Action Plan

Hospital: Priory Hospital Ty Gwyn Hall

Date of inspection: 7th, 8th,9th October 2014

Date of Action Plan: 20th November 2014

Hospital Director: Shaun Cooper

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 15 (1)(a)(b) & (c)	**A review of three sets of patient documentation was examined and the following observations noted:** **For patient A** **1. There was no target weight recorded on the patient's weight monitoring form.** **2. Two key risks were identified in terms of self neglect /non adherence with treatment, but there was no risk management/c**	1. The patients Primary Nurse will meet with A and discuss and agree an appropriate target weight. This will be documented on their weight monitoring form. 2. The patients Primary Nurse will ensure that a care plan and risk management plan is in place to reflect the identified risks of self neglect and non adherence with treatment. This will be reviewed with the patient in a multi disciplinary setting on a monthly basis.	The Patient has agreed a target weight and this has been entered onto their health action plan and weight monitoring form. The care plans and risk assessment for this patient have been fully reviewed and updated by the Primary Nurse and MDT. The identified risks of neglect and non adherence with treatment have a risk management and care plan in place. This is reviewed monthly by the MDT.	MDT MDT		25/11/14 25/11/14	25/11/14 25/11/14

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	are plan formulated in relation to these two key issues. **For patient B** **1. The electronic record created for the patient was dated 08/10/2014 but the patient was admitted on the 07/10/2014.** **2. The paper records for the patient dated 07/10/2014 had very basic information. In addition, there was no confirmation that their rights were read to them under S132 of the MHA 1983.** **3. Two key risks had been identified, excessive alcohol consumption and harm to others, but there was no management plan**	1. Patients due to be admitted to the hospital will have their details confirmed on the Priory Income Processing system prior to their admission. This will allow for our electronic healthcare records (CAREnotes) to generate them onto the system prior to the date of admission. This will ensure that appropriate records can be maintained immediately upon the patient entering the hospital. 2. All patients will have a live CAREnotes record in place prior to admission. This will allow for all relevant information to be entered onto the system in a timely manner and negate the need to hold paper records. Reading of patients rights under S132 will be clearly documented where appropriate. The Hospitals Clinical Services Manager will ensure that Patient B has had his rights under the MHA explained to him. 3. The Multi Disciplinary Team will ensure that a care plan and risk management plan is in place to reflect the identified risks of alcohol consumption and harm to others. This will be reviewed with the patient in a multi	The hospital has implemented a procedure where all proposed admissions are inputted onto our income processing system prior to their admission date. This allows for the patient to be generated onto our CAREnotes electronic health records system. Relevant information including care plans and risk assessments are now documented on the CAREnotes system in preparation for the patient admission. All patients now have a CAREnotes electronic health record in place prior to their admission. This contains relevant information, initial care plans and risk assessments. No paper records will now be required in addition to this. A record will be made in the daily health records notes when, for example a patient has had their rights under S132 read to them. The Primary Nurse for Patient B has confirmed that their rights under S132 have been read. A care plan and risk management plan is in place for alcohol consumption and harm to others. All care plans and risk management plans	Clinical Services Manager/ Admin Team Clinical Services Manager MDT		25/11/14 25/11/14 25/11/14	25/11/14 25/11/14 25/11/14

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	formulated. **4. The patient was on 15 minute observational levels but no care plan had been formulated.** **For patient C** **1. The care plan on diabetes was too general and not specific enough. An entry stated "To be well controlled"** **2. There was no mention of any foot care for the patient or the fact that the patient injects herself on a daily basis.** **3. The patient has a diagnosis of brain shrinkage but there was no care plan in place to deal with the psychological/physical processes.** **4. There was no care plan in place for a**	disciplinary setting on a monthly basis. 4. The Multi Disciplinary Team will ensure that a care plan for intermittent observations is in place and reviewed with the patient in a MDT setting on a monthly basis. 1. The Multi Disciplinary Team will update the diabetes care plan. The care plan will be detailed and accurately reflect the agreed treatment, interventions and outcomes. 2. The diabetes care plan will include what interventions have been agreed in relation to foot care. 3. The Multi Disciplinary Team will develop and implement a care plan that fully supports patient C with her recent diagnosis of brain shrinkage. 4. The Multi Disciplinary Team will develop and implement a care plan that fully supports patient C around her receiving mail from family members that includes threatening language. 5. The patients CTP will be reviewed and updated to accurately reflect the domains within the Mental Health (Wales) measure.	are reviewed by the multi disciplinary team on a monthly basis. A care plan which reflects the appropriate level of intermittent observations is in place and is reviewed on a monthly basis by the MDT. A MDT care plan has been agreed with the patient and accurately reflects the agreed interventions and proposed outcomes in relation to Diabetes. This care plan includes information as to how foot care will be managed. A MDT care plan has been agreed with the patient in relation to brain shrinkage. A MDT care plan has been agreed with the patient around her relationship with family members and how she will be supported by staff should further issues arise. All care plans and risk management plans have been reviewed to accurately reflect the domains within the Mental Health (Wales) Measure.	MDT MDT MDT MDT MDT		25/11/14 25/11/14 25/11/14 25/11/14	25/11/14 25/11/14 25/11/14 25/11/14

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	letter the patient had received which had threatening language. **5. The care and treatment plan did not address the areas identified under the Mental Health (Wales) Measure 2010.**						
Regulation 15 (1) (a)(b) & (c)	**A review is required of the appropriateness of patient D on an all male unit.**	1. A review of the accommodation of Patient D will be undertaken with a specific focus upon being in the main Ty Gwyn Hall building which is otherwise, currently an all male unit	An urgent review was arranged for Patient D on the 21st November 2014 which was attended by the Patient, Advocate, Hospital MDT and Commissioning team. A referral has been placed with a female residential care placement and they have agreed in principle to accept and will arrange a formal assessment W/C 24th November 2014. An initial transition plan has been agreed and shared with Patient which will see her spending increasing amounts of leave within the residential placement and discharge in 6-8 weeks. In the interim period Patient D will continue to be supported by female staff whilst within the service and have female only bathroom facilities provided.	MDT		31/01/15	
Regulation 19(1)(b)	**A member of the bank staff did not have keys or a personal alarm whilst on duty.**	1. A full review of what equipment is provided to staff, including alarms and keys, will be undertaken. An internal policy will be documented and	All Healthcare Assistants, including bank staff are provided with a master bedroom key. Personal alarms are provided to all staff that work within Skirrid View unit.	Hospital Manager Clinical Services Manager		19/12/14	

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	A review of the equipment issued to bank staff is required.	implemented to ensure that all staff are allocated the appropriate level of equipment.	An internal policy and procedure is currently under review which will include an assessment of the need for personal alarms to be provided to staff within Ty Gwyn Hall and Pentwyn House.	Ward Manager		19/12/14	
Regulation 20(2)(a)(b)	**Ten staff files were examined and the following observations were made:** **a. Two files did not have any evidence of a medical questionnaire.** **B. There was a lack of employment information on the RC's file and there was also no training evidence available.** **All identified areas must be addressed.**	1. A review of the HR files will be undertaken and	The HR files have been reviewed by the Hospital Manager and administration team. Staff that had not previously provided a medical questionnaire have now completed this which has been included within their personnel file. The Responsible Clinicians personnel file has now been received from our HR department and is available within the Hospital. This includes all appropriate employment information including DBS checks, references, insurance and evidence of qualifications. The RC is also now included within the Priory's Foundation for Growth education and training system where evidence of completed training is documented and available for review.	Hospital Manager Administrator Hospital Manager Administrator		25/11/14 25/11/14	25/11/14 25/11/14
Regulation 15 (1)(a)(b) & (c)	**A review of the patients who have been at Ty Gwyn Hall for a considerable period of time is required.**	1. Hold CTP review meetings on a minimum 6 monthly basis. Hold MDT meetings on a 4 weekly basis. A discussion regarding the care pathway for the patient will be a fixed agenda item at each of these meetings. 2. Information and contact details for Advocacy and	CTP meetings are scheduled to be held every 6 months or more frequently when required. MDT meetings are held weekly with each patient being reviewed a minimum of 4 weekly. Within each of these meetings a detailed review of the patient's placement and care pathway is discussed and	MDT MDT		Ongoing Ongoing	

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		Independent Mental Health Advocacy will be provided to the patient prior to each meeting. 3. Length of stay statistics will be included within the Hospitals Monthly Clinical Governance meeting.	actions agreed. Independent Advocacy visits on a weekly basis and meets with all patients. Independent Mental Health Advocacy is informed of planned CTP and MDT meetings and patients are supported to make contact. Length of stay has been added to the clinical governance agenda.				
Regulation 20 (1)(a)(2)(a)(b)	**There was a lack of training in place for staff to support patients with an acquired brain injury. Training in acquired brain injury for all staff is required.**	1. An appropriately qualified provider will be identified to facilitate specific training in relation to Acquired Brain Injury. 2. A schedule for training will be agreed and all clinical staff allocated to attend. 3. Training in acquired brain injury will be included within Ty Gwyn Hall's 2015 training plan.	Contact has been made with a Neuropsychologist who has experience of working with acquired brain injury and delivering training to staff in this area. A meeting has been arranged for the 3rd December 2014 to discuss a training package and agree a schedule for this to be delivered to staff.	Hospital Manager		31/12/14	
Mental Health Act 1983	**A review of the administration of the MHA identified the following:** **1. There was a lack of discharge planning.** **2. Extended period of action between application and completion of manager's hearings.** **3. Section 17 leave form for patient E was**	1. Discharge planning (S117) will be included as a set agenda item within the CTP meetings that take place regularly for all patients. Evidence of discussion that this takes place will be clearly documented within the CTP minutes. 2. All detained patients will have a managers hearing no later than 4 weeks following the renewal of their detention. A 6 monthly audit will be facilitated by the MHA administrator to ensure that compliance with these timescales are met.	A review of the patients care pathway and discharge plan is reviewed within CTP and MDT meetings. Section 117 discharge planning meetings are held prior to MHRT/Hospital Managers review meetings. A maximum 4 weeks timescale is in place for hospital manager's hearings to be held from the date that a section is renewed. Compliance with this is being monitored by the MHA administrator. The Section 17 leave form for patient E has been updated by the Responsible Clinician. A system is in place where all	MDT MHA Administrator MDT		Ongoing Ongoing 25/11/14	 25/11/14

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	out of date. **4. Assessment of capacity needs to be completed.**	3. The section 17 leave form for patient E will be reviewed and updated by the RC. A 4. A system to review all S17 leave forms will be implemented by the Clinical Services Manager. 5. A 6 monthly audit of compliance with S17 leave forms will be undertaken by the MHA administrator. 6. A review of all patient's capacity using Priory OP from 65 will be implemented by the Clinical Services Manager. 7. Capacity assessments will be completed for all admissions going forward. 8. The MHA administrator will audit compliance on a 6 monthly basis.	S17 leave forms are reviewed by the Clinical Services Manager. A full review of mental capacity recording is currently being undertaken by the Clinical Services Manager and a report provided to the Clinical Governance team.	Clinical Services Manager		Ongoing 19/12/14	