Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health Follow-Up Inspection (Unannounced)

Coed Du Hall: Ash, Beech and Cedar wards

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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

Healthcare Inspectorate Wales (HIW) undertook a follow-up unannounced Mental Health and Learning Disability inspection to Coed Du Hall, Mold on the evening of the 10th October and during the days of 11th & 12th October 2016. The previous inspection was undertaken on 23-24 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:

- Ash – seven bedded ward comprising of seven individual bedrooms
- Beech – five bedded ward comprising of five individual bedrooms
- Cedar – ten bedded ward comprising of six individual bedrooms and four self contained step-down flats

The hospital offers a service for the treatment and nursing of patients with a mental illness and/or learning disability who may also be detained under the provisions of the Mental Health Act 1983.

During our inspection we reviewed the areas identified, including reviewing patient records, interviewing patients and staff, reviewing the environment of care and observing staff-patient interactions. The inspection team comprised of two peer reviewers, one lay reviewer and three members of HIW staff.

4. Summary

Our inspection at Coed Du Hall hospital took place across all three wards. Since our previous inspection there had been a number of changes in senior management at the hospital, including hospital manager. It was evidence that the hospital was in the process of implementing a number of changes to define the service as a slow-stream mental health rehabilitation; therefore giving direction to the service and a structured patient admission criteria. Overall, we found evidence that the service provided person centred care that was safe and effective.

This is what we found the service did well:

- A hospital environment that was suitable to the patient group and well maintained.
- Evidence of a multi-disciplinary team that provided patient centred care.
- A range of embedded audits to monitor the operation of the hospital.
- A range of activities available to patients both within the ward areas and the community.
- Good provision of hospital food and nutrition to meet patient need, including achieving the Gold Catering Standard from the Soil Association Food for Life.

This is what the service is required to improve:

- Ensure that patient care documentation is maintained in an appropriate format.
- Ensure that there is a robust shift handover process in place for staff.
- Ensure that there is a robust process for monitoring the use of the mental health act at Coed Du Hall to uphold patients' rights.
- Ensure that there is robust audit procedures for the prescribing, administering and recording of medication on Medication Admission Record (MAR Charts).
- Ensure that all staff complete their mandatory training and undertake regular supervision and annual appraisals within the required timeframes.

5. Findings

Core Standards

Ward environment

Coed Du Hall hospital was a single storey building in a rural setting. The hospital has three wards, Ash, Beech and Cedar. We noted the continued improvement to the environment and facilities available to the patient group. The refurbishment to the patient areas was competed at the time of our inspection.

On the whole the hospital environment had been refurbished to a good standard and maintained throughout. It was bright, modern and welcoming. The communal bathrooms and showers were clean, tidy and clutter free.

Outside areas were well cared for and maintained to a high standard. There was seating available for patients including some sheltered seating provision.

The entrance to the hospital building leads to the reception area and clerical staff area; with the Hospital Manager's office adjoined. The reception led onto a communal area containing a Visitors Room, staff kitchen, meeting room, patient laundry and led through to the larger communal area. This area had the suggestions box and suggestion slips for feedback on the service provided.

The large communal area provided lounge space and dining room, with the hospital kitchen adjoined. There was sufficient and appropriate dining tables and chairs for the number of patients at the hospital during our inspection. The weekly menu was displayed by the hospital kitchen serving hatch.

Staff also used this communal area to facilitate some of the occupational therapy activities that were available to patients. The area also displayed information for patients and visitors such as, the group occupational therapy activity timetable, the latest Patient Satisfaction Survey results (Nov 2015), monthly Patient Forum Meeting minutes, bilingual Patient's Charter, independent mental health advocacy information and other statutory patient information.

The large communal area led on to a corridor, off which were situated Ash and Beech wards along with a patient conservatory area. At the end of the corridor was Cedar ward, the nurses' office and clinic.

Ash was a seven bed female ward and Beech was a five bed male ward; all patients had their own individual bedroom. Both wards were refurbished prior to our previous inspection and were in maintained to a high standard. At the

entrance of each ward there was a small kitchen area with integrated cooking appliances including a microwave with a table and chairs were available for patients to sit and eat.

Patient bedrooms were pleasantly decorated and had appropriate furniture that provided patients with sufficient storage. All bedrooms had a sink, a dimmer switch to control the brightness of the light and a nurse call system. However, we noted that not all nurse-call buttons were appropriately placed near the bed which could prevent a patient calling for assistance when required.

Requirement

The registered provider must ensure that nurse-call buttons are appropriately located within patient bedrooms and communal areas.

Ash and Beech had their own lounges which were pleasantly decorated and had a television, DVD player, a storage unit and sufficient and appropriate seating for the patient group.

Cedar had been refurbished since our previous inspection, and like the rest of the hospital, was pleasantly decorated and equipped to meet the needs of the patient group. Cedar could accommodate up to ten patients, split between six individual bedrooms and four self contained step-down flats. Cedar had one main communal area that was split as a lounge and a kitchen-diner. The step down flats had their own bathroom and kitchens.

Throughout the hospital there was clear signage for patients, however the signage was neither bilingual nor pictorial format, which could impact on some patients' understanding of the signage.

Requirement

The registered provider must ensure that appropriate signage is displayed around the hospital to assist patients and visitors.

We also noted that one clock displayed the incorrect time and date which could be disorientating for patients; this was corrected during the inspection.

It was positive to note that there was a new system which discretely notified staff via the nurse call and personal alarms when certain patients left their bedrooms. On our previous inspection the system in place at the time resulted in a loud alarm that would disturb fellow patients, particularly at night.

Patients had access to ample outside space which had been improved since our previous inspection; this enabled the patient group safe access to outside areas. It is recommended that the registered provider regularly monitor the

outside areas to ensure any changes to the mobility of the current patient group or new admissions is reflected in the maintenance and improvement of outside areas.

Just off the main hospital building was a therapy kitchen where patients learnt and refreshed cookery skills under supervision of staff.

Safety

The patients we spoke to said they felt safe at the hospital and the staff we spoke to said they had no safety concerns.

It was identified that there was no ligature point audit in place for the hospital and during our inspection it was evident there were ligature points within patient areas of the hospital. The hospital provides slow-stream mental health rehabilitation and the environment was appropriate to this philosophy of care. Patient risks were monitored on an individual basis and if there were any concerns of self-harm these would be care planed. However, without the hospital undertaking a ligature point audit of the hospital there is no governance around the potential ligature risks and how to manage individual patient behaviours to self-harm.

Requirement

The registered provider must ensure that there are up-to-date ligature point audits to ensure that any risks are managed based on the patient group and individual behaviours.

Since our last inspection the registered provider had updated the interior door lock system. Staff members had electronic wristbands that allowed access to open doors within the hospital; the wristbands were set individually so that access to areas of the hospital was appropriate to the staff member's role. There were a sufficient number of wristbands for all staff at the time of our inspection. Therefore, unlike the previous inspection, there was no issue with staff not having being able to access areas of the hospital due to insufficient number of key cards.

During our audit of medication we identified a number of medication recording errors on patient Medication Admission Record (MAR Charts). This included:

- Gaps on MAR Charts so it was not clear whether medication was administered or the reason why medication was not administered.
- Errors in signing for PRN medication of MAR Charts

- Discontinued medication not being correctly crossed off MAR Charts, therefore discontinued medication may still be administered
- Not always recording the number of MAR Charts a patient had, therefore medication could potentially be omitted to be administered
- Staff did not always record the legal status of patients under the mental health act of the MAR Chart.

Requirement

The registered provider must ensure there are robust audit procedures in place for the prescribing, administering and recording of medication on Medication Admission Record (MAR Charts).

Reviewing the hospital's clinic room we identified that monitoring of the clinic room's temperature and clinic room fridge's temperature was not always undertaken as required. Therefore staff could not be assured that medication was always stored at the correct temperature, this is essential to ensure that medication is safe for use.

Requirement

The registered provider must ensure that the clinic room's temperature and the clinic room fridge's temperature are recorded as required.

During our inspection members of staff at the hospital were not wearing name badges or another form of identification. We recommend that staff members, whether permanent, bank or agency, are identifiable to each other, patients and visitors.

The multi-disciplinary team

The hospital had a multi-disciplinary team in place which included the responsible clinician, registered nurses, a psychologist, an occupational therapist, two occupation therapy assistants and a team of health care support workers.

Staff reported that the multi-disciplinary team worked in a professional and collaborative way and those individual professional views were valued and considered as part of the multi-disciplinary care.

Reviewing staff rotas and staffing levels at the time of our inspection we had no concerns with the staffing levels at the hospital. Nurses and health care support workers at the hospital work 12 hour shifts from 8am to 8pm and 8pm to 8am, with other multidisciplinary team members present throughout the day. The hospital also used a twilight shift where staff members would be

present from the afternoon until midnight to assist with evening patient routines.

Reviewing staff rotas it was evident that there were regular shift patterns for staff members; however there was little rotation of individual staff between shift teams. Therefore, some staff members would only work with the same colleagues and never with others. It would be beneficial for staff to work with as wide range of staff members so that good practice can be shared between staff and to reduce the possibility of shift teams establishing any practices that impact on a consistent provision of care at the hospital. However, we understand that the current staff rota provides regular shift patterns for staff commitments outside of work which also needs to be maintained.

We recommend that the registered provider review staff rotas to ensure that, where possible, staff rotate and work with different team members whilst providing staff with regular shift patterns for staff commitments outside of work.

The shift pattern at the hospital did not provide staff with time to undertake shift handover during their working hours. Registered Nurses were undertaking handover prior to the commencement of their shift in their own time, which is not appropriate. We also noted that the handover record was not sufficient to provide staff with detailed knowledge of the patient group and individual patient needs. This is of particular importance when a registered nurse is commencing their first shift at the hospital after a period of absence, including bank or agency staff. The Hospital Manager confirmed that the handover process was under review.

The weakness in the hospital handover system was evident on the first evening of our inspection. The nurse in charge also had little knowledge of a patient that had recently been admitted to the hospital. However, the nurse in charge of the hospital was clear on the number of patients on each ward, and provided the inspection team, with reference to the patient information record, the legal statuses of each patient, whether detained under the Mental Health Act, under Deprivation of Liberty Safeguards (DoLS) or no restrictions (informal patient).

There was also no formal handover for the health care support workers at the hospital. Staff were relying on informal practices to update health care support workers about the patient group. This is not sufficient to ensure that all staff are aware of the current care needs and risks of the patient group.

Requirement

The registered provider must ensure that there is a robust shift handover process in place for staff during their allocated shift so that

staff are up-to-date on the current care needs and risks of the patient group.

Since our previous inspection the hospital has recruited to some registered nurse posts and health care support worker posts, however there were still vacancies at the hospital. To manage the shortfalls in fulfilling the staff rota the hospital used bank and agency staff. It was noted that where possible the hospital would block book bank and agency staff members so that the staff members had knowledge of the patient group which assisted to provide consistency of care for the patients.

It was positive to note that the hospital maintained a record of the agency staff that they used and their qualifications, induction to the hospital, Disclosure and Barring Check (DBS) and that any professional registrations were still valid. These records were audited by the deputy hospital manager every three months and any discrepancies resulted in action being undertaken prior to that person commencing a shift at the hospital.

The hospital undertook an annual Personnel File Audit to ensure that all essential information regarding the recruitment of permanent members of staff is maintained and available. This also included ensuring that current (DBS) was in place for the employee and professional registrations had evidence on file that they were in date.

During our previous inspection we identified that staff morale was low. Since the previous inspection a number of Senior Management Team have changed, including the appointment of a new hospital manager. It was evident at the time of the inspection that the Senior Management Team were implementing a number of changes to the systems and structures at the hospital.

The registered provider had undertaken a staff survey during September and October 2016 which had yielded positive results and comments. 75% of the total question responses were positive in comparison to the 25% that were negative. An area that was noted for improvement included the level of communication between shifts, which we highlighted above in the staff handover process. Staff also raised concerns regarding the communication between senior staff and support staff at the hospital. It was pleasing to note that in August 2016 the hospital commenced a monthly Communication Update for all staff to keep them informed of decisions, plans and changes to the hospital service.

During our inspection staff spoke of positive and supportive team work at the hospital and staff felt that they could raise concerns and speak to their line managers and senior staff.

We also reviewed the staff sickness record for the last six months; it was positive that this evidenced that there was low staff sickness at the hospital during that period.

Training

Since our previous inspection the hospital had introduced e-learning training for mandatory training modules in July 2016. The hospital also provided classroom based learning to supplement the e-learning for modules that were more physical based such as Basic Life Support.

At May 2016 all mandatory training for staff was at completion rate of above 90% apart from RESPECT physical Intervention training with was at 73%. However, since the implementation of e-learning the training statistics provided from the e-learning system in October showed that staff completion rates of the e-learning modules were significantly low. The statistics evidenced that statutory e-learning modules were only completed by 10-30% of staff apart from Manual Handling, 49%, and RESPECT physical Intervention at 68%.

We reviewed the training completion figures that the hospital held since our previous inspection. Up until the introduction of e-learning the completion rate of mandatory training modules which have switched to e-learning was above 90%. It was evident given the mandatory training figures earlier in the year and the figure being produced by the e-learning system did not reflect the staff's knowledge in the mandatory training; the difference being the result of implementing a new training system.

However, it is essential that training statistics produced by the e-learning system accurately reflect staff knowledge. The hospital manager confirmed that staff were being allocated time to complete the e-learning training. All members of staff need to complete their mandatory e-learning to ensure that their knowledge is evidenced on the current e-learning system.

Requirement

The registered provider must ensure that all staff complete their mandatory training and this is accurately reflected on the hospital's training statistics.

Staff members undertook monthly supervision, reviewing the supervision records it was evidenced that this was regularly completed. However, there were occasions where supervision hadn't been undertaken for over two months.

Requirement

The registered provider must ensure that regular supervision is completed by staff for their professional development.

Since our previous inspection the hospital had introduced monthly group supervision. This was in the early stages of development, however staff we spoke to during the inspection spoke positively about this process.

It was evident that staff were receiving annual performance appraisals, however for three members of staff their annual appraisal was overdue by a month. It is important that these are completed to ensure that staff have feedback on their performance and clear objectives dentified for the forthcoming year.

Requirement

The registered provider must ensure that all staff undertake their annual appraisal within the required time frame.

Privacy and dignity

We observed very good patient interaction and it was evident that the staff present during our inspection were providing care compassionately for patients. Patients told us they had a named nurse and were able to meet them in private.

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 personalise their room with photographs, pictures and posters. Patients were able to lock their bedroom doors which staff can over-ride when required. Patients said that 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. Throughout the inspection the ward payphone was out of use due to it requiring a new part which was on order.

Requirement

The registered provider must ensure that patients have access to a working payphone at the hospital.

Patient therapies and activities

Discussions with staff confirmed that a range of activities were available to patients which 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.

Throughout our visit we observed patients engaged in activities within the hospital which included a quiz, jigsaws and readying books with staff. We also saw a number of patients accessing the community with members of staff. It was positive to note the hospital had five hospital vehicles to help facilitate patients in to the community.

Patients had individual activity plans and there was an overall group activity plan for the hospital. The group activity plan was displayed within the large communal room which highlighted a range of group activities throughout the week. Patients were offered a range of activities and encouraged by staff to request further activities based on their individual interests.

It was positive to note that the Occupational Therapist audited the activity uptake by individual patients to monitor what activities were being undertaken and what were being declined to focus and plan future activities.

In June 2016 the hospital commenced a monthly Patient Forum to gather patients' thoughts and suggestions along with providing patients with information on changes to the hospital. Each Patient Forum had an agenda with some standing items, the meetings were minuted and copies of the minutes were available. Actions from the Patient Forums were developed and monitored at following Patient Forums. This provided patients with a good opportunity to discus changes at the hospital and any development or changes that they wished to happen.

Food and nutrition

There was a pictorial menu and a written menu displayed within the dining room. 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.

Patients told us that on the whole they enjoyed the meals served at the hospital. There was a four week menu cycle 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 when 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.

We observed a positive dining experience with food being served centrally in the main dining room with members of staff eating with the patients which gave meal times a social activity.

Patients requiring a special diet were catered for and the hospital had achieved the Soil Association Food for Life Gold Catering Standard[2], which we noted as a significant attainment. This award recognises 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.

Patients had access to drinks and snacks outside of set meal times and fruit and biscuits were available.

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. The provider had completed their most recent Regulation 28 report in June 2016.

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

Application of the Mental Health Act

We reviewed the statutory detention documents of four of the detained patients being cared for across the three wards at the time of our visit. The following observations were noted on statutory documentation:

- Incorrectly written patient name
- A signature omitted from one form

Requirement

The Registered Provider must ensure that the mental health act is applied correctly at Coed Du Hall

In one case there was also no documentation to state whether a patient had received a copy of their Section 17 Leave form.

For one patient there was no statutory Nearest Relative as defined under Section 26 of the Act. However, there was no documentation to evidence that the hospital enacted Section 29, Appointment by court of acting nearest relative.

Requirement

The Registered Provider must uphold patients' rights under the mental health act.

It was positive to note an improvement from our previous inspection and all documentation in regard to Ministry of Justice restrictions was in place and available.

Where patients were not detained under the Act the use of Deprivation of Liberty Safeguard (DoLS) was considered. The DOLS paperwork we reviewed was accurate and complete.

Monitoring the Mental Health Measure

We reviewed the care and treatment planning documentation for four patients at Coed Du Hall. The patient care documentation at the hospital was kept in hardcopy. The files used by staff were very bulky and difficult to navigate; there was inconsistent filing between different patient files. This meant that finding pertinent care information was difficult; which would be problematic for anyone providing care to the patient group who were not familiar with the documentation, such as bank or agency staff. With the assistance of ward staff we were able to find most of the relevant care documentation.

It was positive to note that since the appointment of the new hospital manager they have been reviewing the patient care documentation to make it user-friendly for staff. The proposed documentation follows the structure of the Care and Treatment Plan, its domains and outcome setting. At the time of the inspection the new documentation was in the process of being ratified by the multi-disciplinary team with the intention of it being implemented before the end of 2016.

Requirement

The registered provider must ensure that patient care documentation is maintained in an appropriate format to so that care staff can easily access relevant information to provide patient care.

The proposed revised documentation did not include an area for staff to record any unmet patient needs. It is important that this is documented to ensure all patient needs are identified within their care documentation.

Requirement

The registered provider must ensure that patient unmet needs are identified within their care documentation.

All patients were registered with a GP and access community services such as dentists, chiropody, opticians, etc. There were detailed records of patients' ongoing physical health monitoring within patients care documentation.

However, there were a number of incidents of patient falls where there was limited physical observations, such as pulse, blood pressure, etc. undertaken following an incident to ensure the physical wellbeing of patients was monitored.

Requirement

The registered provider must ensure that procedures are in place to monitor patients' physical wellbeing after incidents.

We also identified that patient blood sugars levels were being recorded on MAR Charts and not specific blood sugar monitoring charts. This did not enable easy review of blood sugar levels nor document at what time of day the blood sugar levels were taken.

Requirement

The registered provider must ensure that appropriate blood sugar monitoring charts are used when required.

6. Next Steps

The Registered Provider 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 the setting 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: 10 – 12 October 2016

Regulation	Requirement	Action	Responsible Officer	Timescale
26 (2)(a) Fitness of premises	The registered provider must ensure that nurse-call buttons are appropriately located within patient bedrooms and communal areas.	The position of all alarms has been reviewed and, where possible, beds have been relocated to ensure the alarm is within a very close distance, and portable extensions have been purchased to complement the existing systems where relocation is not possible.	Adrian Sheehan, Assistant Manager	All rooms will meet standard by 30/11/2016
26 (2)(c) Fitness of premises	The registered provider must ensure that appropriate signage is displayed around the hospital to assist patients and visitors.	All signage has being reviewed and a plan developed to make them bilingual and pictorial where possible.	Beth Salt, Occupational Therapist	New signs to be in place by 16/12/2016

26 (2)(a) Fitness of premises	The registered provider must ensure that there are up-to-date ligature point audits to ensure that any risks are managed based on the patient group and individual behaviours.	Ligature risk assessment to be completed to identify required any risk management requirements.	Paul E. Hughes, Hospital Manager	By 16/12/2106
9 (1)(m) Policies and procedures 15 (5)(a) Quality of treatment and other service provision	The registered provider must ensure there are robust audit procedures in place for the prescribing, administering and recording of medication on Medication Admission Record (MAR Charts).	The hospital Clinic Audit process has been reviewed and updated to ensure it captures all required information / standards. We are also able to confirm that Speeds Specialist Pharmacy staff will be attending the service monthly to assist staff in managing the clinic and to further improve standards.	Paul E. Hughes, Hospital Manager	Repeat audit by 30/11/2016
9(1)(m) Policies and procedures 15 (5)(a) Quality of treatment and other service provision	The registered provider must ensure that the clinic room's temperature and the clinic room fridge's temperature are recorded as required.	Checklist in place and all nurses reminded of the need to complete both charts daily. This will be reviewed via the Clinic Audit process.	Paul E. Hughes, Hospital Manager	Repeat audit by 30/11/2016

9 (1)(f) Policies and procedures	The registered provider must ensure that there is a robust shift handover process in place for staff during their allocated shift so that staff are up-to-date on the current care needs and risks of the patient group.	Currently under review with a view to implementing in January 2017. A Patient Passport summary document has been developed for all patients, and this presents a summary of needs, risks and communication issues, in order to ensure any new staff can effectively and quickly understand patient needs.	Michael Hartey, Responsible Individual Gordon Nelson, Counsellor All Primary Nurses	January 31/11/2016 All completed and in patient files by 02/12/2016
20 (2)(a) staffing	The registered provider must ensure that all staff complete their mandatory training and this is accurately reflected on the hospital's training statistics.	The new E-Learning system has been fully implemented and staff are aware that all modules must be completed by 30/11/2016. This will be monitored.	Paul E. Hughes, Hospital Manager	100% compliance by 30/11/2016
20 (2)(a) staffing	The registered provider must ensure that regular supervision is completed by staff for their professional development.	The Supervision Matrix has been revisited and all staff are aware of the standards expected. This is to be reviewed monthly at Clinical Governance Meetings.	Adrian Sheehan, Assistant Manager	100% compliance by 30/11/2016
20 (2)(a) staffing	The registered provider must ensure that all staff undertake their annual appraisal within the required time	The Appraisal Matrix has been revisited and all staff are aware of the standards expected. This is to	Adrian Sheehan, Assistant	100% compliance by 30/11/2016

	frame.	be reviewed monthly at Clinical Governance Meetings.	Manager	
26 (2) (c) Fitness of premises	The registered provider must ensure that patients have access to a working payphone at the hospital.	This is due to be replaced week commencing 21/11/16, and interim arrangements are in place for patients to use the hospital cordless phone in a private room.	Adrian Sheehan, Assistant Manager	Fully operational new patient phone by 28/11/2016
20 (1)(a) Staffing	The Registered Provider must ensure that the Mental Health Act is applied correctly at Coed Du Hall.	We have reviewed our MHA Audit process to make it more robust and this is now undertaken every two-months.	Adrian Sheehan, Assistant Manager	Full re-audit completed on 22/11/2016
20 (1)(a) Staffing	The Registered Provider must uphold patients' rights under the Mental Health Act.	We have reviewed our MHA Audit process to make it more robust and this is now undertaken every two-months.	Adrian Sheehan, Assistant Manager	Full re-audit completed on 22/11/2016
23 (3)(a) Records	The registered provider must ensure that patient care documentation is maintained in an appropriate format to so that care staff can easily access relevant information to provide patient care.	New care file system is currently in development; this will make care planning and documentation (including care files) simpler and more accessible to staff and patients.	Paul E. Hughes, Assistant Manager	Fully implemented by 31/12/2016
15 (1)(a)(c) Quality of treatment and other	The registered provider must ensure that patient unmet needs are identified within their care documentation.	The newly developed care plan system / MDT Review record will record any '*unmet needs*' for all patients.	Paul E. Hughes, Assistant Manager	By end-Dec 2016

service provisions				
23 (1)(a)(ii) Records	The registered provider must ensure that procedures are in place to monitor patients' physical wellbeing after incidents.	Protocol / Monitoring Form has been developed and all Nurses are aware of the need to use this effectively.	Dr G. Tanti, Consultant Psychiatrist	Completed and ongoing
23 (1)(a)(ii) Records	The registered provider must ensure that appropriate blood sugar monitoring charts are used when required.	A newly developed chart is now in place for all indicated patients.	Paul E. Hughes	Completed and ongoing