[HIW Regulatory Action Plan]

Hospital: **Priory Hospital Cefn Carnau**

Date of inspection: **22ND /23RD 24TH /09/14**

Date of Action Plan: **12/10/14**

Hospital Director: **Patrick Mhlanga**

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 18 (2) (a) & (b)	Morale amongst staff was generally low. Staff stated they felt under pressure to deliver with inadequate staffing levels, they felt undervalued and some felt burnt out with little support. The morale amongst staff must be improved	1 - All staff to be provided and encouraged to complete monthly supervision on site. Supervision matrix created and implemented on site to structure planned supervisions	FFG compliance for supervision increased since HIW inspection. Ongoing group and individual clinical supervision has been provided across site, with an aim of ensuring 100% completion of bank and full time staff members.	Ward Manager		30/11/14	
		2 – Further training opportunities and personal developmental options provided to full time staff members.	A number of nurses and support staff have expressed an interest in completing their NVQ work. Staff are currently being supported with the application process. A number of full time staff members have been put forward for various training delivered on site. This includes MVA and PBS training.	Ward Manager/ CSM/HD		30/11/14	
		3 – Interim plan with options to explore further incentives for full time staff members to work additional to their planned shift with an increased pay.	A number of outstanding shifts have been covered with full time staff members. This has provided continuity in care and reduced the use of agency across the hospital. Staff have provided positive feedback for this interim plan.	Operational Director / HD		Completed.	09/10/14

		4 – Daily walk around by senior staff members to provide support and up to date information on progress on site. This has allowed staff to discuss any concerns they may have at an earlier opportunity.	A number of staff have taken this opportunity to discuss and resolve issues sooner. This continues to be completed on a daily basis, with actions required followed up by senior staff members.	Ward Manager/ CSM/HD		Completed.	15/10/14
		5 – Appropriate staffing levels maintained on site, with appropriate use of bank and agency staff members.	Bank coordinator over looks all Rota's on site, ensuring agreed staffing levels are maintained with use of appropriate resources.	Bank Coordinator		Completed.	08/10/14
		6 – Additional 9-5 nurse introduced on site in the interim to provide the nurses with support with clinical work on each ward.	A number of tasks required from recent inspection and ongoing clinical work, continues to progress with full completion. This has resulted in a reduction of work load for nurses on site.	Ward Manager/ CSM/HD		Completed.	17/10/2014
Outcome/Standard – (insert outcome/standard)							
Regulation 11 (1) (a) (b) (i) & (iii)	The hospital requires a full time manager to effectively manage the service. The arrangements at the time of our visit was a manager managing two hospitals, which is unsatisfactory and cannot be sustained. In effect this	Patrick Mhlanga appointed Hospital Director in the interim. This allows cover until the newly appointed HD starts and completes a full handover/induction before commencing full responsibility of the hospital.	Patrick Mhlanga in acting HD position in the interim with senior staff members acting up to prevent an increase in work load and, ensuring ongoing personal development for staff on site. New Hospital Director due to start on Monday 20th October 2014.	Operational Director / HD		Completed.	20/10/14

	situation means work is being filtered down and staff were finding the extra tasks very difficult on already busy and challenging wards. A full time hospital manager must be appointed.						
Outcome/Standard – (insert outcome/standard)							
Regulation 15 (1) (a)(b) & (c)	Two sets of care documentation was examined and the following observations were made:	[redacted]					
	a. For patient A on Sylfaen ward, we found:						
	i. The risk management plan did not reflect the current situation. It discussed allegations regarding male staff, however this equally applied to female staff.	Risk management plan updated and completed, to reflect correct information by qualified nurse on the ward.	Completed in full.	Staff Nurse.		Completed.	30/09/14

	ii. The risk management plan identified a strategy in terms of 2:1 observations and gender balance, but this was not being adhered too. At the time of our visit two male members of staff were undertaking the observation of the female patient.	Gender balance changed in risk management plan and approach used to provide safe levels of enhanced observation for the patient.	Completed in full.			Completed.	30/09/14
	iii. There was a large number of care plans with duplication noted.	All nurses have been instructed to streamline nursing care plans, removing duplicates, and to put in place required care plans. This is additional to the core MDT care plans that are already in place.	Prior to the nursing teams restructuring across site, all nurses were provided with guidance to complete this task. There is clear evidence that there has been effort made to consolidate the care plans thus far. Following the restructure, there has been sufficient evidence that nurses are supporting each other to familiarise themselves with newly allocated primary patients and their care plans, to reduce likelihood of care plan duplication. Ward managers are supporting and monitoring this progress to ensure the deadline is met. Support is also being provided via coaching and training by the Quality Improvement Lead.	Ward Managers. Staff Nurses.		30/11/2014	
	iv. The care plan on safeguarding (reviewed 03/09/2014)	Care plan discontinued.	Care plan discontinued as this information is reflected in the risk management plan.	Staff Nurse.		Completed.	15/10/14

	stated “A is nursed on general observations.” This clearly did not reflect the present situation of the patient being nursed with 2 members of staff observing the patient.						
	b. Patient B on Dderwen ward:						
	i. Care plans need to be rationalized to avoid duplication and an excessive amount of plans.	All nurses have been informed to reflect clearly identified interventions and to ensure on reviews that each intervention is reviewed accordingly. All nurses have been instructed to streamline nursing care plans, removing duplicates, and to put in place required care plans. This is additional to the core MDT care plans that are already in place.	Nurses have been instructed to ensure appropriate interventions are identified and to ensure when reviewing care plans identified interventions are addressed to ensure more robust approach to care plan reviews. Prior to the nursing teams restructuring across site, all nurses were provided with guidance to complete this task. There is clear evidence that there has been effort made to consolidate the care plans thus far. Following the restructure, there has been sufficient evidence that nurses are supporting each other to familiarise themselves with newly allocated primary patients and their care plans, to reduce likelihood of care plan duplication. Ward managers are supporting and monitoring this progress to ensure the deadline is met.	Ward Manager. Nurses.		30/11/2014	
Outcome/Standard – (insert outcome/standard)							

Regulation 20 (1) (a)	The manager of Sylfaen ward was working a significant number of night shifts. The ward manager needs to be working primarily days to effectively lead and manage the ward	Hospital director and operational director discussed and confirmed the ward manager on Sylfaen to work days instead of nights, to ensure effective management on the ward.	Ward manager is not currently working on nights.	Operational director / HD		Completed.	30/09/14
Outcome/Standard – (insert outcome/standard)							
Regulation 26 (2) (a) & (c)	We reviewed the environment and the following observations were made:	[redacted]					
	a. On Sylfaen Ward:						
	i. Patient C did not have sufficient storage space in her bedroom and a significant amount of clothing was stored on the floor.	To fit in the approved additional storage, this had been agreed and ordered prior to the inspection date.	Additional approved storage furniture for all patient rooms within the hospital have been ordered and are due to be delivered by 16/10/14.	Estates and Facility.		Completed.	16/10/14

	ii. The vision panels on patients bedroom doors did not have any facility to enable patients to close the panels when they wanted privacy within their bedrooms.	To be discussed between operational director, hospital director and estates and facilities the appropriate course of action: whether new panels need to be ordered, or whether modifications can be made to current viewing panels.	Estates and Facilities need to be contacted to arrange an inspection of the current viewing panels in order to assess appropriate action.	Operational Director. HD. Estates and Facilities.		30/11/14	
	iii. The bathroom on the first floor had an overflowing bin and required a thorough clean.	In the interim, hourly monitoring forms to be placed in all bathrooms areas across wards and to be checked by staff members to ensure cleanliness of area is maintained.	The monitoring forms have been introduced to Bryntirion ward to good effect. To be introduced to the remaining two wards, with nurses being instructed to clearly allocate staff members to utilise these forms during shifts. Regular checks to be completed to ensure full compliance in the interim.	Ward manager. Nurses. Housekeeping Department.		Completed.	17/10/14
		Housekeeping department have been informed and have ordered new, appropriate bins for all bathrooms areas across the three wards.	New suppliers have been identified to provide the adequate bins required to be placed in bathrooms areas. These have been ordered.	Housekeeping Department.		30/11/14	
	The environmental requirements must be addressed.	Maintenance work is ongoing to ensure that the environmental requirements are being met.	Maintenance work continues on the site, which began prior to the inspection. Staff and patients remain updated with this progress, with significant work taking place on and off ward to ensure the safety of all.	Estate and Facility. Operational Director. HD		31/03/15	
Outcome/Standard – (insert outcome/standard)							

Regulation 20 (1) (a) & (b)	All agency staff must have a documented induction. A random sample of 3 agency workers names were obtained but only 1 of these had a recorded induction on file.	A centralised file will be placed in reception with completed induction forms for all grades of agency staff. Blank copies of the generic induction booklet will be available in this file, for the staff working in reception area to hand out to new agency staff members, to be completed on the ward. These will be returned completed to the file at the end of the shift. Nurses will be informed of the new process to ensure full compliance.	Relevant induction booklets and file have been sourced to keep in Reception.	Clinical Services Manager. Bank Coordinator.		30/11/14	
Outcome/Standard – (insert outcome/standard)							
Regulation 20 (1) (b) & 21 (2) (b) & (d)	There was no information available to confirm agency staff had the necessary skills and experience to work at the hospital. The hospital must ensure that agencies provide comprehensive information regarding the agency worker to ensure the person has the appropriate skills and experience for the patient group	The bank coordinator has contacted the approved agencies to source relevant information relating to agency members.	Approved agencies to supply required information of agency staff to the Bank Coordinator, to ensure the competencies, training, and appropriate skills to work at the hospital.	Bank Coordinator. Operational Director.		30/11/14	
Outcome/Standard – (insert outcome/standard)							

Regulation 15 (1) (a) (b) & (c)	There was no positive behavioral support plans (PBS) in place. We were informed this was because of a lack of training. This point was highlighted in April (point 4). All patients must have a PBS in place.	Arrangements have been made for the nurses to complete Positive Behavioural Support plan training on site, in order to be able to complete effective and valid PBS plans for their primary patients.	Training date to be confirmed and cascaded from the 31/10/14.	Quality improvement lead / Hospital Director.		31/01/15	
Outcome/Standard – (insert outcome/standard)							
Regulation 21 (2) (a) (b) (c) & (d)	Ten (10) staff files were examined and the following observations were made:	[redacted]					
	a. Three (3) files did not contain a medical check prior to starting employment.	All personnel files to be audited and actions followed up if required. This is to be completed with support from Human Resources Department.	Operational director to source HR staff to be based at Cefn Carnau to provide support to complete tasks. HR department currently completing an Audit, to support with required actions.	Operational Director.		31/12/14	
	b. Two (2) files did not contain references or only had one reference on file.	All personnel files to be audited and actions followed up if required. This is to be completed with support from Human Resources Department.	Operational director to source HR staff to be based at Cefn Carnau to provide support to complete tasks.	Operational Director.		31/12/14	

	c. Start dates could not be obtained from the information contained on file for 2 employees.	All personnel files to be audited and actions followed up if required. This is to be completed with support from Human Resources Department.	Operational director to source HR staff to be based at Cefn Carnau to provide support to complete tasks.	Operational Director.		31/12/14	
	All staff must have the necessary employment information available.	All personnel files to be audited and actions followed up if required. This is to be completed with support from Human Resources Department.	Operational director to source HR staff to be based at Cefn Carnau to provide support to complete tasks.	Operational Director.		31/12/14	
Outcome/Standard – (insert outcome/standard)							
Regulation 20 (2) (a)	There was a lack of evidence of regular documented supervision taking place. One out of the ten personnel files looked at contained a supervision record completed in 2014. Evidence of regular supervision must be available	Supervision matrix completed for the entire hospital site, to clearly document responsibilities and hierarchy. Clinical supervision was noted as an issue due to staff being unable to effectively document supervisions completed on the FFG internal system. Allocated ward manager is now to log all clinical supervisions personally to ensure effectively logging on the system. There has been a push for all clinical supervisions to take place this month, to good effect thus far. Nurses have been informed that clinical supervisions will now take place monthly, which can be completed on an individual or group basis.	Significant number of supervisions have now taken place effectively and logged on FFG, with improved compliance of FFG training percentage.	Ward manager.		31/12/14	
Outcome/Standard – (insert outcome/standard)							

Regulation 20 (2) (a)	There was a lack of evidence of appraisal documentation on file. Despite the Foundations for Growth e-learning system reporting a 96.7% compliance rate, no forms were evident in the personnel files looked at. Evidence of regular appraisal must be available.	Attempts to find completed appraisal documentation to be made. If this proves unsuccessful, appraisal reviews will be completed in order to document topics discussed during initial appraisal, in order for topics to be documented effectively. Appraises will be informed that appraisal documentation will henceforth be documented and stored effectively on site, to ensure a trail of completed paperwork. A copy of each appraisal will be stored in the HR file for each individual.	Personnel files to be audited with support from HR department.	Hospital Director.		31/12/14	
Outcome/Standard – (insert outcome/standard)							
Regulation 15 (5) (a)	The nurses office on Sylfaen ward was also a treatment and clinic room, but the office was very busy and the location of the treatment room meant that Registered Nurses were continually being interrupted by patients whist trying to administer medication. A separate/designated clinic for drug administration is required on the ward.	Maintenance work has been achieved to create separate rooms for treatment room and nurses office. Further work to ensure safe working environment for both clinic and office is created. Remaining action for relevant documents to be transferred to nurse's office to complete the changes.	Maintenance work has been achieved to create separate rooms for the treatment room and nurses office. Working space created and ensuring appropriate equipment relocated safely.	Estates and Facilities		31/11/14	

Outcome/Standard – (insert outcome/standard)							
Regulation 15 (9) (a) & (b)	Food continued to be an issue for patients and staff (Highlighted in April, point 5). Patients and staff told us that portion sizes were small and food was of poor quality. The last meal served at the hospital was at 16:00hrs which meant that many patients were hungry and consumed snack foods in the evening. The chef told us of his approaches so far of trialling themed dishes and taster menus. However, these initiatives had not resolved the issues and therefore a review of the food provision is required.	Meetings have taken place with kitchen staff to ensure that portion sizes are appropriate and consistent across site. Staff are now being offered two free meals per day to ensure a positive and inclusive dining experience for patients. Sandwiches are now being provided at suppertime to reduce the need for patients to eat snack foods in the evenings. The food comments book remains on all three wards and patients/staff are encouraged to leave comments to pass on to the kitchen. Meals are now being dished up on the ward, as opposed to being dished up prior to going to the ward, to ensure appropriate meal sizes for each patient and for meal freshness. Staff to be given guidance as to how to do this effectively across the wards. Patients will be encouraged to give regular feedback in relation to the food this can be as issues arise or during set intervals to be agreed with the patients. This feedback will be provided directly to the kitchen from unit staff and through clinical governance meetings on a monthly basis.	A number of the action plans have been achieved. The maintenance work being done in the kitchen has created some delays and this is on-going.	Estates and Facilities. Kitchen Department. HD.		30/11/14	

Outcome/Standard – (insert outcome/standard)							
Regulation 15 (1) (b) & (2)	A number of staff complained that personal alarms were not working. An urgent review is required to ensure that staff and patient safety is not compromised.	Adequate alarms have been provided and are available on site. Alarms are checked daily on reception and weekly on the ward using the security checklist. During the inspection, the alarm system had a fault, which was being addressed with the appropriate company.	The alarm system is currently working without fault.	Estates and Facility. Hospital Director.		Completed.	15/10/14
Outcome/Standard – (insert outcome/standard)							
Regulation 20 (1) (a) & (2) (a) & (b)	Statistics provided showed 29.2% of staff were late or expired in relation to break away training. Managing violence and aggression (MVA) training had 27.9% of staff listed as late or expired. These figures were worse than identified at our previous visit in April and must be addressed urgently.	Staff with outstanding MVA training to be booked on first available training date with MVA instructor to ensure full compliance with mandatory training. A shortage of MVA instructors has been observed and full time staff members have been encouraged onsite to put their names forward for the position, There will be a selection process as per Priory policy due to the responsible nature of this position . This will allow more MVA training to be held on site and increase compliance and refresher courses to be completed in a timelier manner.	MVA instructors onsite are currently unavailable (one is on annual leave, one is on paternity leave). There are currently no MVA instructors available from local priory hospitals within the region. Hospital director to source MVA instructors as soon as possible to ensure full compliance with MVA training. In the interim, support will be requested from Priory Thornford Park.	HD. MVA instructors.		31/12/14	
Outcome/Standard – (insert outcome/standard)							

Regulation 15 (1) (a) (b) (c) & (19) (1) (a) & (b)	A number of decisions appeared arbitrary and there was a blanket approach regarding patients having no keys to their bedroom doors. On Sylfaen ward. CD/DVDs were limited to 20 per room. A review of such blanket decisions is required.	All bedroom keys have been identified and given to the wards. This is to be discussed with patients, with relevant documentation completed to ensure access to own bedroom door key. Blanket approach to be reviewed on patient decision-making to ensure more person-centred approach is taken. By doing so, to ensure in line with low secure policies and procedures, contractual agreements can be made between patient and hospital for health and safety, and security.	Keys have been identified. To be discussed in clinical governance, as well as a more person centred approach with regards to patient decision making and individual risk assessment completed.	HD. Ward managers. CSM.		31/12/14	