Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Priory Hospital Church Village

Parkcare Homes (No.2) Ltd

Inspection date:

5 - 7 February 2018

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection of Priory Church Village on the evening of 5 February 2018 and following days of 6 and 7 February. The following sites and wards were visited during this inspection:

- Priory Hospital Church Village - Main building
- Priory Hospital Church Village - Garth View

Our team, for the inspection comprised of two HIW inspectors and two clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer). The inspection was led by a HIW inspection manager.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act.

HIW explored how the service complied with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and met the National Minimum Standards (NMS) for Independent Health Care Services in Wales. Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Further details about how we conduct independent mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Patients we spoke with were positive about the care they received and we observed staff engaging with patients in a caring and respectful manner.

Improvements are required in recordkeeping and ensuring that care focuses on rehabilitation and recovery.

This is what we found the service did well:

- Staff interacted and engaged with patients respectfully
- Patients were positive about the care they received
- The environment of care was appropriate for the patient group
- Medicines management was safe and effective
- High compliance in mandatory training, supervision and appraisals

This is what we recommend the service could improve:

- Recordkeeping of patient files and completion of documentation
- Care so that it's focused on rehabilitation and recovery
- The availability and format of information for patients

We identified regulatory breaches during this inspection regarding recordkeeping that impacted upon the availability of up to date patient care information and statutory Mental Health Act documentation. Further details can be found in Appendix B. Whilst this has not resulted in the issue of a non compliance notice, there is an expectation that the registered provider takes meaningful action to address these matters, as a failure to do so could result in non-compliance with regulations.

3. What we found

Background of the service

Priory Church Village is registered to provide an independent learning disability hospital at Priory Hospital Church Village, Church Road, Tonteg, CF38 1HE.

The service is registered to provide a maximum of 12 persons only, who are over the age of 18 and under the age of 65; the main building ten beds and Garth View two beds. At the time of inspection, there were six patients.

The service was first registered on 13 May 2013. The service employees a staff team including a Hospital Director, a Director of Clinical Services along with nursing and support staff. At the time of the inspection there were a number of multi-disciplinary team positions being filled on a locum bases whilst recruitment was being completed, some positions had been appointed to which included the consultant psychiatrist and occupational therapist.

Quality of patient experience

We spoke with patients,, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We observed that staff interacted and engaged with patients appropriately and treated patients with dignity and respect.

Patients we spoke with were positive about the care they received at the hospital; however improvements should be made to ensure that care focuses on rehabilitation and recovery.

Health promotion, protection and improvement

Patients told us that they were able to access activities within the hospital and the community; these included walks, pampering sessions, board games, karaoke and a knitting group. Throughout the inspection we observed some of these activities being undertaken. There was also some information on display for patients that included health promotion and activities that they could undertake by themselves or with staff and peers.

The hospital had an occupational therapies area that included an Activities of Daily Living Kitchen, relaxation room and cardio exercise equipment; however staff stated that this equipment was infrequently used due to lack of fulltime occupational therapy support.

There were a range of activities being undertaken by patients at the hospital. However, overall they lacked a focus on rehabilitation that would help patients gain skills that would prepare them for discharge to a less structured community environment. Ward staff that we spoke with also expressed that they wished to provide more structured rehabilitation activities for patients to promote recovery.

At the time of the inspection the registered provider had appointed a permanent occupational therapist but was yet to commence their employment at the hospital. A locum occupation therapist was in post to help maintain activities at the hospital until the permanent occupational therapist was in post.

Improvement needed

The registered provider must ensure that there is an embedded structured programme of individualised rehabilitation activities for patients.

Dignity and respect

We observed staff interact and engage with patients appropriately and treating patients with dignity and respect. The staff we spoke to were committed to provide dignified care for the patients.

We heard staff speaking with patients in calm tones throughout our inspection. When patients approached staff members they were met with polite and responsive caring attitudes. On the whole we observed staff being respectful toward patients including prompt and appropriate interaction in an attempt to prevent patient behaviours escalating.

All patients that we spoke with told us that they were treated with respect and kindness. Patients were very complimentary of the care, treatment and support provided at the hospital.

Within the main building each patient had their own en-suite bedroom with toilet, sink and a shower. Patients were able to lock their bedroom doors to prevent other patients entering; staff could override the locks if required. There were two bedrooms within Garth View and the patients had access to one shared bathroom and toilet within this area.

We observed a number of bedrooms and it was evident that patients were able to have personal items within their rooms. Patients had sufficient storage for their possessions within their rooms. Any items that were considered a risk to patient safety, such as razors, aerosols, etc. were stored securely and orderly on each of the wards which patients would request access to.

Patient information and consent

There was some information on display which was available for patients that included activities, health promotion and safeguarding information. However, additional information should be displayed for patients to include contact information for advocacy services and Healthcare Inspectorate Wales. There was also limited information in a format that could assist patients with a learning disability understand the information.]

It was positive that the patients we spoke with were aware of the advocacy service and how to contact them if they wished. They also confirmed that a representative of the advocacy service regularly attends the hospital.

Improvement needed

The registered provider must ensure that there is clear information displayed on how to contact Healthcare Inspectorate Wales.

The registered provider must ensure that patient information displayed within the hospital is in a suitable format, this includes a format that could assist patients with a learning disability understand the information.

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff ensured that they communicated appropriately and effectively with patients. Staff took time to undertake discussions using words and language suitable to the individual patient. Where patients remained unclear, or what they were trying to communicate was misunderstood, staff would patiently attempt to clarify what they had said.

There were daily planning meetings every morning to arrange the activities, within the hospital and the community, alongside other activities and meetings, such as care planning meetings, tribunals, medical appointments, etc.

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. With patients' agreement, wherever possible, their families and carers were also included in some meetings.

All patients that we spoke with told us that they felt listened to by staff and were involved in their relevant care meetings and kept up to date with their care and treatment. Patients also confirmed that they knew how to raise a complaint and would be happy to raise any issues with ward staff or management.

Care planning and provision

There was a clear focus on providing safe and effective care for patients at the hospital. However, as identified within this report, improvements could have been made in patient care by being more focused on rehabilitation. This would assist in providing care that was more individualised and focused on recovery, either at the hospital or in the community.

Equality, diversity and human rights

Staff practice was aligned to established hospital policies and systems which ensured that patients' equality, diversity and rights were maintained. Patients could also access the Independent Mental Health Advocacy (IMHA) and Independent Mental Capacity Advocacy (IMCA) services.

However, statutory documentation to detain patients under the Mental Health Act (the Act) was poorly maintained at the hospital. To validate those detentions were compliant with the Act we were required to retrieve further information from the Mental Health Act Manager located at another hospital. Copies of the relevant documentation must be available to staff at the hospital in which the patient is detained.

Citizen engagement and feedback

There were regular patient meetings to allow for patients to provide feedback on the provision of care at the hospital.

There was a complaints policy and procedure in place at the hospital and patients we spoke with stated that they were happy to raise their concerns with staff.

The hospital undertook patient surveys, however the response rate to the most recent surveys were low, which did not provide the service with meaningful information to analyse.

Improvement needed

The registered provider should consider additional approaches to patient surveys to gather feedback on the service from the patients and other concerned individuals.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

The hospital environment was well maintained and equipped with suitable furniture, fixtures and fittings for the patient group.

There were embedded process to ensure safe medicine management and infection prevention and control.

Improvements in record keeping are required to ensure that there is a clear and up to date record of patient care and statutory documentation available to staff.

Managing risk and health and safety

There were processes in place to manage and review risks and maintain health and safety at the hospital. These included regular ligature point audits, blind spot and general environmental audits; following these, action plans had been developed to address or manage the identified risks.

It was positive to note that the registered provider had made improvements to the safety of the environment since our previous inspection and work was ongoing to enhance this further. The furniture, fixtures and fittings at the hospital were appropriate for the patient group.

Staff wore personal alarms which they could use to call for assistance if required; these were allocated to staff when they entered the hospital. There were also nurse call points through the hospital.

Overall, the hospital was well maintained which upheld the safety of patients, staff and visitors. Staff were able to report environmental issues to the hospital estate team who maintained a log of issues and work required and completed.

Access to the hospital building was either via steps from the car park or via a ramp which provided appropriate access for persons with mobility difficulties. The hospital entrance was secured to prevent unauthorised access.

Infection prevention and control (IPC) and decontamination

The registered provider employs dedicated housekeeping staff for the hospital. Throughout the inspection we observed the hospital to be visibly clean and free from clutter. Cleaning equipment was stored and organised appropriately.

A system of regular audit in respect of infection control was described. This was completed with the aim of identifying areas for improvement so that appropriate action could be taken where necessary. Staff confirmed that cleaning schedules were in place to promote regular and effective cleaning of the wards and were aware of their responsibilities around infection prevention and control.

There were hand hygiene products available in relevant areas of the hospital; these were accompanied by appropriate signage. Staff also had access to infection prevention and control and decontamination Personal Protective Equipment (PPE) when required.

Appropriate bins were available to dispose of medical sharp items, these were not over filled.

Nutrition

We found that patients were provided with a choice of meals on a four-week menu. We saw that the menu was varied and patients told us that they had a choice of what to eat. The menu was displayed within the dining room which included pictorial assistance for patients. Additionally, we were told that alternative meals were available in response to individuals' cultural requirements and medical needs.

There were cold drinks readily available and patients could ask staff for hot drinks throughout the day, however there were no facilities for patients to make their own hot drink within the main hospital building. We were informed that patients could use the Activities of Daily Living (ADL) kitchen to make drinks but this would require staff to accompany the patient to access this area. The ADL kitchen could also be used by patients to learn or practice making their own meals.

At the time of the inspection it was acknowledged that the ADL kitchen was not regularly used by patients. Allowing patients to regularly make their own hot drinks and food would enable patients to practice daily skills within a rehabilitation environment in preparation for discharge to a less secure environment.

Overall patients' comments regarding food were positive. We also sampled a selection of the meals available to patients, and found them to be of good quality.

Improvement needed

The registered provider must support patients, based on individual patient risk assessments, to make their own hot drinks and food at the hospital.

Medicines management

On the whole we found safe management of medication at the hospital. The clinic room was locked and medication was stored securely. There were very good arrangements for the storage and use of Controlled Drugs; these are checked as required by the organisation's policy.

There were clinical audits in place, including regular external pharmacy audit, which provided assurance that medication was being stored and used safely.

It was evident that staff monitored the temperature of the clinic fridge to ensure that medication was stored at the correct temperature as indicated by the manufacturer. The clinic room temperature was controlled with air conditioning to ensure it was maintained to an appropriate temperature.

We reviewed a sample of Medication Administration Record (MAR charts). All the MAR Charts reviewed contained the patients name and their Mental Health Act legal status. MAR Charts also included a photograph of the patient to assist staff in identifying the patient. where a patient declines to have a photograph taken there was an appropriately written description of the patient. Charts were consistently signed and dated when prescribed and administered or the reason recorded when medication was not administered.

There was a weekly clinical audit in place to ensure that all emergency equipment was present in case it was required.

Safeguarding children and safeguarding vulnerable adults

There were established processes in place to ensure that the hospital safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Medical devices, equipment and diagnostic systems

There were regular clinical audits at the hospital and a weekly audit of resuscitation equipment. The hospital had a number of ligature cutters that were located throughout the hospital in case of an emergency.

Safe and clinically effective care

Overall we found governance arrangements in place that helped ensure that staff at the hospital provided safe and clinically effective care for patients. However, as stated within the Records Management section this report, due to disorganised patient records it was difficult to quickly identify the care needs of individual patients.

Records management

Patient records were a combination of paper files that were stored and maintained within the locked offices, with electronic information, which were password-protected. We observed staff storing the records appropriately during our inspection.

However, patient records were spread across a number of paper and electronic files which made it difficult to navigate and review the care provided to patients. Additionally, different disciplines kept their own records that other disciplines were unable to freely access. Through our review of records we identified that information held in some records was not the most up to date information, or in some cases absent. This could impact negatively upon the quality of patient care.

Improvement needed

The registered provider should look at consolidating the patient records, as far as is practical. Minimising duplication and providing easier access to specific information.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients across both wards, the Main Building and Garth View.

The statutory documentation and associated records were poorly organised at the hospital and therefore difficult to navigate to provide assurance that detentions were compliant with the Act and adhered to guidance of the Mental Health Act Code of Practice for Wales, 2016 (the Code). However, the

registered provider retrieved copies of the original documentation from the Mental Health Act Manager located at another hospital to provide assurance that detentions were compliant with the Act.

All leave had been authorised by the responsible clinician on Section 17 Leave authorisation forms.

Medication was provided to patients in line with Section 58 of the Act, Consent to Treatment; with consent to treatment certificates always kept with the corresponding Medication Administration Record (MAR Chart). This meant staff administering medication could refer to the certificate to ensure that medication was prescribed under the consent to treatment provisions of section 58 of the Act.

Due to the disorganised record keeping it was difficult to establish that practice followed guidance set out in the Code. Whilst it was documented that patients' detentions were reviewed by the Mental Health Review Tribunal and at Hospital Managers[1] Hearings, there was little information available regarding these appeals that provided assurance that practice followed the guidance set out in chapters 12 and 38 of the Code.

It was also not evident in each set of patient records that we reviewed whether the patient's had been provided with their rights as defined under Section 132 of the Act. There was no clear record that patients had been provided with their rights on detention and at regular intervals. Therefore there was also no record to state whether the patient had understood their rights.

Improvement needed

The registered provider must ensure that detention papers are readily available at the hospital so that staff can be assured of the validity of detentions under the Act.

[1] The organisation (or individuals) responsible for the operation of the Act in a particular hospital. Hospital managers have various functions under the Act, which include the power to discharge a patient.

The registered provider must ensure that documentation regarding appeals against detention are available within patient records.

The registered provider must ensure that patients are informed of their rights and that this is documented within patient records.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed the care plans of a total of three patients. Overall patient records were of an inconsistent standard with some sets of records having areas omitted from the files or out of date information.

In the three set of records there were a lack of clear discharge plans for the patients. Therefore there was no clear care pathway setting out achievable goals of the care, time frames of the goals and the person(s) responsible for achieving the goals. The care records did not provide clear person-centred rehabilitation care for the patients at the hospital.

Whilst each of the records we reviewed had risk assessments in place for the patient, in one case the risk assessment did not refer to some of their historical risks that were present during their detention.

Patients stated that they were supported to manage their physical health which included attending services in the community such as the GP, dentist and optician. However, whilst there were physical health records in place for patients; in some instances it was not clear what actions or follow-up had been taken. Therefore it was difficult to establish how the care for patient's physical health was being fulfilled. This included lack of physical health care checks regarding diabetes, attendance at opticians and dentist. Whilst for one patient there were records of monthly dietician input, this was independent from the nursing staff with no integrated monitoring of the patient's eating, drinking and activity.

The Hospital Passports[2] and Health Action Plans reviewed lacked detail and need to be improved to clearly document patients' physical health needs.

Improvement needed

The registered provider must ensure that care plans support person-centred rehabilitation care that setting out achievable goals, timeframes and the person(s) responsible for achieving the goals.

The registered provider must ensure that each patient has up to date risk assessment that include current and historical risks.

The registered provider must ensure that there are clear and comprehensive records of physical health care.

The registered provider must ensure that Hospital Passports and/or Health Action Plans are up to date and include all relevant details of the patient.

[2] Hospital Passport and Health Action Plan are documents which contain important information about someone with a learning disability and provides hospital staff with important information about them and their health when they are admitted to hospital.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Independent Health Care Regulations and National Minimum Standards.

Recruitment was undertaken in an open and fair process with appropriate employment checks being carried out prior and regularly during employment. Staff undertook regular mandatory training, supervision and annual appraisals.

The appointment of permanent multi-disciplinary team members would strengthen the collaborative care provision at the hospital.

Governance and accountability framework

We found that there were well defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and its established governance structure which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care. Those arrangements were recorded so that they could be reviewed.

Identified senior managers had specific responsibilities for ensuring that the programme for governance remained at the forefront of service delivery. However, as identified earlier in the report improvements are required in the maintenance and audit of patient records, including documentation in respect to the Act.

It was positive that, throughout the inspection, the staff at Priory Church Village were receptive to our views, findings and recommendations. Given the areas for improvement identified during this inspection, consideration should be given to ensuring that there are more effective and proactive arrangements in place at the service to monitor compliance with relevant regulations and standards. Whilst no specific recommendation has been made in this regard, the expectation is that there will be evidence of a notable improvement in this respect at the time of the next inspection.

Dealing with concerns and managing incidents

As stated earlier in the report, there were established processes in place for dealing with concerns, along with managing incidents at the hospital.

It was evident that the registered provider monitored concerns and incidents locally at Priory Church Village and corporately through regular reporting mechanisms.

Workforce planning, training and organisational development

We reviewed the staffing establishment at the hospital against that stated within their Statement of Purpose. There were two full time equivalent registered nurses vacancies that the registered provider was attempting to recruit to.

To cover any shortfalls in fulfilling the staffing rota that may occur due to vacancies, the registered provider utilised agency registered nurses. When we reviewed the staff rotas it was evident that generally the use of agency registered nurses was of regular individuals who were familiar with working at the hospital and the patient group. This assisted with the continuity of care for patients.

At the time of the inspection there were a number of changes to the multi-disciplinary team. It was apparent through our conversations with senior management within the organisation that there were plans in place to stabilise the multi-disciplinary team which would greatly benefit the patient group. This included the imminent appointment of a permanent consultant psychiatrist and permanent occupational therapist; both these roles were filled by locum appointments at the time of the inspection. The registered provider was in the process of recruiting a psychologist; at the time of the inspection this was being filled by a locum psychologist.

We reviewed the mandatory training and clinical supervision statistics for staff at the hospital and found that completion rates were very high. The electronic system provided the senior managers with details of the courses completion rates and individual staff compliance details.

The hospital manager gave examples of the support that they received from their managers and peers within the organisation which demonstrated collaborative working across hospitals within the organisation.

Ward staff also commented favourably upon the peer support within the nursing team at the hospital. However, due to changes in the multi-disciplinary team within the hospital some ward staff said that they felt disconnected from the

multi-disciplinary team. Through our conversations with senior managers within the organisation it was expressed that, with the appointment of permanent members to the multi-disciplinary team there would be greater cohesion between disciplines. This would include ward staff, and would improve multi-disciplinary working at the hospital. We also suggest that the registered provider considers including health care support workers within multi-disciplinary team meetings so that they can provide their opinion and ideas on the care and progress of individual patients.

Improvement needed

The registered provider is requested to provide an update on the recruitment to registered nurse and other multi-disciplinary team vacancies.

Workforce recruitment and employment practices

The review of recruitment processes that were in place at the hospital evidenced that there were systems in place to ensure that recruitment followed an open and fair process. Prior to employment staff references were received, Disclosure and Baring Service (DBS) checks were undertaken and professional qualifications checked.

A system was in place to ensure that (DBS) checks were carried out every three years and clinical staff still held their professional registrations.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect independent mental health services

Our inspections of independent mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of independent mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent mental health services.

Further detail about how HIW inspects mental health and independent services can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.	Not applicable	Not applicable	Not applicable

Appendix B – Improvement plan

Service: Priory Church Village

Wards: Priory Church Village

Date of inspection: 5 - 7 February 2018

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The registered provider must ensure that there is clear information displayed on how to contact Healthcare Inspectorate Wales.	9. Patient information and consent	Contact details for HIW have now been made more prominent and displayed on the patient notice board on the ward.	Diana Tyrrell, Hospital Director	Completed
The registered provider must ensure that patient information displayed within the hospital is in a suitable format, this includes a format that could assist patients with a learning disability understand the information.	9. Patient information and consent	All patient notice boards are currently being reviewed to ensure information is displayed in the correct format. A member of staff is being allocated to be responsible for keeping the information up to date and in suitable format.	Diana Tyrrell, Hospital Director	30/04/2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider should consider additional approaches to patient surveys to gather feedback on the service from the patients and other concerned individuals.	5. Citizen engagement and feedback	The hospital currently holds monthly patient feedback meetings, and obtains patient feedback from monthly clinical governance meetings. In addition to this the service will: Develop local questionnaires Reintroduce a suggestion box	Diana Tyrrell, Hospital Director	30/05/2018
Delivery of safe and effective care				
The registered provider must support patients, based on individual patient risk assessments, to make their own hot drinks and food at the hospital.	14. Nutrition	The service has obtained a quote to have hot drink making facilities installed in the dining room for patients to make their own drinks. This is being considered. In addition to this individual patients will be supported to use the separate activities bungalow to make their own drinks, dependent upon individual risk.	Diana Tyrrell, Hospital Director Emer Scallon, Occupational Therapist	31/07/2018 30/04/2018
The registered provider should look at consolidating the patient records, as far as is practical. Minimising duplication and providing	20. Records management	A full review of records has taken place. All records have been consolidated to one set of essential hard copy records,	Diana Tyrrell, Hospital Director	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
easier access to specific information.		in addition to electronic patient records. This will be monitored through the sites quality walkaround process		
The registered provider must ensure that detention papers are readily available at the hospital so that staff can be assured of the validity of detentions under the Act.	Mental Health Act	A review is currently under way to ensure all records contain a copy of the latest detention papers. Original detention papers will be moved back to site once new lockable storage has been obtained.	Diana Tyrrell, Hospital Director John Harris, Mental Health Act Administrator	15/04/2018 30/04/2018
The registered provider must ensure that documentation regarding appeals against detention are available within patient records.	Mental Health Act	A review is currently under way to ensure all records contain a copy of appeals against detention documents. Original documentation will be moved back to site once new lockable storage has been obtained.	Diana Tyrrell, Hospital Director John Harris, Mental Health Act Administrator	15/04/2018 30/04/2018
The registered provider must ensure that patients are informed of their rights and that this is documented within patient records.	Mental Health Act	Current multidisciplinary documentation to be adapted to capture this information.	Diana Tyrrell, Hospital Director	30/04/2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Reading of Patients Rights to be added to nurses daily check sheets to ensure completion. This will be monitored using the sites documentation quality walkrounds.		
The registered provider must ensure that care plans support person-centred rehabilitation care that setting out achievable goals, timeframes and the person(s) responsible for achieving the goals.	Mental Health (Wales) Measure 2010	The multidisciplinary meeting process has recently been improved, with all member of the team inputting into care plans in order to help patients achieve their goals. All care plans are in the process of being reviewed again to ensure goals are rehab focused, with a clear discharge plan evident.	Laura Pocock, Director of Clinical Services.	30/05/2018
The registered provider must ensure that each patient has up to date risk assessment that include current and historical risks.	Mental Health (Wales) Measure 2010	All risk assessment and formulations are in the process of being reviewed by the multidisciplinary team as part of the new meeting process.	Dr Owen Roberts, Consultant Psychiatrist	30/05/2018
The registered provider must ensure that there are clear and comprehensive records of physical health care.	Mental Health (Wales) Measure 2010	The site plan on introducing a separate physical health checklist/record. This will be held in the hard copy records, and information from it transferred to the	Laura Pocock, Director of Clinical Services	30/05/2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		electronic records. It will include sections for physical health monitoring such a as blood pressure, weight etc, but also sections to document dental appointments, optician appointments, cervical screening and breast screening.		
The registered provider must ensure that Hospital Passports and/or Health Action Plans are up to date and include all relevant details of the patient.	Mental Health (Wales) Measure 2010	This is being discussed with the nursing team, and all Hospital Passports and Health Action Plans are in the process of being updated.	Laura Pocock, Director of Clinical Services	30/05/2018
Quality of management and leadership				
The registered provider is requested to provide an update on the recruitment to registered nurse and other multi-disciplinary team vacancies.	25. Workforce planning, training and organisational development	A new permanent Consultant Psychiatrist, specialising in Learning Disability has now started at the hospital. The hospital also has a permanent part time Occupational Therapist. An additional part time Occupational Therapist has been appointed and is likely to start 16/04/2018.	Diana Tyrrell, Hospital Director	30/05/2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		The hospital continues to use a locum Psychologist. However, interviews have been arranged for a permanent Clinical Psychologist who will be employed full time.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Diana Tyrrell

Job role: Hospital Director

Date: 23rd March 2018