Mr Trevor Torrington
Independent Community Living Ltd
Proiry House
Randalls Way
Leatherhead
Surrey
KT22 7TP

Direct Line: 0300 062 8163
Fax: 0300 062 8387
E-mail: John.powell@wales.gsi.gov.uk

6 October 2014

Dear Mr Torrington,

Re: Visit undertaken to Cefn Carnau Hospital on the 22nd, 23rd, and 24th September 2014

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to Cefn Carnau independent hospital on the evening of 22nd and all day on the 23rd and 24th September 2014. The main focus of the visit was to establish progress in addressing the issues highlighted in our earlier visit in April 2014.

The Priory hospital Cefn Carnau is a low secure hospital, located between Caerphilly and Thornhill, Cardiff. The hospital can provide care for up to 22 adults with a diagnosis of a learning disability who may also present with mental illness, personality disorder and an autistic spectrum condition. The hospital has three wards, an eight bedded ward for females, an eight bedded ward for males and a six bedded ward for males.

Our visit highlighted areas that are noteworthy and include:

- The way staff engaged with the inspection process.
- The continuing good rapport we observed between patients and staff.
- The array of patient information available on all wards. Notices and posters were in an appropriate, easy read format.

Healthcare Inspectorate Wales • Arolygiaeth Gofal Iechyd Cymru
Welsh Government • Llywodraeth Cymru
Rhydycar Business Park • Parc Busnes Rhydycar
Merthyr Tydfil • Merthyr Tudful
CF48 1UZ
Tel • Ffôn 0300 062 8163
Fax • Ffacs 0300 062 8387
www.hiw.org.uk

- The range of activities available both on and off site was notable. A social group was taking place during the evening of 22nd September. Golf and cycling trips were taking place on subsequent days.

- The effective multi disciplinary team (MDT) working between the disciplines.

- Some innovative work from both the activities team and occupational therapy (OT).

We also identified some improvement in aspects highlighted in our earlier (April 2014) visit:

- A significant amount of refurbishment was taking place. (point 2, April 2014 letter) However, some environmental issues were highlighted during our September visit, see point 5 below.

- Regulation 28 reports were being undertaken by The Priory Group and were being updated to reflect the issues identified in our April 2014 letter (point 1)

- The dining experience for patients had improved. On Bryntirion ward, dining tables were set ready for patient mealtimes. (point 6)

Our visit also highlighted a number of issues. We provided a verbal overview of our concerns to your registered manager at the end of our visit on 24th September 2014. A summary of these, which include regulatory breaches is set out below:

Issue of concern	Regulation
1. 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.	Regulation 18 (2) (a) & (b)
2. The hospital requires a full time manager to effectively manage the service. The arrangements at the time of our visit was a manger managing two hospitals, which is unsatisfactory and cannot be sustained. In effect this 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.	Regulation 11 (1) (a) (b) (i) & (iii)
3. Two sets of care documentation was examined and the following observations were made: 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	Regulation 15 (1) (a) (b) & (c)

staff, however this equally applied to female staff. 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. iii. There was a large number of care plans with duplication noted. iv. The care plan on safeguarding (reviewed 03/09/2014) 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 Derwen ward: i. Care plans need to be rationalised to avoid duplication and an excessive amount of plans.	
4. 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.	Regulation 20 (1) (a)
5. We reviewed the environment and the following observations were made: 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. 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. iii. The bathroom on the first floor had an overflowing bin and required a thorough clean. The environmental requirements must be addressed.	Regulation 26 (2) (a) & (c)
6. 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	Regulation 20 (1) (a) & (b)

induction on file.	
7. 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.	Regulation 20 (1) (b) & 21 (2) (b) &(d)
8. There was no positive behavioural 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.	Regulation 15 (1) (a) (b) & (c)
9. Ten (10) staff files were examined and the following observations were made: a. Three (3) files did not contain a medical check prior to starting employment. b. Two (2) files did not contain references or only had one reference on file. c. Start dates could not be obtained from the information contained on file for 2 employees. All staff must have the necessary employment information available.	Regulation 21 (2) (a) (b) (c) & (d)
10. 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.	Regulation 20 (2) (a)
11. 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.	Regulation 20 (2) (a)
12. 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.	Regulation 15 (5) (a)
13. Food continued to be an issue for patients and staff	Regulation 15 (9)

(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.	(a) & (b)
14. 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.	Regulation 15 (1) (b) & (2)
15. 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.	Regulation 20 (1) (a) & (2) (a) & (b)
16. 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.	Regulation 15 (1) (a) (b) (c) & 19 (1) (a) & (b)

Mental Health Act Monitoring – The Administration of the Act

We reviewed the statutory detention documents of 5 of the detained patients being cared for on 3 wards at Cefn Carnau hospital at the time of our visit. The following noteworthy practice was observed:

- The Mental Health Act (MHA) administrator was supportive of the legal processes.
- Section 17 leave forms were very comprehensively completed with a high level of detail.
- There was good audit processes for the MHA 1983.
- There was 100% compliance of administrative and medical scrutiny of the MHA 1983.

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

17. Social worker assessment material in relation to the MHA 1983 did not always accompany the patient on transfer. Social worker assessments must accompany the patient.

You are required to submit a detailed action plan to HIW by **27th October 2014** setting out the action 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 Ms Gayle Walstow, Acting Manager at Cefn Carnau Hospital and Mr Patrick Mhlanga, Clinical Services Manager.

Yours sincerely

Mr John Powell
Head of Regulation

Cc – Ms Gayle Walstow, Cefn Carnau Uchaf, Thornhill, Caerphilly CF83 1LY

- Mr Patrick Mhlanga, Clinical Services Manager, Cefn Carnau Uchaf, Thornhill, Caerphilly CF83 1LY