v) Support plan 13 mentions a previous manager who has not been at the hospital for a number of years		Update support plan 13 for resident E.	LB	14.07.14	Completed

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	w) Patient E is a borderline diabetic but there was no care plan in place.		Deliver diabetic care plan for E.	LB	25.07.14	Completed
	x) The activity programme for patient E was poor with no meaningful activities listed.		Deliver weekly activity programme identifying meaningful and therapeutic activity.	LB	25.07.14	Completed
12	There was a lack of staff meetings being undertaken and these must be organised and a record maintained.	Regulation 18 (2) (a) & (b) & 19 (2) (e)	Regular staff meetings to be diarised and publicised to facilitate staff attendance. Ensure meetings are recorded and records available for scrutiny. Records to be available for scrutiny during the regulation 28 site visit.	HM/EJ EJ HM	16.06.14 16.06.14 05.09.14	Completed Completed/ Ongoing Ongoing
13	There were a number of patients who had been at the hospital for significant periods of time. A review of these placements must be undertaken as a matter of urgency with a view to finding alternative and more suitable accommodation.		Engage with BCUHB to coordinate comprehensive review of all patients. Work in partnership with BCUHB to identify those patients who are ready for rehabilitation. Ensure that any transfer is in the patient's best interest and is supported through the MDT process. Where complex and challenging patients are considered for rehabilitation into a community setting, the MDT must be assured all risks can be managed within the community setting. All activity must be documented and available for scrutiny.	MDT/BCUHB	Started 23.06.14	Ongoing
	Mental Health Act Monitoring					
	• The Mental Health Act (MHA) Administrator had not undertaken		Review availability of appropriate training for administrators of the MHA 1983.	OD	Training sourced and to be delivered	Scheduled for completion

	training in the administration of the Act. Training must be provided for the MHA Administrator.		Source a provider and coordinate detailed training. Deliver the training to coordinators within the group and nursing staff to ensure comprehensive cover and sustainability. Ensure evidence is recorded to demonstrate compliance.		by Peter Edwards Law on 08.08.2014	08.08.14
	• The hospital had a new responsible clinician (RC) and new assessments of capacity had not been completed. However, at the time of leaving Coed Du Hall, the RC was in the process of renewing them.		Review all patients that require assessment of capacity. Deliver capacity assessments to all patients as required. Ensure all documentation is available for scrutiny. Documentation to be reviewed as part of regulation 28 site visits.	AB HM	09.07.14 CO2/CO3 revised for all patients where required. 05.09.14	Completed Ongoing