Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health/ Learning Disability Inspection (Unannounced)

Cefn Carnau: Sylfaen, Bryntirion & Derwen: Priory Group Limited

11th ,12th & 13th August 2015

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1. Introduction

Our mental health and learning disability inspections cover both independent hospitals and mental health services provided by the National Health Service (NHS). Inspection visits are a key aspect of our assessment of the quality and safety of mental health and learning disability services in Wales.

During our visits Healthcare Inspectorate Wales (HIW) ensures that the interests of the patients are monitored and settings fulfil their responsibilities by:

- Monitoring the compliance with the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards
- Complying, as applicable, with the Welsh Government's National Minimum Standards in line with the requirements of the Care Standards Act 2000 and the Independent Health Care (Wales) Regulations 2011.

The focus of HIW's mental health and learning disability inspections is to ensure that individuals accessing such services are:

- Safe
- Cared for in a therapeutic, homely environment
- In receipt of appropriate care and treatment from staff who are appropriately trained
- Encouraged to input into their care and treatment plan
- Supported to be as independent as possible
- Allowed and encouraged to make choice
- Given access to a range of activities that encourage them to reach their full potential
- Able to access independent advocates and are supported to raise concerns and complaints
- Supported to maintain relationships with family and friends where they wish to do so.

2. Methodology

The inspection model HIW uses to deliver the mental health and learning disability inspections includes:

- Comprehensive interviews and discussions with patients, relatives, advocates and a cross section of staff, including the responsible clinician, occupational therapists, psychologists, educationalists and nursing staff
- Interviews with senior staff including board members where possible
- Examination of care documentation including the multi–disciplinary team documentation
- Scrutiny of key policies and procedures
- Observation of the environment
- Scrutiny of the conditions of registration for the independent sector
- Examination of staff files including training records
- Scrutiny of recreational and social activities
- Scrutiny of the documentation for patients detained under the Mental Health Act 1983
- Consideration of the implementation of the Welsh Measure (2010)[1]
- Examination of restraint, complaints, concerns and Protection of Vulnerable Adults referral records
- An overview of the storage, administration, ordering and recording of drugs including controlled drugs
- Consideration of the quality of food
- Implementation of Deprivation of Liberty Safeguards (DOLS).

HIW uses a range of expert and lay reviewers for the inspection process, including a reviewer with extensive experience of monitoring compliance with the Mental Health Act 1983. These inspections capture a snapshot of the standards of care patients receive.

[1] The Measure is primary legislation made by the National Assembly for Wales; amongst other matters it makes provision in relation to assessment, care planning and coordination within secondary mental health services.

3. Context and description of service

The Priory Hospital Cefn Carnau is a low secure hospital providing care and treatment for up to 22 adults with a diagnosis of a learning disability who may be liable to be detained under the Mental Health Act 1983. The hospital is located between Caerphilly and Cardiff and is owned by the Priory Group Limited. The hospital is registered to provide the following:

- Sylfaen ward is a low secure service for a maximum of eight female adults over the age of 18 years diagnosed with a primary diagnosis of a learning disability who may be liable to be detained under the Mental Health Act 1983.
- Bryntirion ward is registered for a maximum of eight male adults over the age of 18 years diagnosed with a primary diagnosis of learning disability who may be liable to be detained under the Mental Health Act 1983.
- Dderwen ward is a low secure service for a maximum of six male adults over the age of 18 (eighteen) years diagnosed with a primary diagnosis of learning disability who may be liable to be detained under the Mental Health Act 1983.

4. Summary

Our inspection at Cefn Carnau hospital took place across all three wards.

We found scope for improvement and were disappointed to identify a number of regulatory breaches, but were also pleased with a number of positive findings.

During our visit, we noted the positive way staff engaged with the inspection process and we observed a positive rapport between staff and patients. In particular we observed the de-escalation of the challenging behaviour of two patients which was handled professionally and calmly. It was disappointing, therefore to arrive at the hospital on the evening of 11th August 2015 and identify non compliance in relation to staffing.

Upon arrival at Cefn Carnau we identified that there were no permanently employed registered nurses on duty. The three wards were being managed by two agency nurses and one bank nurse who were unfamiliar with the hospital and were working without the involvement of any regularly employed staff. In addition, discussions with one agency staff member uncovered that they did not have the necessary knowledge, skills and experience to work with the patient group (provide the care required by the patients) at the hospital. The agency staff member did not have up to date training in restraint and was unable to tell inspectors what a section 37/41 was. It is essential that any agency staff employed at Cefn Carnau have the skills, knowledge and experience required for the patient group to ensure quality and competency of care is provided.

A review of the information kept on the agency file identified another area with significant non compliance regarding skills and experience. The file did not contain a copy of a CV or induction information for the two agency staff on duty. Therefore it was impossible to confirm the skills, experience and knowledge of the two agency staff. The impact of a lack of information about the agency staff contracted by the service is significant. The skills and competency levels could not be determined and this could have significant results for the hospital in terms of quality of service, safety and continuity of care.

Following our visit we issued a non compliance notice and the organisation has responded and provided an action plan regarding the steps they have put in place to address the regulatory breaches. The notice and action plan are published on HIWs website.

Significant investment had been put into the environment. Since our previous visit in September 2014 we were pleased to note improvements. New windows had been fitted, the exterior of the building had been painted and wards had been re-decorated and new furnishings were evident.

Comments from patients and staff confirmed food had also improved since our visit in September 2014. The choice and quality of the food served were areas we had the most positive comments. It was noted that the evening meal time had changed from 16:00 to 17:15 which provided a more reasonable gap between lunch and evening meal.

A review of staff files identified some areas that require attention, in particular ensuring all files have two references and evidence of relevant qualifications are documented. A review of the staff files is required to ensure the consistency of information saved on file and to gain information about the standard of employment practice and standard of staffing at the Hospital.

A review of training statistics and discussions with staff indicated deficits of training in Mental Capacity Act, Positive Behavioural Plans, the Measure (Wales) 2010 and de-fibrillation training. Training needs to be reviewed to ensure all staff and bank staff have up to date and relevant training.

A lack of regular supervision was identified and the way supervision was conducted requires review. Some staff had not received supervision for some time and other members of staff told us how supervision was used punitively to address issues. A system of regular supervision with the purpose of learning and development needs to be implemented for all staff.

The introduction of pet therapy was having a positive impact on the patient group. The recent arrival of two cats and some chickens were providing alternative therapies and activities for patients. A wide range of activities were offered and we observed patients participating in activities during our visit, however motivation on the female ward was having an impact on patient participation in activities.

The in-house educational service for patients had been significantly reduced and accreditation had been stopped despite this service being advertised on the Priory's website. The re-introduction of in-house education and accreditation must be re-considered because this had always been a highlight of the service provision of Cefn Carnau hospital and removing these opportunities will have a significant impact on patient progress.

The advocacy service was commented upon favourably by patients and staff and there were posters and information clearly displayed on the wards. The administration of the Mental Health Act was very comprehensive with a range of effective systems in place.

There was a lack of robust and appropriate audit and governance processes in place and these need to be implemented. In addition, under Regulation 28 of the Independent Health Care (Wales) Regulations 2011, the registered provider must provide a written report on the areas listed within Regulation 28 to HIW on a 6 monthly basis. HIW has not received copies of any reports undertaken by the registered provider.

5. Findings

Core Standards

Ward environment

It was evident upon our arrival at the hospital that investment had been made to the environment. The hospital had been painted externally and new windows were evident throughout the hospital. Internally, all the wards had benefitted from redecoration and some updated furnishings and fittings.

On entering Sylfaen ward a welcome sign was displayed along with photographs of some patients who wanted to introduce themselves to visitors. The ward had been re-decorated and pictures and notice boards were displayed throughout the ward. The notice boards had information regarding Mental Health Act information, ward rules, how to make a complaint, patient guide, fire evacuation procedure, HIW contact details and what's on information.

Two lounges were available for the patient group. Both lounges had a TV and sufficient seating. There was a conservatory off the main lounge and access to a garden area. The garden appeared well kept with some planting in the garden. Seating and facilities for smoking were also available.

The kitchen area at the time of our visit only had one table and four chairs which was not enough for the patient group, however, staff confirmed that additional seating was available and brought out to enable all patients to eat together. The kitchen was bright, a menu was displayed and facilities were available for patients to store their own food items. At the time of our visit, the fridge contained items which were out of date, specifically a rice pudding dessert dated 9 August and cream dated 10 August. Food items need to be regularly checked to ensure they are in date and safe for consumption.

A nurse's office and dispensing room were situated on the ground floor as well as a bathroom, with toilet and sink. The facilities were clean and the environment was bright.

Patient bedrooms were situated upstairs and all patients had their own room. Due to the time of our visit and because we did not want to disturb patients we did not go upstairs to observe the environment

Bryntirion ward is situated on the second floor of the hospital and is accessed via a staircase. All facilities for the patients are on the same floor, with bedrooms situated on one side of the ward and patient living areas the other side. The ward had one lounge with a TV and games console. Patient lockers were located in the lounge in which they could store personal items. The

lounge had been re-decorated and new seating was being used. The lounge had a homely feel with a coffee table in the middle of the lounge that had some board games and books stored on it. Furnishings displayed on the window sill further complemented the homely environment.

A kitchen/dining room was located at the end of the ward. The room had also been re-decorated and new kitchen cupboards had been fitted. A large wooden dining table with sufficient seating occupied the middle of the room. The table had a fruit bowl available with a variety of fruit offered to the patients. Placemats were set on the table and this presented a positive dining experience for the patients. A dumb waiter/serving hatch was in the room in which meals would be delivered and served.

On entering the ward, there is a large foyer in which the nurse's office is situated. There were some seats for patients to sit on and notice boards displaying a variety of patient information. Patients had completed jigsaws and these were framed and displayed on the walls of the ward.

The patients could access the garden area which was located downstairs. The area was well kept, with cut lawns and flower beds. A patient had their own patch in which they were growing some vegetables and flowers.

Dderwen ward, like Bryntirion was all situated on one floor. On entering the ward there was a bathroom and further along patient bedrooms. A lounge and conservatory provided patients with rooms to relax and watch TV and access to the garden was from the conservatory.

The garden was well maintained and facilities were available for smoking should patients require this.

A dining room was situated at the end of the ward which had sufficient seating and tables for the patient group. A nursing office and clinic room were also on the ward.

Since our previous visit in September 2014 we noted the ward had been re-decorated and provided patients with a bright and clean environment.

Requirements

All food items stored in fridges need to be checked regularly to ensure they are in date and safe for consumption.

Safety

On the evening of the 11 August 2015 there was no nominated person in charge of the hospital. In the event of an emergency/situation there would

have been no central coordination. The registered provider must ensure that a suitable person is in charge of the hospital.

During the evening visit we identified that there were no permanently employed registered nurses on duty. The three wards at Cefn Carnau were being managed by two agency nurses and one bank nurse. The registered provider must ensure that at least one permanently employed registered nurse is on duty at the hospital.

During discussions with one agency staff member it was evident that the person did not have the necessary knowledge, skills and experience to work at the hospital. In particular the agency nurse could not explain what a section 37/41 was and the associated patient care implications. Additionally they did not have updated training in restraint or appropriate training in Managing Violence and Aggression (MVA) which is the preferred model used at Cefn Carnau. It is essential that any agency staff employed at the hospital has the skills and experience required for the patient group to ensure quality and competency of care is provided.

In addition, we reviewed the agency file in which agency staff CVs were stored and were disappointed to learn that the agency members on duty at the time of our visit had no information on file to confirm their skills and experience. There was also no documented induction on file. As a result of the absent information, it was impossible to confirm the skills, experience and knowledge of the two agency staff. The impact of a lack of information on agency staff is significant. The skills and competency levels could not be determined and this could have significant results for the hospital in terms of quality of service, safety and continuity of care. The registered provider must ensure that agency and bank staff have the necessary skills and experience to work at the hospital.

The issues highlighted regarding no-one in charge of the hospital, agency staff and their knowledge, skills and experience and the lack of information stored on file resulted in HIW issuing a non compliance notice because the service was not compliant with the regulations. We have received an action plan from the hospital confirming the procedures and processes they have put in place to address the issues. The notice and action plan has been published on our website.

Requirements

The registered provider must ensure that at least one permanent member of the nursing team is on duty at all times.

It is essential that any agency staff employed at the hospital have the skills and experience to provide safe and effective care.

The registered person must ensure that agency and bank staff have the necessary skills and experience to work at the hospital.

The multi-disciplinary team

All the staff we spoke to said the multi disciplinary team (MDT) worked in a professional and collaborative way. Staff said that professional views were obtained and valued and staff felt respected.

MDT meetings took place on a monthly basis and one of the Responsible Clinicians (RC) had split his MDT meetings into two days which staff said worked better because it allowed them to get back on the wards and not sit in the MDT meeting all day.

General Healthcare

A review of the treatment/clinical room on two wards was undertaken and the following observations identified:

- Expired medications need to be disposed of at the time and date by which they expire to prevent the risk of use of out of date medicine.

Requirements

The Hospital must put in place a system of regular review of medication expiry date and ensure all expired medication is disposed of.

Privacy and dignity

All patients had their own bedrooms and shared toilet and showering facilities. One patient said that sometimes the toilets were dirty, however during our visit we did not observe an unclean environment, but regular checking of facilities is required to ensure standards are maintained.

Patients said they could store and display personal items in their rooms and all patients said they could lock their room. Patients said they felt their dignity and privacy was respected at the hospital.

All the patients we spoke to said when they were admitted they were shown around the ward and on the whole the majority of patients said they felt safe.

There were facilities for patients to receive visitors and patients had access to telephones to maintain contact with family and friends. All patients said they had a named nurse they could discuss private matters with.

Patient therapies and activities

Patients had access to a number of therapies and activities, however staff told us that motivation was a key issue, specifically on Sylfaen ward. Some staff said that some patients seemed institutionalized with many of the patients not attending the morning meeting to discuss the day ahead. Many of the patients we spoke to from Sylfaen ward did tell us there was not enough to do and during our visit we observed one patient complaining to an agency support worker that there was nothing for her to do and she was going back to bed. The agency worker did not offer any alternative activity and took the patient to her room.

Patients told us they had an individual activities timetable and described the activities they had participated in, including, walking within the grounds, cooking, golf at the local range, cycling and card and board games. A social club takes place every evening in which patients gather together and chat, play games and listen to music. During our visit we observed more activities taking place on Dderwen and Bryntirion wards than Sylfaen. One patient on Dderwen ward was playing on the video game console and another patient was gardening and had grown a number of different vegetables and flowers, which provided a colourful and appetising display.

The hospital had large grounds and poly tunnels and greenhouses were in operation growing a variety of vegetables. Patient involvement was encouraged and it was pleasing to note that produce grown as a result would be used by the kitchen.

At weekends, staff told us that mostly on-site activities took place, but staff would try and take out as many patients as they could, depending on staffing levels and access to hospital vehicles. Patients with section 17 leave would like to arrange visits home to see family and friends.

Pet therapy was a recent initiative put in place by the new hospital manager with cats and chickens taken up residency at the hospital. Patients told us about their interactions with the animals including feeding; caring and ensuring the chickens were put to bed at night. The animals at the time of our visit were certainly a highlight for both patients and staff. In addition, some patients were involved in dog walking which also received positive feedback as an activity.

The in-house education provision had been significantly reduced and accreditation had been stopped. This was a huge disappointment which was echoed by staff. The education and accreditation programme was still being advertised on the Priory's website despite not being in place and in-house education and accredited programmes should be re-introduced.

A number of therapies were in place for the patients and these were delivered by psychology, occupational therapy and an art therapist. Staff told us that an activity coordinator role was trailed for a month; this has now ceased but worked well on Dderwen ward.

All the patients we spoke to told us that if required, appointments would be made to see a GP, optician, dentist or equivalent if needed.

The advocacy service was commented on favourably by staff and patients and there were posters on all wards informing patients of the service, including a name and contact details.

Requirements

A review of the activities offered to patients, specifically on Sylfaen ward is required to ensure they are appropriate for the patients and as close as they can be to their likes to ensure more engagement and participation.

The re-introduction of in-house education and accreditation programmes must be considered.

Food and nutrition

On the whole patients and staff commented favourably upon the choice and quality of the food served, with seven out of nine patients we spoke to saying they enjoyed the meals at the hospital.

There were two chefs in post at the time of our visit and patients said they had a menu from which they would choose their food options. Patients and staff told us that the food had improved which was an improvement from our previous visits in April and September 2014. In addition, we were pleased to note that the last meal served at the hospital had changed from 16:00 to 17:15 therefore extending the gap between lunch and tea and helping to prevent snacking during the evening which was observed in September 2014.

Patients told us they could buy and store their own snacks and they could have a drink and snack outside of set meal times. None of the patients we spoke to said they had problems receiving a diet appropriate for their religion or culture and any patients with allergies or diet problems would be given a menu suitable for their needs.

Nearly all the patients we spoke to said the food served was enough for them and staff confirmed that portion sizes were good. Patients on Bryntirion ward told us they had a comments book in their kitchen/diner in which they could

write feedback regarding the food served and the catering staff would regularly review it.

Staff told us patients were regularly weighed and if required, appointments would be made with a dietician via the GP.

Training

We reviewed 10 staff files and noted some inconsistencies with the information kept on file. One file had no written references and there was a lack of documentary evidence of relevant qualifications. Other variations included some files having a photograph of the employee and some that did not, and some files containing medical questionnaires while other files had none. Similar issues regarding staff files was raised in September 2014, therefore a review of staff files is required to ensure employee information contained on file is consistent.

A system was in place to record and monitor Disclosure and Barring Service information (DBS) and we noted and endorse the good practice adopted by Cefn Carnau hospital to regularly renew DBS checks for all staff. This practice ensures the hospital has an independent check that helps enhance the organisations ability to assess a person's integrity and character.

An analysis of the training statistics and discussions with staff indicated deficits in certain training modules. In particular, training needs to be provided for staff in Mental Capacity Act 2005, The Measure (Wales) 2010, Positive Behaviour Support plans and de-fibrillation training.

There was a lack of evidence that staff were receiving regular appraisal and supervision. Only half of the staff files reviewed had a copy of an appraisal on file. Of these appraisals seen, the dates of when the last appraisal took place ranged from December 2012 to March 2014. Statistics provided from the Foundations for Growth[2] system however did highlight March 2015 dates for two employees, but there was no evidence on their files. This was an issue in September 2014 and a system needs to be put in place to address the issue.

Only four out of ten files had copies of staff supervision. Two of the files had supervision records dated in 2014 and two files had the last supervision in June and July 2015. Discussions with staff confirmed that supervision did not take place on a regular basis. Some staff told us they had supervision once every six months. In addition, supervision was being used to raise discrepancies with staff which they said felt punitive. A lack of supervision was

[2] Foundations for Growth is an on-line learning and development programme for all Priory staff. For more information visit http://www.priorygroup.com/working-for-the-priory-group/learning-and-development

identified in our September 2014 visit and a system of regular supervision must be implemented for all staff.

A random sample of two agency workers and one permanent employee indicated that no documented induction had been undertaken. All staff must have a documented induction.

A review of access to the IT system for recording information on Care Notes is required. On our evening visit when agency and bank staff were overseeing patient care on all three wards, it was apparent that none of the staff had their own log-in account and were either reliant on permanent staff signing in or not having access at all. It is essential that any person adding notes to the system does so under their own identity and not that of someone else to enable an accurate record of recording.

Requirements

A review of all staff files is required to ensure they contain relevant and consistent information, including two references and documented evidence of relevant qualifications.

A review of training is required and deficits addressed. In particular training needs to be delivered in Mental Capacity Act 2005, The Measure (Wales) 2010, Positive Behaviour Support plans and de-fibrillation training.

A system of regular appraisal and supervision needs to be put in place for all staff and evidence of these practices need to be recorded and filed for evidence.

All staff must have a documented induction.

A review of access to the IT systems is required to ensure all staff, including bank and agency can record notes on the system under their own identity to enable accurate recording.

Governance

We identified a lack of robust and appropriate audit and governance processes in place and these need to be implemented to ensure the organisation has a clear view of the hospital's strengths and weaknesses.

Under Regulation 28 of the Independent Health Care (Wales) Regulations 2011, the registered provider must provide a written report on the areas listed within Regulation 28 to HIW on a six monthly basis. HIW has not received copies of any reports undertaken by the registered provider.

Requirement

Robust governance and audit processes must be implemented by the registered provider.

Regulation 28 visits need to be carried out on a six monthly basis and reports sent to HIW.

Application of the Mental Health Act

We reviewed the statutory detention documents of four of the detained patients being cared for on two wards at the time of our visit. The administration of the Mental Health Act 1983 (MHA) was very comprehensive and a range of effective systems were in place. We noted the pictorial information leaflet in relation to the MHA as an area of good practice.

A review of four sets of documentation of the Mental Health Act 1983 identified a lack of MHA 11 forms for non consenting patients.

Requirement

All non consenting patients must have appropriate forms completed including MHA 11.

Monitoring the Mental Health Measure

We reviewed the care and treatment planning documentation for three patients at Cefn Carnau and identified the following observations:

- Of the files examined, it was difficult to see how the Measure was being implemented in the care plan documentation
- There was a lack of time specific goal setting in the care plans reviewed
- There was a lack of evaluation in line with identified timescales

Requirement

All the areas identified must be addressed, including ensuring the Measure is implemented in care plan documentation, time specific goal setting is included in care plans and evaluation in line with identified timescales is completed.

6. Next Steps

Cefn Carnau Hospital is required to complete an Improvement Plan (Appendix A) to address the key findings from the inspection and submit its Improvement Plan to HIW within two weeks of the publication of this report.

The Improvement Plan should clearly state when and how the findings identified at Cefn Carnau Hospital will be addressed, including timescales.

The Improvement Plan, once agreed, will be published on the Healthcare Inspectorate Wales website and will be evaluated as part of the on-going mental health/learning disability process.

HIW Inspection Action Plan

Hospital: Priory Hospital Cefn Carnau

Date of inspection: **11th August – 13th August 2015**

Date of Action Plan: **10th September 2015**

Hospital Director: **Vicky O'Dea**

RAG Rating
Green = Action Completed
Amber = Action in Progress
Red = Action Over Timescale for Completion

Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
15 (1) (b)	All food items stored in fridges need to be checked regularly to ensure they are in date and safe for consumption	Fridge temps are checked every day and during this check, the food contained within will be reviewed for being in date and safe for consumption.	This is now in place.	CSM/Senior Support Worker		05.09.15	
Standard	**Judgment Comments/ Evidence**	**Action**	**Progress To Date**	**By Whom**	**RAG**	**Timescale for Completion**	**Date Completed**
20 (1) (a) & (b)	The registered provider must ensure that at least one permanent member of the nursing team is on duty at all times	Staff Rosta is now done 4 weeks in advance and shortfalls highlighted. Every Thursday the HD and CSM check the next 7 days rota and remedy any shortfalls.	This is in place and monitored weekly by HD or CSM. Any short falls are addressed at this stage and remedy the deficits.	HD		14/08/15	14.08.15
Standard	**Judgment Comments/ Evidence**	**Action**	**Progress To Date**	**By Whom**	**RAG**	**Timescale for Completion**	**Date Completed**
21 (1) (a) and 21 (2) (b) & (d)	It is essential that any agency staff employed at the hospital has the skills and experience required for the patient group to ensure quality and competency of care is provided	HD written to all agencies, highlighting skills and experience required. This is then checked by CSM via C.V.'S and training records provided by agency.	Files have been updated and are located centrally. These are checked weekly by the CSM, discussed at the Clinical Governance meetings and is monitored as part of the Quality Walk rounds by the HD.	CSM		14.08.15	14.08.15

Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
21 (1) (a) & (b)	The registered person must ensure that agency and bank staff have the necessary skills and experience to work at the hospital.	Bank staff have been written to reminding them of their training requirement including MHA, MCA, PMVA and Learning Disabilities.	Letters have been issued and training records updated. FFG modules have been reallocated to staff.	CSM/HR		31/10/15	
Standard	**Judgment Comments/ Evidence**	**Action**	**Progress To Date**	**By Whom**	**RAG**	**Timescale for Completion**	**Date Completed**
19 (1) (b)	A system for the regular review of medication is required to ensure all expired medication is disposed of.	Set up and embed the process for weekly audit by night nurses to review for expired medication. Waste medication is placed in pharmaceutical waste bins and collected for disposal.	CSM will write to nurses including reminders in the correspondence handover book. Discussion in ward meetings and reviewed regularly by pharmacy provider.	CSM		31/10/15	
Standard	**Judgment Comments/ Evidence**	**Action**	**Progress To Date**	**By Whom**	**RAG**	**Timescale for Completion**	**Date Completed**
15 (1) (a)	A review of the activities offered to patients, specifically on Sylfaen ward is required to ensure they are appropriate for the patients and as close as they can be to their likes to ensure more engagement and participation.	OT to review previous activity checklists and assessments, and then meet with named nurses and patients to develop patient specific and group activities. This review will be done quarterly.	This is ongoing to involve discussion with patient groups.	CSM/OT		31.10.15	
Standard							
15 (1) (a) (b) & (c)	The reintroduction of in-house education and accreditation programmes must	The Therapies lead is being recruited and will review education provision in detail. Consideration will be given to sessional education input for baseline	Advert has been published closing date is the 30.09.15. HD is exploring sessional input from local colleges.	SC/MD/ HD		22/01/16	

Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
	be considered	assessments and addressing specific educational needs.					
Standard	**Judgment Comments/ Evidence**	**Action**	**Progress To Date**	**By Whom**	**RAG**	**Timescale for Completion**	**Date Completed**
21 (2) (a) & (d)	A review of all staff files is required to ensure they contain relevant and consistent information, including two references and documented evidence of relevant qualifications.	A review of all staff files has commenced to identify and rectify all deficits. This will be stored on a HR spreadsheet so that there is a catalogue of where items are missing. If there are items missing this they will be sourced where able but if unable to a file note will be included identifying the action taken.	A review is currently being conducted and will be monitored via the training meeting.	HD/HR		31/10/15	
Standard	**Judgment Comments/ Evidence**	**Action**	**Progress To Date**	**By Whom**	**RAG**	**Timescale for Completion**	**Date Completed**
21 (2) (a) & (d)	A review of training is required and deficits addressed. In particular training needs to be delivered in Mental Capacity Act 2005, The Measure (Wales) 2010, Positive Behaviour Support plans and de-fibrillation training.	The training matrix will be reviewed to ensure it covers all these requirements	Essential training has been rolled out and is being reviewed via the Clinical Governance Meeting.	HD/HR		30/11/15	
		MCA and PBS training is available in a E-learning and staff will be required to complete within 1 month	Training has commenced	HD/HR		31/10.15	
		PBS Face to Face training has already began by the Psychology dept	Training has commenced	HD/Psychology		30/11/15	
		We are sourcing an appropriate trainer for the Welsh Measure.		HD/Psychology		22/01/16	
		Defib – this is part of the basic life support training – implemented via rolling programme for staff	Training has commenced	HD/HR		27/11/15	

Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
Standard	**Judgment Comments/ Evidence**	**Action**	**Progress To Date**	**By Whom**	**RAG**	**Timescale for Completion**	**Date Completed**
20 (2) (a) (b)	A system of regular appraisal and supervision needs to be put in place for all staff and evidence of these practices need to be recorded and filed for evidence	Newly appointed Business Support Manager will be responsible for recording and file evidence of supervision (clinical and non clinical) to ensure it is regularly audited and reviewed in monthly clinical governance meetings Clinical supervision training is now being addressed	Clinical supervision spreadsheet is being developed. The clinical supervision training is being delivered by the Quality Lead – Train the Trainers have been identified and trained to deliver supervision	BSM/HR/HD and CSM HD		14/12/15 30/11/15 01/10/15	
Standard	**Judgment Comments/ Evidence**	**Action**	**Progress To Date**	**By Whom**	**RAG**	**Timescale for Completion**	**Date Completed**
20 (2) (a)	All staff must have a documented induction	All personnel files will be audited and missing documents and any induction deficits will be addressed. These will also be recorded on the HR spreadsheet when they have been filed once completed.	Ongoing audit in place and is being monitored by the training meeting.	HD/CSM/HR		02/10/15	
Standard	**Judgment Comments/ Evidence**	**Action**	**Progress To Date**	**By Whom**	**RAG**	**Timescale for Completion**	**Date Completed**
20 (1) (a) (b)	A review of access to the IT systems is required to ensure all staff, including bank and agency can record noted on the system under their own identity to enable accurate recording	HD to liaise with Priory IT dept to develop system of bank staff and visitor login ID's plus develop a robust system to record how user ID's are allocated on a day to day basis		HD/IT		07/01/16	
Standard	**Judgment Comments/ Evidence**	**Action**	**Progress To Date**	**By Whom**	**RAG**	**Timescale for Completion**	**Date Completed**
9 (1) (f)	Robust governance and audit processes must be implemented by the registered provider	Annual Priory compliance visit carried out on 02/03 Sept (findings consistent with HIW and long term recommendations – action to parallel this plan)	Awaiting full action plan from audit team This will also include robust implementing of Priory Quality	HD and CSM		31/11/15	

Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
		This action plan to be reviewed in monthly clinical governance meetings and via weekly quality walk around audits	systems such as sound clinical governance minutes, implementing lessons learnt, monitoring of quality via quality walk rounds, completing audits on the Divisional audit calendar.				
Standard							
19 (1) (a) (b)	Regulation 28 visits need to be carried out on a six monthly basis and reports sent to HIW	HD will liaise with Regional Ops Director about any additional written information which can be provided from his frequent site visits and the service user involvement meetings that he chairs. To set up a process for Reg 28 visits to be completed 6 monthly and submitted to HIW.		Ops Director		31/10/15	
Standard							
28 (1)&(2) (a) (b) (c) &(3) & (4) (a) (b) (c) & (5) (a) (b) (c)	All the areas identified must be addressed, including ensuring the Measure is implemented in care plan documentation, time specific goal setting is included in care plans and evaluation in line with identified is completed	Priory internal compliance visited 02/03 Sept. A copy will be forwarded to HIW For all patients commissioned by NHS Wales: CTP/CPA coordinator to monitor completion and uploading of CTP documentation for all eligible patients (including new admissions) MDT format is being revisited to ensure all care plans are clearly reviewed on a monthly basis by MDT and named nurse in line with goals set at previous CTP meeting	This action plan once agreed with HIW will be monitored monthly during Quality Walk round and Clinical Governance. This is in place via Coordinator and will be monitored via the MDT's.	HD HD HD/MD		30/09/15 31/11/15 30/11/15 30/11/15	
N/A	All non consenting patients must have appropriate forms completed including MHA 11	MHA Administrator will re-audit and contact relevant parties to complete forms		HD/AG/MD		30/11/15	
	Regular checks of Toilets	To be added to cleaning schedules at site and to be checked during quality		HD/CSM/SSM		30/10/15	

Standard	Judgment Comments/ Evidence	Action	Progress To Date	By Whom	RAG	Timescale for Completion	Date Completed
		walk rounds that they are being completed.					