DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

# Mental Health/Learning Disability Inspection (Unannounced)

## Coed Du Hall: Ash, Beech and Cedar wards: Coed Du Hall Limited

23rd & 24th September 2015

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## Contents

## 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

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[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.

- 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.

## 3. Context and description of service

Healthcare Inspectorate Wales (HIW) undertook an unannounced Mental Health and Learning Disability visit to Coed Du Hall, Mold on the evening of the 23 September and all day on the 24 September 2015.

Coed Du Hall independent hospital was first registered with HIW in April 2004 and at the time of our visit was registered to provide care to twenty two (22) patients on three wards. The hospital offers a service for the treatment and nursing of patients with a learning disability and functional mental illness who may also be detained under the provisions of the Mental Health Act 1983.

During our visit we reviewed the areas identified, including reviewing patient records, interviewing patients and staff, reviewing the environment of care and observing staff-patient interactions. The review team comprised of one Mental Health Act Reviewer, one peer reviewer, one lay reviewer and two members of HIW staff.

## 4. Summary

Our inspection at Coed Du Hall hospital took place across all three wards.

We found significant scope for improvement, with some issues still outstanding from our previous visit in October 2014, but were also pleased with a number of positive findings.

The investment in the environment had made a significant improvement to the facilities for patients. Although at the time of our visit the redecoration had not been finalised for the whole hospital, the areas that had been finished were modern and bright, compared to the areas that had yet to be completed.

The outside space would provide an excellent area for all patients if some adjustments were made to ensure the safety of patients with mobility and sight issues. In particular, hand rails and solid paths would enable all patients access to the grounds.

A review of some of the seating is required. At the time of our visit, there were dining chairs without arm rests, therefore could not support frail patients. In addition, some of the easy chairs located in the OT/dining area and on Cedar ward were very low and difficult to get up from.

The new key card system in operation was a new addition since our previous visit, however there were a lack of available key cards for all staff. Staff had to share their cards with other colleagues. Additional key cards are required to enable staff unlimited access to all areas.

The system of alert in place that notified staff when a patient had left their room was noisy. During our night visit there was an alarm going off which was loud and clearly would disturb fellow patients. A review of this system is required to ensure the noise, especially at night is not having an effect upon patients sleep.

It was good to note improvements in the multi disciplinary team (MDT), with all disciplines having equal input. One area that needs addressing is the communication resulting from actions from MDT. Any significant changes to a patient’s care needs to be communicated to all staff to ensure the patient has the care required.

Morale remained an issue amongst staff, with staff citing the uncertainty around leadership and the future of the service as main contributing factors. Morale needs to be improved.

All the staff files reviewed contained evidence of a current appraisal and that regular supervision was taking place. A programme of mandatory training was in place and although we identified that more than 50% of staff had between 90-100% compliance, there were some staff with most training modules overdue. Some areas need to be given priority and these included safeguarding, Mental Health Act and Respect training.

Staffing numbers were reported as often short and there was a high use of agency staff. The recruitment of permanent staff is crucial to ensure continuity of care and must be facilitated. In addition, if agency staff are to be used, block booking regular agency staff would be beneficial in providing continuous patient care.

Throughout our visit a number of agency staff were on shift and a review of the agency file revealed that for some agency staff there was no information regarding their skills, experience or knowledge. Some agency staff that had been used recently had expired training, so in the event of an emergency would not have up to date skills to deal with the circumstance. In addition, issues were identified regarding agency staff inductions, whereby the staff signature was missing and it was unclear if the agency staff had received an induction. The carelessness of this situation is unacceptable and the registered provider needs to ensure that necessary information is obtained before any agency staff is hired. It is also necessary to ensure that a thorough and robust induction is given to ensure the member of staff can effectively take charge of their shift.

A review of patient care planning documentation was reviewed and numerous issues about the quality of documentation were identified. Specific detail was given to the provider during feedback which included patient initials to ensure the individual records could be amended. A number of plans were not in place for some patients and others were not accurately completed.

We noted an improvement in the patient dining experience, whereby all patients went to the dining room to eat rather than wait for the serving trolley to be delivered to each ward. The menus displayed had colour coded food options to indicate healthy eating foods and higher fat/sugar foods. The pictorial menus were seen as noteworthy.

The achievement of the Gold Catering Standard from the Soil Association Food for Life was significant, recognising the hospitals efforts into improving standards in a number of ways.

## 5. Findings

### *Core Standards*

**Ward environment**

Coed Du Hall hospital is a single storey building set in a rural landscape. The hospital has three wards, Ash, Beech and Cedar and we noted the investment has in the environment made a significant improvement to the facilities available to the patient group. At the time of our visit, Beech ward was redecorated but unoccupied and redecoration was due to begin on Cedar ward.

The hospital is entered via a reception area, which had desks for staff members. Beyond reception was an office for the hospital manager. A door from reception leads onto a communal area containing a visitors room, staff kitchen and meeting room.

The OT/dining room was a large, open plan area with a dining area situated in one corner. There were four tables and 16 chairs, sufficient for the number of patients at the hospital during our visit. None of the dining chairs had arms to help support patients should they require this provision and this need should be considered. Located by the serving hatch was a menu which displayed the week's choices.

The OT/dining area had been redecorated, had new furniture, including chairs, bookcases and a TV. The chairs were too low and patients with mobility problems would struggle to rise from the chairs. Bookcases contained a range of reading material and patient information boards displayed a good range of information for patients including advocacy, activities, places of interest and patient events.

A door from the OT/dining room led to a long corridor, off which were situated Ash and Beech wards. At the end of the corridor, the nurses' office and clinic was located adjacent to Cedar ward.

At the time of our visit Beech ward was empty and Ash ward was accommodating female patients. Both wards had been newly refurbished and decorated. On entering Ash ward, you arrive in a small kitchen area which had been newly tiled and had new work surfaces and units. Integrated appliances including a microwave gave the kitchen area a modern look. A small table with four chairs were available for patients to sit and eat.

Patient bedrooms had been redecorated and new furniture provided patients with ample storage.  All bedrooms had a nurse call system, a sink and dimmer switch to control the brightness of the light.  The ward had two bathrooms, one had a bath and the other was a wet room, both rooms had toilets.  At the time of our visit there was a slight odour of damp in the wet room.

The lounge had a new carpet and curtains, a storage unit, a TV, as well as sufficient seating for the patient group.

In the long corridor, a conservatory area with seating had been refurbished and doors added to give some privacy to patients and staff.

Cedar ward, a ten bedded unit was occupied by seven male patients.  In contrast to the rest of the hospital, Cedar ward appeared to be tired and well worn, however plans were in place to redecorate.

All the bedrooms on Cedar ward had en-suite facilities and provided sufficient space for patients to store their belongings.  The lounge/kitchen diner was at the time of our visit the hub for the patient group.  The room had sufficient seating for the patients and a new TV was being fitted during our visit.  The kitchen provided unrestricted access to drinks and snacks, should patients require them.  A notice board near the kitchen area had patient information displayed.

Patients had access to an outside space containing a smoking shelter and gardens.  A new therapy kitchen had been installed.

At the time of our visit, there were alarms on two bedrooms which alerted staff when the patient left his bedroom.  The alarm was loud and would disturb fellow patients, particularly at night.  A review of this system is required.

***Requirements***

***A review of the suitability of the furniture, particularly the dining chairs and easy chairs for the patient group is required.***

***A review of the alarm system to alert staff when patients leave their bedrooms is required to ensure the noise of the alarm does not disturb patients, particularly at night.***

## Safety

The patients we spoke to said they felt safe at the hospital and the majority of staff we spoke to said they had no safety concerns.  However, comments were made regarding the safety of the physical environment specifically for those patients who were wheelchair users and/or partially sighted.  Some areas outside the hospital had gravel paths and slopes making it difficult for these patients to use the outside space safely and unaided. Staff suggested that hand rails were needed to make some areas safe and the gravel needs to be replaced with a path to make access easier for wheelchair users.

Our observations regarding some seating at the hospital identified that easy chairs were very low and none of the dining room chairs had arm rests to support patients. Some staff told us that patients required assistance getting up if they sat on the low seating and issues regarding low seating had been raised but no action taken.

At the time of our visit one patient was listed twice on the patient information board, which resulted in confusion regarding patient numbers. It is essential that patient information is recorded properly to ensure this type of confusion is avoided, because in the event of an emergency wrong numbers would be given to emergency services.

There was a new key card door system in operation which allowed staff to access all areas. At the time of our visit, there was a shortage of key cards, with staff having to share. Additional key cards must be made available.

A review of staff numbers is required. Staff told us that after 4pm, staffing numbers reduce significantly, often leaving two support workers on a ward. On occasions there has been one staff member on a 1:1 while the other care support worker looked after the other patients. Situations like this leave staff in a vulnerable position and also compromises patient care.

***Requirements***

***A review of outside areas is required to ensure all these areas are accessible and safe for all patients.***

***Additional key cards must be acquired to ensure all staff have their own.***

***A review of staffing numbers is required to ensure all wards have sufficient staff to provide safe and effective care.***

## The multi-disciplinary team

The hospital had a multi disciplinary team (MDT) in place which included the responsible clinician (RC), nursing staff, psychologist and occupational therapists. Staff who were members of MDT told us that it was working more effectively and that patient’s were reviewed every month.

Members of MDT said they worked in a professional and collaborative way and that their professional views were valued.

Staff told us that there was room for improvement regarding communication, because very little feedback from MDT was communicated.  A key worker was disappointed when changes made to a patient's diet had not been communicated.  A colleague happened to mention it in passing which was not ideal.  Key messages regarding patient care need to be communicated to all appropriate staff to ensure continuity of care is provided.

**Privacy and dignity**

All patients had their own bedrooms with shared bathroom facilities on Ash and Beech wards and en-suite facilities on Cedar ward.  The bedrooms offered sufficient storage and patients were able to personalize their room with pictures and posters.  Staff lock and unlock bedroom doors and patients said staff respected their privacy and dignity.

Facilities were available for patients to spend time with family and friends, with a visitor room located near the reception area.    A payphone was situated in the ward corridor and the office phone was also available for patients to use.

Patients told us they had a named nurse and were able to meet them in private.

**Patient therapies and activities**

During our visit we observed some patients engaged in activities which included a quiz and jigsaws.  Some patients were being transported into the community to participate in shopping and leisure activities.  Discussions with staff confirmed that a range of activities were available and included arts and craft, board games, colouring and DVDs.  Personal shopping trips, bowling, local walks, swimming and visits to local markets were available in the community, however staff did say that some patients with complex needs were difficult to manage and cater for.  There was a commitment to take patients out two or three times per week but some patient's required three to one supervision which can impact on staffing numbers.

Patients said they did not have enough to do, but were asked what they like to do.  OT told us the activities patients can do was increasing and that OT would record a patients activities on a daily basis.  A new system was in place where patients complete an activity request form for community based activities.  This new system required a lot of prompting from OT's to get patients to use the forms and plan their time.

OT told us that more collaborative working with care support workers was taking place, and they were encouraging patients to take part in a number of activities on the wards. Art and craft, games and music were having a positive impact.

All patients were registered with a GP and access to a dentist, chiropodist, optician and so on was facilitated. Laundry facilities were available at the hospital and patients were encouraged and supported to use them.

**Food and nutrition**

Patients told us that on the whole they enjoyed the meals served at the hospital. Menus were displayed on the ward as well as in the dining room. There was a pictorial menu displayed next to the written menu and the written menu had colour coded options to help patients choose foods that were suitable for their needs, including green coding for healthy eating options and red coding for foods that were higher in fat.

There was a four week menu rota in operation and patients were offered three meals per day, including breakfast, lunch and tea. Breakfast consisted of cereals, porridge, toast plus conserves and drinks and was self service with help from nursing and support staff. Lunch was served at 1pm where the main meal was provided. Three choices were offered to patients including a vegetarian option and fruit or yogurts were offered for dessert. Tea was served at 5pm and offered patients lighter snacks, such as soup, flatbreads, salads and dessert.

Patients requiring a special diet were catered for and it was pleasing to learn that the hospital had achieved the Soil Association Food for Life Gold Catering Standard[2], which we noted as a significant attainment. This award recognizes the effort made by the hospital to improve food standards in a number of ways, including at least 15% of the food budget is spent on organic items.

It was pleasing to note that the dining experience had improved since our previous visit, with food being served centrally in the dining room rather than delivered to each ward via a serving trolley.

Patients had access to drinks and snacks outside of set meal times and fruit and biscuits were available. The majority of staff said portion sizes were satisfactory, however some patients said the portions could be bigger.

**Training**

A review of five staff files was undertaken and we found evidence that all files had a current disclosure and barring check (DBS) in place. This practice

[2] For more information on the Soil Association Food For Life Catering Mark, visit http://www.sacert.org/catering/hospitalscaresettings

ensures the hospital has an independent check that helps enhance the organisations ability to assess a person's integrity and character. Staff with professional registrations had evidence on file that they were in date.

Although there was evidence on the files reviewed that the employees had a contract, offer letter, two references and interview questions, some of the paperwork was for different roles within the organisation. In particular, an employee had an offer letter that was for their previous role and an application for their first role within the organization, there was no consistent paperwork on file to evidence the employee's current post.

All the files containing the Coed Du Hall Individual File Audit for 2015 had the photo box ticked, however none of the files had a photo attached. If files require this information it is essential that it is added.

It was pleasing to note that all files had evidence of a current appraisal. Documented, regular supervision was also taking place, with staff confirming they received a session every four to eight weeks.

A programme of mandatory training was in place for all staff and the training spreadsheet in place to record and monitor data was comprehensive and easy to follow. At the time of our visit more than 50% of staff had between 90% and 100% compliance with their mandatory training. However the data provided highlighted that for some members of staff, their mandatory training for most of the modules was overdue. This needs to be reviewed and addressed to ensure all staff are up to date with their training.

The completion rate for safeguarding and the Mental Health Act need to be monitored because the completion rate could be improved, but attention and priority needs to be given to Respect training, where the completion rate was less than 50%.

It was noted that a recently appointed staff member had started work in the kitchen without having received any mandatory training.

Staff told us that staffing numbers were often low and there was a high use of agency staff. The use of a significant number of agency staff did not facilitate continuing care for the patients and it is recommended that if agency staff are utilized then a request for the same staff would be beneficial. In addition, the recruitment of registered nurses and care support workers was needed to ensure the continuity of care for the patient group.

Staff reported that morale was very low across the hospital and the reasons given as contributing to low morale was the departure of good staff, feelings of uncertainty about the service and its future, staff shortages and the reduced time spent with the patients. Low morale remains an issue amongst staff and the uncertainty around leadership and the future of the service are two areas that significantly affect this.

Throughout our visit a number of agency staff were on shift. During our evening visit an agency nurse was in charge of the hospital. A review of the agency staff file revealed that for some agency workers, there was no information regarding their skills, experience and knowledge on file. This issue has been identified from previous visits and it is important that information is obtained regarding the skills, knowledge and experience of staff.

In addition, the agency nurse on duty during our evening visit had an induction completed on her previous shift in August 2015. The staff signature section to confirm the agency staff had received the correct information during the induction was blank, therefore it was unsure if the agency staff had been given a proper induction to the hospital. The agency nurse confirmed they had completed their Controlled Physical Intervention (CPI) training in 2012. Therefore if an event had arisen in which restraint was required, the nurse would not have had up to date training. Two agency staff had been used in September and their CVs provided by the agency highlighted that their training had expired in November 2014 and April 2015 respectively. This situation is unacceptable and places unnecessary risks onto other staff and the patient group. The registered provider must ensure that agency staff have the necessary skills, experience and knowledge suitable for the patient group.

An analysis of complaints is recommended to determine any themes or trends that are recurring to enable the hospital to address issues.

***Requirements***

***The registered provider/manager must ensure that relevant information is obtained and analysed regarding agency workers before they commence a shift to ensure they have the right skills, knowledge and experience necessary for the patient group.***

***The recruitment of registered nurses and support staff must be facilitated to ensure the staffing compliment is achieved.***

***It is recommended that block bookings of agency staff are made to ensure consistency in patient care.***

***All staff must have up to date training, with specific attention given to Respect, Safeguarding and the Mental Health Act.***

***All new staff must receive training in the mandatory programme before or shortly after commencing employment.***

***A review of staff files is required to ensure relevant paperwork regarding an employees current role is in place.***

***Staff morale must be improved, with particular emphasis on leadership and the future of the service.***

***An analysis of complaints is required to determine any themes or trends that may be emerging that need attention.***

## Governance

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 since September 2014.

***Requirement***

***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 following observations were noted:

- Assessment of capacity forms for the files reviewed had not been completed
- A social worker assessment for one file was not found
- For one file, there was no written agreement from the Ministry of Justice (MoJ) that section 17 leave could be allowed.

***Requirement***

***All assessment of capacity forms must be completed by the current RC for all patients***

***Written confirmation is required from the MoJ to determine if section 17 can be granted***

***The missing social worker assessment needs to be located and added to the patients file.***

## *Monitoring the Mental Health Measure*

We reviewed the care and treatment planning documentation for two patients at Coed Du Hall and identified the following observations:

- Observational records were not accurately completed for one patient
- We identified that if a patient required a more hands on approach to de-escalation, there was only one member of staff trained in that level of Respect training.
- There was a significant number of documents in place, including positive behaviour support plans, risk assessments and care and treatment plans (CTP) when one would have been adequate.
- One patient who required a weight management plan, did not have a plan in place
- The risk assessment for one patient had another patients name on the form
- One patient had a significant increase in weight and their current plan was not robust, in particular there was no reference to a dietician input.

(During the feedback meeting the hospital were provided with initials of the patient's name to ensure their care and treatment plans could be amended)

***Requirement***

***All the areas identified must be addressed, including observational records completed accurately, more staff trained in Respect, weight management plans put in place and that the plan is robust, risk assessment form amended with the patients correct name and a review of the number of documents in place and which format the hospital will be using.***

## 6. Next Steps

Coed Du Hall 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 Coed Du Hall 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.

*Appendix A*

**Mental Health / Learning Disability: Improvement Plan**

**Provider: Coed Du Hall Limited**

**Hospital: Coed Du Hall**

**Date of Inspection: 23rd and 24th September 2015**

| Page Number | Requirement | Regulation | Action | Responsible Officer | Timescale |
|---|---|---|---|---|---|
| **11** | A review of the suitability of the furniture, particularly the dining chairs and easy chairs for the patient group is required. | 15 (1) (a) | Feedback from staff and patients was incorporated into the selection process and as an example, the low easy chairs in Ash & Beech were removed as a part of this process and replaced with those more appropriate and easy to use for the patient group.<br><br>This process will be repeated when Cedar is refurbished.<br><br>The requirement for a small number of dining chairs with arms had already been identified but | Michael Hartey / Gerald Taylor | 31.12. 2015 & Ongoing for Cedar refurbishment |

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| | | | these were not available within the chosen range. The supplier is looking to find an alternative model to meet this requirement.<br><br>We have already had very positive feedback from residents but intend to undertake a patient survey specific to satisfaction with furniture, fittings and décor on completion to identify any further improvements. | | |
| **11** | A review of the alarm system to alert staff when patients leave their bedrooms is required to ensure the noise of the alarm does not disturb patients, particularly at night. | 19 (1) (b) | A review of the current stand-alone bedroom alert system has been undertaken.<br><br>It has been identified that the best way of reducing the noise to avoid disturbing other patients is to install a new system fully integrated into the nurse call system.<br><br>This modification has been ordered and scheduled for installation during w/c 30 November 2015. | Michael Hartey / Chris Morris | 4.12.2015 |

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| **12** | A review of outside areas is required to ensure all these areas are accessible and safe for all patients. | 15 (1) (a) (b) (d) | A review of the outside areas will be undertaken as a part of the hospital refurbishment. Improvements in certain areas have already been identified and these will be implemented by April 2016. | Michael Hartey / Gerald Taylor / Beth Salt | 31.12.2015 & Ongoing |
| **12** | Additional key cards must be acquired to ensure all staff have their own. | 9 (1) (d) & 19 (1) (b) | Additional key cards have been ordered, received and distributed to all staff as required. | Adrian Sheehan | 30.10.2015 |
| **16** | A review of staffing numbers is required to ensure all wards have sufficient staff to provide safe and effective care. | 15 (1) (a) (b) & 20 (1) (a) | A review of the current staffing establishment has been undertaken to ensure sufficient staff are on duty to provide safe and effective care and meet needs of the patient population. | Gerald Taylor / Michael Hartey | 30.11.2015 |
| **16** | The registered provider/manager must ensure that relevant | 21 (2) (b) | The Responsible Individual has previously developed a comprehensive system to gather | Michael Hartey / Gerald Taylor | 31.12.2015 |

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| | information is obtained and analysed regarding agency workers before they commence a shift to ensure they have the right skills, knowledge and experience necessary for the patient group. | | all relevant information and ensure it is checked so that all agency staff have the appropriate skills, knowledge and experience prior to the commencement of any shift.<br><br>Besides assessing the relevant skills, knowledge and experience, a formal induction is meant to be completed and signed by a competent and experienced staff member.<br><br>Under the management at the time of the inspection this was not being followed.<br><br>The assistant manager assisted by the senior support staff now have responsibility for following this system.<br><br>A monthly audit of all agency staff personnel files has now been set up. | Adrian Sheehan / Senior Support Workers<br><br>Gordon Nelson | 31.12.2015<br><br>31.12.2015 |

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| **16** | The recruitment of registered nurses and support staff must be facilitated to ensure the staffing complement is achieved. | 20 (1) (a) | A recruitment campaign has already been carried out to facilitate achieving the staffing compliment.<br><br>As a result of this exercise, new support staff have been taken on however there is a noticeable shortage of registered nurses in North Wales. Further recruitment efforts will be continued including the use of employment agencies to fill identified posts. | Gerald Taylor /<br><br>Adrian Sheehan | 30.11.2015<br><br>& Ongoing |
| **16** | It is recommended that block bookings of agency staff are made to ensure consistency in patient care. | 20 (1) (b) | Certain excellent agency staff that have demonstrated the pre requisite skills, knowledge and experience have been identified and now form part of a block booking rolling program to ensure consistency in patient care until our own staff appointments are made. | Gerald Taylor/ Adrian Sheehan | 30.11.2015 & Ongoing |

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| **16** | All staff must have up to date training, with specific attention given to Respect, Safeguarding and the Mental Health Act. | 20 (1) (a) | A comprehensive training programme has been implemented to provide regular courses for all modules including Respect, Safeguarding and the Mental Health Act.<br><br>A regular review of the updated training matrix is now being undertaken to monitor compliance with requirements, identify shortfalls and take appropriate actions. | Natalee Claydon Yates /<br><br>Colin Loxton | 30.11.2015 & Ongoing<br><br>30.11.2015 & Ongoing |
| **16** | All new staff must receive training in the mandatory programme before or shortly after commencing employment. | 20 (1) (a) (2) (a) | A new mandatory training programme has been developed whereby each area is covered every 6 weeks by our in-house trainer. This will help ensure new staff receive mandatory training either before or shortly after commencing employment. | Natalee Claydon-Yates | 31.12.2015 & Ongoing |
| **16** | A review of staff files is | 21 (2) (d) | Audit all personnel folders and | Gordon Nelson | 31.12.2015 |

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| | required to ensure relevant paperwork regarding an employee's current role is in place. | | ensure up to date and relevant job descriptions are in place and staff have signed the job description indicating their understanding of the role and requirements. | | |
| **16** | Staff morale must be improved, with particular emphasis on leadership and the future of the service. | 18 (2) (a) & (b) | The Responsible Individual (RI) was equally concerned about staff morale despite assurances from senior management that improvements had been made. Over the course of a two week period in October, the RI interviewed the majority of staff employed at Coed Du Hall on a one to one basis. Following on from this exercise, certain members of the senior management team were replaced and a number of the issues identified by this process dealt with, including inconsistent shift patterns and pay rates, lack of | Michael Hartey / Gerald Taylor | 30.11.2015 & Ongoing |

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| | | | strategy in the use of agency staff and the creation of a fear based culture.<br><br>Staff morale has now significantly improved and the introduction of new staff members should have a further positive impact.<br><br>Regular staff meetings now have the future direction of the service as a standing agenda item to keep staff involved and informed. | | |
| **17** | An analysis of complaints is required to determine any themes or trends that may be emerging that need attention. | 24 (5) | Review the existing monthly audit of complaints and analyse data for thematic and/or trends. | Gerald Taylor / Lauren Turnbull | 15.12.2015 |
| **17** | Regulation 28 visits need to be carried out on a six monthly basis and reports sent to HIW. | 28 (1) (2) (a) (b) (c) (3) (4) (a) (b) (c) & (5) (a) (b) (c) | A Regulation 28 visit was carried out on 24 March 2015 however it appears that this was not forwarded to you. A copy of this report will be forwarded to you under separate cover. | Michael Hartey / Gerald Taylor / Esther Jones / Rosemary Melbourne | 31.12.2015 |

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| | | | Copies of future reports will be forwarded directly to HIW.<br><br>Regulation 28 report and any remedial action plans to be delivered to HIW on completion. | | |
| | All the areas identified must be addressed, including observational records completed accurately, more staff trained in Respect, weight management plans put in place and that the plan is robust, risk assessment form amended with the patients correct name and a review of the number of documents in place and which format the hospital will be using. | 15 (1) (a) (b) (c) | All staff to receive training in relation to accurate recording and completion of observation records.<br><br>Deliver improved compliance in relation to staff training with particular emphasis on 'Respect' (proactive, active and reactive interventions). Compliance in September was evidenced at 46%. This has increased to 76% at the end of November 2015.<br><br>Ensure all patients who require a weight management plan have a diet/nutritional assessment and weight management plan in place. | Gerald Taylor Natalee Claydon-Yates.<br><br>Beth Salt<br><br>Helle Rollins / Steph Steel | 31.12.2015<br><br>30.11.2015 & Ongoing<br><br>31.12.2015 |

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| | | | Amend the error on the identified patients risk assessment to ensure accuracy.<br><br>Review all risk assessments and risk management plans.<br><br>All documentation is now agreed and reviewed through the MDT process. | Helle Rollins<br><br>Gerald Taylor and MDT | 30.09.2015<br><br>31.12.2015 |
| **Mental Health Act** | | | | | |
| **18** | All assessment of capacity forms must be completed by the current RC for all patients | N/A | Complete assessment of capacity for the current patient population.<br><br>Ensure capacity assessment is completed on admission for any new patients. | Dr Amrith Shetty | 31.12.2015<br><br>& Ongoing |
| **18** | Written confirmation is required from the MOJ to determine if section 17 can be granted | N/A | Provide evidence of written confirmation from the MOJ for restricted patients to grant section 17 leave. | Dr Amrith Shetty | 31.12.2015 |

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| **18** | The missing social worker assessment needs to be located and added to the patients file | N/A | Request social worker assessment from the identified local authority and once received ensure the assessment is appropriately filed and available for scrutiny. | Dr Amrith Shetty / Adrian Sheehan | 31.12.2015 |