Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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21 November 2014

Dear Mr Hartey,

Re: Visit undertaken to Coed Du Hall on the 13th, 14th and 15th October 2014

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to Coed Du Hall on the 13th, 14th and 15th October 2014. The main focus of the visit was to establish progress in addressing the issues highlighted in our earlier visit in June 2014.

Our visit highlighted areas that are noteworthy and include:

- The positive way staff co-operated with the inspection process.
- The continuing good rapport observed between patients and staff.
- Patients and staff continued to comment positively about the variety and quality of food, however issues regarding distribution of meals were identified. (See point 11)
- The pictorial patients guide and charter was a positive initiative.

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

- HIW received a Regulation 28 report in September 2014 which was detailed and comprehensive. (point 5, June 2014 visit)

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- Staff attendance in mandatory training courses had significantly improved, with a more robust system in place for monitoring.

- Staff files had been audited and were well presented. Employment information was more consistent and staff appraisals had and were taking place. (point 9)

- Patient documentation had improved with discharge plans in place. (point 11)

- There was clear evidence of multi disciplinary team (MDT) input into the care planning process. (point 4)

Our visit also highlighted a number of issues. We provided a verbal overview of our concerns to your manager at the end of our visit on 15th October 2014. A summary of these is set out below:

Issue of concern	Regulation
1. On the evening of 13/10/2014 the agency registered nurse on duty was unaware of some key information; a. The number of patients in the hospital. b. The number of beds in the hospital. c. The patient information board in the office. d. If any patients were subject to Deprivation of Liberty Safeguards (DoLS). e. Access to the handover report stored on the computer. All the areas identified must be addressed and the issues around the registered nurse fed back to the agency concerned	Regulation 15 (1) (a) & (b) & Regulation 20 (1) (a) & (b)
2. Upon arrival at Coed Du Hall and making our way to Cedar ward, it was evident that at least two staff were on Cedar unit who should have been on other wards. The reality of this situation was that other wards were left without staff. All wards must be appropriately staffed at all times.	Regulation 15 (1) (a) & (b) & Regulation 20 (1) (a)
3. The induction checklist for agency registered nurse A was not complete and it was therefore difficult to ascertain what aspects of induction had been completed for agency staff. This point was highlighted in June 2014 and requires attention.	Regulation 20 (1) (b)
4. During our visit there were agency staff on duty (A and B) however there was no information available to confirm what skills and experience they had. This point was highlighted in June 2014 (point 2) and	Regulation 21 (2) (b)

requires immediate attention. The registered provider must have evidence that agency staff have the necessary training and experience to enable consistency of care for the patient group. 5. A sample of patient care documentation was examined and the following observations were made: a. Patient C on Cedar ward: i. The observational record was not up to date. At 11:20 when HIW checked the records, the last entry was recorded at 10:00 and this entry was not fully completed. ii. Other observational records were not fully completed and did not contain sufficient detail. iii. The care plan on discharge was not evaluated in line with identified timescales. iv. The activity schedule needs to be further developed and "*morning routine, breakfast and tidy room*" remained a common feature. b. Patient D on Ash ward: i. A lack of evidence in the daily entry notes of treatment and therapeutic interventions. ii. Vulnerability had been assessed as "*very high risk*" but the risk management strategy in response to this was not robust and lacked detail. iii. There was a lack of written evidence that the patient had been involved or had the opportunity to be involved in the risk assessment process. iv. The support plan on diabetes did not consider the area of foot care and physical health complications sufficiently. v. The activity schedule (November 2014) needs to be further developed. c. Patient E, Cedar ward: i. There were a number of gaps in the observational records. ii. The activity schedule needs to be further developed because it lacked details of meaningful activities. d. Patient F, Beech ward: i. There was a lack of evaluation of the	Regulation 15 (1) (a) (b) & (c)

behavioural support plan undertaken by the psychologist and it was unclear how this document fitted in with other support plans. ii. The risk management strategy on aggression towards others only took account of a two person hold/escort when there had clearly been occasions when a restraint had required more than two persons. All areas identified must be addressed.	
6. A number of patients had limited opportunity to leave the hospital on recreational and social activities. All patients must have an opportunity to attend community based activities.	Regulation 15 (1) (a) & (b)
7. Following the staffing review (point 3, June 2014 letter) there still remained issues of patients not having recreational and social leave outside Coed Du Hall. The registered provider must undertake an analysis of all patient leave/activities (outside of Coed Du grounds) within the last 3 months (July-September 2014) and report the findings to HIW.	Regulation 15 (1) (a) & (b) & 19 (1) (a) & (b)
8. On-going redecoration and refurbishment of the hospital is required. The areas that require attention were: a. Ward level kitchens, specifically Beech ward which had chipped work surfaces. b. Beech lounge had liquid stains on the walls and ceiling. c. The seating on the wards needs to ensure they are suitable for the patient group. On Cedar ward some sofas and chairs were exceptionally low and some patients struggled to get up from them.	Regulation 26 (2) (a) & (b)
9. An on-going review of patient placements is required. Whilst some patients had moved on, there remained a number who have been at the hospital for a significant period of time. This point was identified in June 2014 (point 13) and the review of these placements must continue.	Regulation 15 (1) (a) & (b)
10. Infection control processes continued to be inadequate and were identified in June 2014 (point 7). In the bathroom on Ash ward, there was a red bag of soiled clothes on the floor, which was broken	Regulation 9 (1) (n) & 15 (1) (c)

and spilling out onto the floor. Clean towels were stacked on the soiled bin lid and the WC was heavily soiled. Effective infection control processes are required and must be implemented immediately.	
11. A review of the distribution of food is required and it should take into account of the following points; a. Staff from primarily Ash ward was allocated the daily task of serving food to patients on all wards. b. Staff and patients stated that Cedar ward was frequently the last ward to receive the food trolley. As a result the temperature of the food was not sufficiently hot and the choice could be limited because the other wards had been served first.	Regulation 15 (9) (b)
12. The uncertainty of the way the service was developing and a breakdown in communication between some disciplines was having a negative effect on morale. A decision regarding the development of the service and improvement of communication is required.	Regulation 18 (2) (a) & (b)
13. Feedback from patients and staff indicated a lack of awareness of the advocacy provision. Awareness of advocacy services must be promoted.	Regulation 15 (1) (a) & (b)

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 noteworthy practice was observed:

- The Mental Health Act (MHA) administrator and key staff had attended the MHA training.

- All the files examined contained up to date renewal papers and legal representation was in all the files looked at.

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

14. There were no approved mental health persons (AMHP) assessments available with the legal documents. AMHP assessments must accompany the legal documents.

15. The hospital had a new responsible clinician (RC) and new assessments of capacity had not been completed. Assessment of capacity is required.

You are required to submit a detailed action plan to HIW by **12th December 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, Interim Manager.

Yours sincerely

Mr John Powell
Head of Regulation

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