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25 September 2014

Dear Mr Torrington,

Re: Visit undertaken to The Priory, Church Village Hospital on the 2nd, 3rd and 4th September 2014

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to the Priory, Church Village independent hospital on the 2nd, 3rd and 4th September 2014. The main focus of the visit was to establish progress in addressing the issues highlighted in our earlier visit in April 2014. Our visit highlighted areas that are noteworthy and include:

- The continuing good rapport observed between patients and staff. Patients spoke highly of staff and the care that they received.
- All patients and staff spoke positively in relation to the quality, variety and taste of the food served.
- The environment was again noted to be very clean and free from unpleasant odours.
- The enthusiasm of the staff to promote effective care was evident.
- It was evident that the Mental Health Act (MHA) administrator and staff worked well together to maintain the requirements of the Act.

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- The positive and constructive way the majority of staff engaged in the inspection process.

We also identified some improvement in aspects highlighted in our earlier visit:

- There was some improvement with communication and joint working of the Multi Disciplinary Team (MDT) but there is still some scope for further improvement in working as a team to be made. (point 4, April 2014 letter)

- Staff files had improved, and historical information had been archived and there was no duplication of information. This made the files more streamlined and easier to use and find information. (point 5)

- A considerable degree of improvement in relation to all aspects of medicine administration, storage and handling.

Our visit also highlighted a number of issues. We provided a verbal overview of our concerns to your hospital manager at the end of our visit on 4th September 2014. A summary of these, which include regulatory breaches is set out below:

Issue of concern	**Regulation**
1. Three patients had been admitted to the hospital within the last 2 weeks and this had clearly had a dramatic effect on the running of the hospital. A cluster of new admissions can have a very negative impact on the service and must be avoided.	Regulation 9 (1) (a); 15 (1) (a) (b) & (c) & 19 (1) (b)
2. Four sets of care documentation was examined and the following observations were made: a. The risk management plan for patient A was unclear as to how non-adherence with treatment, risk of infection and inhaler medication was managed. b. For patient A, there was a complete lack of a description of how the wound was currently presenting. c. The last entry on the wound assessment entry chart for patient A was 01/08/2014. d. The wound care plan for patient A had not been updated to reflect the fact that there are foreign bodies within the wound. e. A review of wound care on the 03/09/2014 for patient A stated "…*has been healing well*". This statement does not provide sufficient detail regarding the wound. f. When HIW arrived on the 2nd September, there was no care plans available for patient B, even though some key areas such as	Regulation 15 (1) (a) (b) (c) & (d)

	diabetes had been identified. A basic plan was formulated during our visit. g. There was no care plan in place for 15 minute observation levels for patient B. h. There was no evidence of any patient involvement in the care planning process for patient B. i. For patient B, areas identified on the risk assessment included potential medical complications that had not been addressed within the recently formulated care plan. j. There was no care plan on section 3 for patient B. k. It had been identified in the pre-admission assessment for patient B that she can become verbally aggressive when agitated or experiencing hallucinations, but these areas were not reflected in the risk assessments. l. Patient B has a history of non-compliance with medication but this was not captured in the risk assessment. m. Risk assessment for patient C did not reflect the prior history of self harm, but a plan was in place. n. The risk assessment for patient C did not reflect the current issues of non-adherence to treatment (the patient refuses to take medication) and issues around diet and health. o. For patient C, other risk factors need to reflect obesity and health promotion and other complications as a result of morbid obesity. p. Patient C had 2 big toe nails removed and there was no care plan in place to indicate how the pain was being assessed and managed. The patient required dressings but again no care plan was in place. q. Patient D had no care plan in place for a fractured left ankle, for which the patient was in a cast, receiving antibiotics and pain relief. r. Reference was made in the notes of patient D requiring an air flow mattress, however it was not clear what this decision was based upon and there was no evidence of a pressure risk assessment being undertaken. s. Based on the above point, a mattress had not been facilitated for patient D. t. The risk assessment plan for patient D lacked detail. For her self harming it stated “staff to	

redirect [patients name] if they feel she is at risk". u. Risk area of inappropriate sexual behaviour was not addressed by a management plan for patient D. All areas identified must be addressed.	
3. A significant number of staff were still not receiving supervision. All staff must receive regular and meaningful supervision.	Regulation 20 (2) (a)
4. A number of staff had not received Managing Violence and Aggression (MVA) training and this included new staff. All staff must receive MVA training if they are involved in restraint.	Regulation 20 (1) (a) & (2) (a)
5. A number of staff complained that there was a lack of a debrief session following a restraint. A documented de-brief session must follow all incidents of restraint.	Regulation 19 (2) (c) (i)
6. A number of staff had no or limited access to the shared drive and care notes on the electronic system. All appropriate staff must have full access to the electronic system.	Regulation 15 (1) (b) & (c)
7. There was no information at ward level in relation to community activities for patients. This point was noted in April 2014 and needs to be actioned. Community activities must be promoted for patients.	Regulation 15 (1) (a) (b) & (c)
8. Some decisions taken were very arbitrary and a blanket approach, for example there was a limit on the number of CDs/DVDs that a patient could have in their bedroom. A review of arbitrary decision making processes must be undertaken.	Regulation 15 (1) (a) (b) & (c) & 19 (1) (a) & (b)
9. A review of the treatment/clinic room identified the following areas: a. Aripipazole 30mgs was commenced on the 04/09/2014 according to the administration chart, but patient E had received 20mgs on this date. Therefore, either the start or administration date of the medication was incorrect. b. Patient F was prescribed ibuprofen gel, however there was no label on the gel container or box. c. Patient G's drug record was clearly written by	Regulation 15 (5) (a) & (b)

someone different to the prescriber. Cerazette tablets were incorrectly transcribed as 75mgs instead of 75mcgs. This had also been identified in a pharmacy audit.	
10. There was a lack of a robust governance/audit process for care documentation.	Regulation 19 (1) (a) & (b)

Mental Health Act Monitoring – The Administration of the Act

We reviewed the statutory detention documents of 3 of the detained patients being cared for at The Priory, Church Village hospital at the time of our visit. The following noteworthy practice was observed:

- The admission notes of three new patients were reviewed and it was noted that all notes were kept in a folder which was easy to access.

The following points were identified and needs to be included in your action plan:

11. Mental Health Act (MHA) audits were well completed, however, an action plan in response to audit deficits was not always available.

You are required to submit a detailed action plan to HIW by **16 October 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 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