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3 July 2014

Dear Mr Hartey,

Re: Visit undertaken to Coed Du Hall on the 11th, 12th, 13th June 2014

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to Coed Du Hall on the 11th, 12th and 13th June 2014. Our visit highlighted areas that are noteworthy and include:

- The good rapport observed between patients and staff.
- Staff commented that the hospital was moving forward.
- Patients and staff commented positively about the variety and quality of food.
- The array of patient information displayed throughout the hospital.
- Patient artwork and craft displayed throughout the hospital.
- The refurbishment of bathrooms and replacement of some furniture.
- The well maintained gardens for patients to use.

Our visit also highlighted a number of issues. We provided a verbal overview of our concerns to you and your interim manager at the end of our visit on 13th June 2014. A summary of these is set out below:

Healthcare Inspectorate Wales • Arolygiaeth Gofal Iechyd Cymru
Welsh Government • Llywodraeth Cymru
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Issue of concern	Regulation
1. A significant number of agency nurses had no documented induction available. All agency staff must have a documented induction.	Regulation 20 (1) (b)
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)
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)
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)
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)
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) and 19 (1) (a) & (b)
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)
8. We reviewed the hospital environment and the following issues were identified: a. The fire door on Beech lounge was wedged open. b. There were cracked and missing wall tiles in the laundry room. These must be replaced. c. The rehabilitation kitchen units were sticky, dirty and worn. Door handles were also	Regulation 26 (2) (a) (b) & (c) & (4) (a)

missing from cupboards. This area requires refurbishment. 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. An audit of the environment must be undertaken and an action plan addressing the environmental issues must be formulated with specific timescales.	
9. An audit of 10 staff files was undertaken and the following issues were identified: a. There were no up-to date appraisals available. b. There was conflicting start of employment dates on file. The personal portfolio had a different date to the personnel file. c. There was a lack of appointment information. Some staff files contained 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. All the above areas identified must be addressed.	Regulation 20 (2) (a) & 21 (2) (d)
10. A review of staff training was undertaken and the following issues were identified: 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. b. All staff was overdue with fire awareness training. c. The Mental Health Act (MHA) and Mental Capacity Act (MCA) were overdue for a number of staff. d. The majority of staff were overdue for the mandatory Confidentiality and Complaints training. All areas identified must be addressed as a matter of urgency.	Regulation 21 (2) (b) &

11. A review of 5 sets of patient documentation identified the following issues: a. There was little evidence in nursing notes of treatment and therapeutic interventions for patients A, B, C, D and E. b. The discharge plan for patient A was not updated to reflect the situation and was overdue for evaluation. c. Goal planning for patient A was not signed by the MDT and the patient. d. The activity programme for patient A lacked detail. The programme for mornings just stated “morning routine”. e. There was a lack of patient involvement documented in support plans for patient A. f. There was a lack of evidence of MDT input into the care planning/risk assessment process for patients A, C, D and E. g. There was no care plan on observational levels for patient A. h. The care plan on vulnerability for patient A was not updated to reflect the current situation. i. The care and treatment plan for patient B was not dated and there was no indication of when a review was due. j. There was no mention of domestic abuse in the care plans for patient B since November 2013. k. A discharge plan for patient B must be developed with full MDT input. l. Support plans for patient C were not being reviewed monthly in line with the identified timescales. m. There was a lack of evidence of patient involvement in the care planning process for patient C. n. The risk of patient D starting a fire was very high. This was not being robustly managed. o. The risk management plan titled ‘smoking in bedroom’ for patient D referred to another patient. p. A documented fire check on rooms was last completed on 22/01/2014. q. The activity programme for patient D was not detailed. r. The care and treatment plan for patient E was not signed by the patient and care co-ordinator. s. The risk dependency and support	Regulation 15 (1) (a) (b) & (c)

assessment for patient E was not dated. t. Monthly on-going reviews of risk strategies were not undertaken for patient E. u. The risk management strategy for patient E was not signed and dated. v. 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. w. Support plan 13 mentions a previous manager who has not been at the hospital for a number of years. x. Patient E is a borderline diabetic but there was no care plan in place. y. The activity programme for patient E was poor with no meaningful activities listed. All the areas identified must be addressed as a matter of urgency.	
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)
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.	Regulation 15 (1) (a) (b) (c)

Mental Health Act Monitoring – The Administration of the Act

We reviewed the statutory detention documents of 6 of the detained patients being cared for on 3 of the wards at the time of our visit. The following issues were identified and need to be included in your action plan:

- The Mental Health Act (MHA) Administrator had not undertaken training in the administration of the Act. Training must be provided for the MHA Administrator.

- 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.

You are required to submit a detailed action plan to HIW by **31st July 2014** setting out the action you have already taken as well as that which 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 you are 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 Malcolm Carr, Manager.

Yours sincerely

Mr John Powell
Head of Regulation

cc – Mr Malcolm Carr, Coed Du Hall, Nantalyn Road, Mold, CH7 5HA