Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Ty Catrin

Priory Group

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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 Ty Catrin on the evening of 22 April 2018 and following days of 23 and 24 April 2018. The following sites and wards were visited during this inspection:

- Bute - Male Low Secure - 11 beds
- Roath - Male Low Secure - 8 Beds
- Victoria - Female Low Secure - 11 Beds
- Sophia - Female Low Secure - 8 Beds
- Trelai - Female Low Secure - 4 Beds
- Heath - Female Locked Rehabilitation - 3 Beds

Our team, for the inspection comprised of two HIW inspectors and three 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

Overall, we found evidence that the service provided safe and effective care. There was a focus on least restrictive care to aid recovery and supported patients to maintain and develop skills.

Significant improvements are required in the registered provider's fulfilment of statutory responsibilities of the Mental Health Act..

This is what we found the service did well:

- Staff interacted and engaged with patients respectfully
- The environment of care was appropriate for the patient group
- Focused on least restrictive care to aid recovery and supported patients to maintain and develop skills
- Medicines management was safe and effective
- High compliance in mandatory training, supervision and appraisals

This is what we recommend the service could improve:

- Fulfilment of its statutory responsibilities of the Mental Health Act
- Provision of information for patients
- Documentation within and supporting Care and Treatment Plans

We identified regulatory breaches during this inspection regarding the fulfilment of statutory responsibilities of the Mental Health Act. 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

Ty Catrin is registered to provide an independent Mental Health Hospital at Ty Cartrin, Dyfrig Road, Cardiff CF5 5AD.

The service has 44 beds across six gender specific wards. At the time of inspection there were 40 patients.

The service was first registered on 26 October 2009.The service employees a staff team which includes a Hospital Director, a Director of Clinical Services, four ward managers, two night co-ordinators and a team of registered nurses and healthcare workers. There are also multi-disciplinary team members which include consultant forensic psychiatrists, psychologists, occupational therapists and social workers.

The hospital employs a team of maintenance, catering and domestic staff. The operation of the hospital is supported by a team of administration staff.

The hospital is supported by the management and organisational structures of The Priory Group.

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 throughout the hospital interacted and engaged with patients appropriately and treated patients with dignity and respect.

The registered provider must improve the range of information for patients displayed throughout the hospital.

Health promotion, protection and improvement

There was a range of health promotion, protection and improvement initiatives available to the patients at Ty Catrin which assisted in maintaining and improving patients' wellbeing. However, at the time of the inspection there was little information displayed throughout the hospital to inform patients and staff of these; we were told that this was in part due to ongoing refurbishment of the hospital environment. It would be of great benefit to the patient group if information on health promotion, protection and improvement was displayed throughout ward and communal areas within the hospital.

Ty Catrin had a practice nurse who held a general nurse registration. However, there was no employed assistant available to aid the practice nurse in the role or when absent from the hospital. Through speaking to staff and reviewing documentation it was evident that some patients had been required to be escorted to community healthcare services whereas if there were staff who had training in additional healthcare skills, competencies and minor procedures this would enable more timely and appropriate physical healthcare. Therefore impacting less upon staff time who regularly take patients to outpatient clinics or A&E.

Patients were able to access GP, dental services and other physical healthcare professionals in the community. Access to these types of appointments was confirmed through conversations with patients and staff along with being documented in patients' records.

There was a range of facilities to support the provision of therapies and activities at the hospital. The hospital staffing included two occupational therapists, four occupational therapy assistants and a sports therapist.

The hospital had recently refurbished the Occupational Therapy kitchen which provided a facility for staff to support and assess patients in daily living skills such as, cooking and laundry. Each ward had its own ward kitchen that patients could access with staff to prepare their own drinks and snacks. It was positive to note that as part of the ongoing refurbishment of Ty Catrin each ward would have their own laundry room so that patients could be supported to undertake their own laundry on the ward.

The communal area for all patients, known as the Piazza, on the first floor of the hospital had also been recently refurbished which provided an inviting space for group activities such as therapy sessions, breakfast group, coffee mornings and film groups.

The art room provided the opportunity for patients to participate in a range of arts and crafts activities at the hospital. The art room also had computers with internet access, we observed patients (under staff supervision) using these to undertake some internet shopping for personal items.

We were informed that patients have the opportunity to enrol in the Priory's education programme, The Recovery College, which includes a range of educational courses including IT skills and internet security. Through our conversations with some patients they explained that they had undertaken English and mathematics classes whilst at the hospital.

There was a suitable room available on the first floor for facilitating visitors, multi-faith services and relaxation sessions. There was a designated child visiting area on the ground floor accessed through the main hospital reception. This was suitably located so that child visitors were only required to enter the hospital reception. Whilst there was a selection of toys available the registered provider could review the furniture and décor to make it more welcoming for child visitors.

At the time of our inspection the hospital gym and pool were closed. The registered provider was due to refurbish the areas to make a gym more suitable to the patient group. Patients with authorised leave from the hospital were able to access leisure facilities within the community.

Improvement needed

The registered provider must display information on health promotion, protection and improvement throughout ward and communal areas within the hospital.

The registered provider must consider how to provide additional physical health provision available at Ty Catrin to support the practice nurse.

The registered provider should review the furniture and décor of the child visitor room.

The registered provider is requested to provide an update on the refurbishment of the hospital gym, including timescales.

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.

Since our previous inspection the registered provider had developed two Intensive Care Suites at Ty Catrin. These areas could be monitored by staff via CCTV, there is a potential that this could impact upon the privacy and dignity of patients within these areas. The registered provider must ensure that there are clear governance arrangements around the use off CCTV; this is detailed later in the report.

Most patients that we spoke with told us that they were treated with respect and kindness and were complimentary of the care, treatment and support provided at the hospital. However, some patients commented that they found it difficult to approach unfamiliar staff who may have been working on the ward as an agency member of staff, bank staff or a staff member covering from another ward.

Through our conversations with senior management and reviewing staff records it was evident that the provider was attempting to provide a consistent workforce by block-booking bank and agency staff where ever possible to fill

any shortfalls in the staffing rotas. Inconsistency of staff tended to be a result of short notice sickness or unexpected patient escorts from the hospital.

On each ward, patients had their own en-suite bedroom with toilet, sink and a shower. Patients were able to lock bedroom doors to prevent other patients entering; staff could override the locks if required. However, we were informed that not all bedroom locks on Roath were locking, and therefore some patients were concerned that they could not secure their own room. Staff confirmed that this issue had been reported to maintenance and they were due for repair, however no date for completion could be provided at the time of the inspection. It is important that patient bedroom locks are working so that patients feel safe within their own rooms.

During our observation of the environment we noted that the default position for bedroom observation panels was not always in the closed position; this meant that anybody passing the bedroom could look in to the bedroom which would impact upon the patient's privacy. We were informed that a number of observation closing mechanisms had become difficult to operate throughout the hospital which was partly the reason why we'd observed some panels left in the open position. The registered provider must ensure that all bedroom observation panels are operating correctly to help maintain patients' privacy.

During the first night of our inspection we observed a number of ants within an unused bedroom on Roath; during our conversation with a patient on the same ward they also raised a concern about seeing ants within their own bedroom. Senior managers explained that they were aware of periodic ant infestations that have occurred over a number of years. Whilst the registered provider had addressed previous infestations and confirmed they'd take prompt action to remove this one, there is a need to ensure a long term remedy for this issue to prevent future infestations.

Improvement needed

The registered provider must ensure all bedroom door locks are functioning.

The registered provider must ensure all bedroom door observation panels are operational.

The registered provider must ensure a long term remedy for the ant infestation to prevent future issues.

Patient information and consent

There was information displayed on some wards for patients, however this was not consistently displayed across the hospital. We were informed that this was in part due to notice boards being taken down to undertake the refurbishment programme. Despite this, the range of information displayed could be improved across all wards and other areas of the hospital such as the reception area.

The registered provider must ensure that there is information displayed which includes;

- statutory information
- information on the Mental Health Act and advocacy provision,
- how to raise a complaint and
- information on Healthcare Inspectorate Wales.

The registered provider should also consider displaying information about the hospital, activity programme and local community facilities.

Patients were able to contact a representative of the statutory advocacy service either by telephone or making an appointment for a representative to come visit the patient at the hospital. We were informed that the statutory advocacy service no longer provides regular drop in sessions at the hospital, where a representative would attend the hospital on a given day for patients to speak with without an appointment.

We were informed by staff that there was no automatic referral to advocacy services at the hospital and that patients had to refer themselves (or request a staff member to make a referral on their behalf) to the advocacy service. We are concerned that patients who may lack the capacity to understand the role of the advocacy service would not receive the input that they are entitled to. The registered provider should review their automatic advocacy referral processes to ensure that patients have the opportunity to receive this input.

Improvement needed

The registered provider must ensure that there is information displayed which includes statutory information, information on the Mental Health Act and advocacy provision, how to raise a complaint and information on Healthcare Inspectorate Wales.

The registered provider should consider displaying Information about the hospital, activity programme and local community facilities.

The registered provider should review their automatic advocacy referral processes to ensure that patients have the opportunity to receive advocacy input.

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.

Each ward had 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.

There were weekly ward community meetings where patients had the opportunity to provide feedback on the care they receive at the hospital and discuss any developments or concerns.

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.

Care planning and provision

There was a clear focus on providing safe and effective care for patients at the hospital. Care was individualised and on the whole focused on recovery that was supported by least restrictive practices, both in care planning and ward or hospital practices.

Each patient had their own programme of care based on their individual needs such as medication, therapy sessions and activities. These included individual and group sessions, based within the hospital and the community (when required authorisation was in place).

Equality, diversity and human rights

Staff practices aligned to established hospital policies and systems ensured that the patients' equality, diversity and rights were maintained.

Mental Health Act detention papers had been completed correctly to detain patients at the hospital. However, the registered provider must implement improvements to the application of the Act (at Ty Catrin and other hospitals) to fulfil its statutory duties under the Act and as set out in the Mental Health Act Code of Practice for Wales 2016. These are detailed later in the report.

Citizen engagement and feedback

There were regular patient meetings to allow for patients to provide feedback on the provision of care at the hospital. The hospital also undertook patient surveys; however information on the outcomes of the survey, what actions the registered provider has and will be taking were not displayed on the wards for patients or in the reception area for visitors.

There was a complaints policy and procedure in place at the hospital. The policy provides a structure for dealing with all patients' complaints for services within Ty Catrin.

Complaints were categorised as informal and formal complaints. Informal complaints were logged on each ward within a paper document with formal complaints recorded on a computerised complaints log for the whole hospital. The hospital director confirmed that the provider was reviewing the complaints procedures to combine the process in to one system. This would assist in identifying trends and disseminating any shared learning.

A sample of informal and formal complaints established that an independent person was assigned to investigate the complaint and actions were taken in line with the organisation's complaints policy to ensure that complaints were dealt with appropriately at the hospital.

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 was undergoing a refurbishment programme and on the whole the environment was well maintained and equipped with suitable furniture, fixtures and fittings for the patient group.

The registered provider must ensure that the use of CCTV in the Intensive Care Suites is risk based to ensure that the privacy and dignity of the patient is upheld whilst maintaining safety.

Improvements are required in the fulfilment of the registered provider's statutory responsibilities of the Act and that practice follows the guidance set out in the Code.

Managing risk and health and safety

Ty Catrin had processes in place to manage and review risks and maintain health and safety at the hospital. The hospital provided individualised patient care that was supported by least restrictive practices, both in care planning and hospital or ward practices.

The hospital entrance was secured to prevent unauthorised access with all staff and visitors registering at reception. The hospital had security procedures in place to minimise the risk of restricted items being brought on to the wards. Each shift had an allocated security nurse on each ward that was responsible for maintaining the security protocols on each ward.

The hospital had a list of prohibited items displayed at reception and there were secure lockers available to store any items that can not be taken on to the ward, i.e. mobile phones, lighters, flammable liquids, etc.

Staff wore personal alarms which they could use to call for assistance if required. There were nurse call points around the wards and within patient bedrooms so that patients could summon assistance if required.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system that included the names of patient(s) and staff involved, a description, location, time and length of the incident. Any use of restraint was documented, including who was involved and the body positions of each person involved in the restraint. Incident reports were automatically linked to the individual patient's electronic care notes which ensured that these were up-to-date.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner by a member of the clinical team involved in the individual patient's care and an employee responsible for hospital health and safety.

Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed. Additional reports could be produced as required to look at specific areas as required. The incident reporting system and reporting schedules ensured that incidents were recorded, reviewed and monitored to assist in the provision of safe care at Ty Catrin.

As part of the hospital's strategy for managing challenging behaviour, there were two Intensive Care Suites (ICS) built since our previous inspection, one on the ground floor for the male wards Roath and Bute and another on the first floor for the female wards. The ICS facilities had appropriate self-contained toilet and shower facilities.

Staff's implementation of the use of ICS was the final stage in managing patient behaviours, and could be used for patient Seclusion[1]. If a patient's risk determined it a requirement, anti-rip clothing and bedding was provided to help maintain their dignity whilst being cared for within an ICS. The Registered Provider had a policy in place for the use of the ICS and Seclusion which stated that patients could be in ICS for a brief period of time (e.g. a few minutes) or for

[1] The supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.

prolonged periods of days or weeks. The use of ICS and seclusion at the hospital was recorded and monitored.

There was CCTV available for the observation of all areas of the ICS. The registered provider must ensure that the use of CCTV is risk based on an individual patient and incident basis to ensure that the privacy and dignity of the patient in ICS is upheld whilst maintaining the safety of the patient and staff. The registered provider must ensure that the decision to use CCTV is clearly documented. The registered provider must review their policy of CCTV use to ensure that it follows the Information Commissioner's Office guidance set out in their 2017 CCTV Code of Practice[2].

During our inspection a small number of staff we spoke with were unclear on the controlled and automatic egress systems in place in the event of a fire at the hospital. The hospital director confirmed that fire evacuation procedures complied with relevant fire safety regulations. The registered provider must ensure that all staff are aware of fire evacuation procedures and there are no restrictions in place that would contravene fire safety regulations and the registered provider's policy.

It was positive to note that there was a dedicated Night Co-ordinator who was a registered nurse in charge of the hospital on each night shift. This role provided leadership and support for ward staff. The Night Co-ordinator that we met with on the first night of the inspection was able to provide essential information regarding the hospital staffing and patient group. This evidenced that there was clear oversight of the hospital's operation at night.

[2] https://ico.org.uk/media/for-organisations/documents/1542/cctv-code-of-practice.pdf

The code also reflects the wider regulatory environment. When using, or intending to use surveillance systems, many organisations also need to consider their obligations in relation to the Freedom of Information Act 2000 (FOIA), the Protection of Freedoms Act (POFA), the Human Rights Act 1998 (HRA) and the Surveillance Camera Code of Practice issued under the Protection of Freedoms Act (POFA code).

Improvement needed

The registered provider must review their policy of CCTV use to ensure that it follows the Information Commissioner's Office guidance set out in their 2017 CCTV Code of Practice.

The registered provider must ensure that all staff are aware of fire evacuation procedures and there are no restrictions in place that would contravene fire safety regulations and the registered provider's policy.

Infection prevention and control (IPC) and decontamination

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 hospital and were aware of their responsibilities around infection prevention and control.

The training statistics provided by the registered provider evidenced that 81% of staff were up to date with their infection control training and that the remaining 19% were scheduled to complete their refresher training.

Generally we observed the hospital to be visibly clean and free from clutter. However, on Roath and Bute we observed a number of areas of the ward that were stained or marked. Staff explained the reasons for a number of these and whilst a number related to patient behaviours the marks should be cleaned as soon as practicable. It was evident that stains on Roath remained despite the patient being transferred to Bute.

It is positive to note that the registered provider is increasing the number of laundry facilities available to patients across the hospital as part of its refurbishment programme.

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

There were suitable arrangements in place for the disposal of waste. Appropriate bins were available to dispose of medical sharp items, these were not over filled.

As stated earlier in the report, there are regular ant infestations at Ty Catrin; the registered provider must address this issue.

Improvement needed

The registered provider must ensure that stains and marks are promptly removed.

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 menus also varied seasonally through the year. As well as the meals provided patients were able to use the occupational therapy kitchen to prepare their own meals and order take-away deliveries to the hospital.

Patient feedback on the meals and menu options were collated and this assisted in the review and compiling the menu options. The patients we spoke with during our inspection had mixed views on the food provided at the hospital. We understand that there had been ongoing vacancies within the catering team with the team only comprising of one chef and two kitchen assistants. The registered provider had recently appointed to the vacant second chef post and was advertising for an additional kitchen assistant.

The catering staff we spoke with felt that this had impacted upon the capacity and consistency of staff with the requirement to use agency staff. They also stated that felt they had fallen short of the service they would wish to provide, for example they were unable to attend patients meetings to discuss issues around food as they used to with the full complement of staff.

There were ward kitchens on each of the wards so that patients could access drinks and their snacks throughout the day and night.

Improvement needed

The registered provider must provide an update on the establishment of the catering team at Ty Catrin.

Medicines management

We reviewed three of the four hospital clinics and found that medicines management was safe and effective. Medication was stored securely with

cupboards and medication fridges locked. There was regular pharmacy input and audit undertaken that assisted the management, prescribing and administration of medication at the hospital.

There was evidence that there were regular temperature checks of the medication fridge and clinic room to ensure that medication was stored at the manufacturer's advised temperature.

There were appropriate arrangements for the storage and use of Controlled Drugs and Drugs Liable to Misuse. On the whole these were accurately accounted for and checked daily, however there were four occasions within the previous month when controlled drug medication was administered and was not signed for by two members of staff.

The hospital had a new shared clinic for Bute and Roath; whilst the Controlled Drugs cupboard was secure it was waiting shelving to allow for better organising of medication. The registered provider confirmed that this was ordered and to be installed imminently.

The Medication Administration Record (MAR) Charts reviewed contained the patient's name, photograph of the patient and their mental health act legal status. MAR charts included copies of the consent to treatment certificates and MAR charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered.

Improvement needed

The registered provider must ensure that all Controlled Drugs are accounted for in line with relevant legislation.

The registered provider must ensure that Controlled Drug cupboards have appropriate shelving to remain organised.

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. As stated above, there were appropriately located child visiting facilities at the hospital.

The training statistics provided by the registered provider evidenced that 81% of staff were up to date with their child and adult safeguarding training and that the remaining 19% were scheduled to complete their refresher training.

Medical devices, equipment and diagnostic systems

There were regular clinical audits at the hospital and a nightly audit of resuscitation equipment, staff had documented when these had occurred to ensure that the equipment was present and in date. The hospital was redeveloping their checklist to ensure that there was a consistent audit across the hospital.

There were ligature cutters located throughout the hospital in case of an emergency.

Improvement needed

The registered provider must ensure that there is a standardised emergency equipment audit checklist across the hospital.

Safe and clinically effective care

Overall, we found governance arrangements in place that helped ensure that staff provided safe and clinically effective care for patients. The arrangements for the hospital fed through to The Priory Group governance arrangements which facilitated a two way process of monitoring and learning.

Records management

Patient records were electronic which were password protected to prevent unauthorised access and breaches in confidentiality.

We reviewed a sample of patient records across the wards. It was evident that staff from across the multi-disciplinary teams were writing detailed and regular entries which provided a live document on the patient and their care.

Original Mental Health Act statutory documentation was stored securely at Ty Catrin. However, only one member of staff at the hospital was able to access the original statutory documentation for patients. There was no contingency for other designated professionals to access the original documentation in the absence of this member of staff. This is a potential risk for the registered provider if there were unforeseen circumstances preventing the one member of staff attending the hospital.

Improvement needed

The registered provider must ensure that access to original mental health act statutory documentation is available at any time.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients across two wards, Bute and Victoria. We also reviewed the governance and audit processes that were in place for monitoring the use of the Mental Health Act (the Act) across all six wards at Ty Catrin.

The three sets of statutory documentation verified that the patients were legally detained at Ty Catrin. However, during our scrutiny of patient detention files and the review of processes regarding statutory responsibilities under the Act and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 (the Code) we saw significant omissions in practice.

We identified that fundamental areas of the Act were not being completed at Ty Catrin and through conversations with relevant staff lacking at a number of other Priory hospital within Wales. These included:

- Provide patients with copies of their detention papers, paragraph 4.14
- Information for patients about consent to treatment, paragraph 4.23
- Information for patients' nearest relative, paragraphs 4.36 - 4.40
- Records of discussions of treatment with patients, paragraph 24.34
- Record of patients being provided with information on their rights with regards to medication, paragraph 24.37

There were insufficient staff resources with appropriate knowledge to fulfil the registered provider's statutory responsibilities of the Act and that practice follows the guidance set out in the Code.

We identified a potential conflict of interest with the make-up of Hospital Manager Hearing panel members. We explained the specific case to the hospital director to review following our inspection and take appropriate action.

There were not copies of the Code on each of the wards at Ty Catrin, either in English or Welsh. Copies of the Code must be made available in English and Welsh for patients and staff.

Improvement needed

The registered provider is required to ensure that there are sufficient staff resources with appropriate knowledge to fulfil the registered provider's statutory responsibilities of the Act and that practice follows the guidance set out in the Mental Health Act 1983 Code of Practice for Wales, Revised 2016.

The registered provider must ensure that there is an appropriate system in place to prevent any conflict of interest of Hospital Manager Hearing panel members.

The registered provider must ensure that copies of the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 are available in English and Welsh.

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

We reviewed the care plans of a total of four patients.

The Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed. Overall individual Care and Treatment Plans drew on patient's strengths and focused on recovery, rehabilitation and independence.

To support patient care plans, there were a range of patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them. However, reviewing the recently implemented Priory patient risk assessment there was limited information documented on the risk assessment; particularly in relation to evidencing and documenting the clinical judgement behind the outcome of the risk assessment. Staff were also unable to provide the criteria for judging a risk to be low, medium or high. Therefore staff were unable to provide clear rationale to their assessment of risk.

For three of the four CTPs reviewed we were unable to easily identify the named care coordinator for the patient. The registered provider must ensure that this is clearly documented for all patients with a CTP.

The patient records we reviewed evidenced good physical health monitoring, however we identified that for one patient there was no dietician input which would assist the multi-disciplinary team care plan for weight management.

In addition, one patient did not have a care plan for medication under the Medication and Other Treatment CTP domain but had received rapid tranquilisation and regular medication.

It was also common that staff were not clearly documenting any unmet needs a patient may have whilst being cared for at the hospital. It is important that unmet needs are documented so that these can be regularly reviewed by the multi-disciplinary team to look at options for meeting those needs.

Patients and staff we spoke with told us that patients were involved in discussions around their care (when patients wished to engage). However, reviewing patients' records this was not always clearly documented, some records failed to document if the patient was involved, their views or whether the patient had declined to be involved.

There was also little record of family or carer involvement in patients' care documented in the patient records we reviewed. This was despite clear records of patients undertaking leave to family members' homes. Staff and patients confirmed that for some patients their relatives or carers are active in the patient's care, this needs to be documented in patient records or the reason why family members or carers are not involved.

On the whole entries on to the electronic patient records by staff were of a good professional standard; however some entries lacked detail, particularly around patient's mental state, such as 'appears low in mood' or 'remains unsettled'. More detailed entries explaining the reasons behind the patient's metal state and interventions attempted would assist multi-disciplinary team care review and planning.

Improvement needed

The registered provider must ensure that patient risk assessments evidence and inform the clinical judgement of the outcome.

The registered provider must ensure that the care coordinator is clearly documented for all patients with a CTP.

The registered provider must ensure that there is dietician input to Ty Catrin when required.

The registered provider must ensure that the Medication and Other Treatment CTP domain is completed for patients who are receiving medication.

The registered provider must ensure that any unmet needs are recorded in

patients' CTPs.

The registered provider must ensure that patient's involvement in their care is clearly documented.

The registered provider must ensure that family and/or carer involvement in their care is clearly documented in patient records.

The registered provider must ensure that clinical entries are detailed, particularly in reference to patients' mental state.

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.

We saw good management and leadership at Ty Catrin which was supported by The Priory Group. We observed a committed staff team who had a good understanding of the needs of the patients at the hospital.

Mandatory training, supervision and annual appraisal completion rates were generally high. However an area that needed improvement across all wards was PMVA Breakaway Training.

Recruitment was undertaken in an open and fair process with appropriate employment checks being carried out prior and regularly during employment.

Governance and accountability framework

Overall 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.

However, as detailed earlier in the report, significant improvement is required to ensure that registered provider fulfils its statutory responsibilities of the Act and that practice follows the guidance set out in the Code.

Since our previous inspection, there had been a number of changes to the ownership and management of Ty Catrin. There had been a change in the registered provider from Partnerships in Care to Priory Healthcare, a new Hospital Director had been appointed less than a month prior to our inspection and new appointments to some multi-disciplinary team members.

It was positive that despite a number of changes at Ty Catrin, through our conversations with staff, observing multi-disciplinary team meetings and engagement, and reviewing patient records there was evidence of strong multi-disciplinary team-working. Staff commented favourably on multi-disciplinary working stating that they felt that their views were listened to and respected by other members of staff.

It was also noted that during a multi-disciplinary team meeting that there was evidence of effective and collaborative multi-disciplinary team working. The patient who attended their review was welcomed warmly and treated with great sensitivity and their views were actively sought and taken in to consideration during the meeting.

Each discipline had a head of department who provided leadership for their team and linked in collaboratively with other heads of department within The Priory Group.

Staff spoke positively about the leadership and support provided by senior managers, ward managers and support from colleagues across the disciplines. We found that staff were committed to providing patient care to high standards.

It was positive that, throughout the inspection, the staff at Ty Catrin were receptive to our views, findings and recommendations.

Dealing with concerns and managing incidents

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

It was evident that the registered provider monitored concerns and incidents locally at Ty Catrin and corporately through regular reporting mechanisms.

Workforce planning, training and organisational development

We reviewed the staffing establishment at Ty Catrin with that stated within their Statement of Purpose. There were six registered nurses and seven healthcare support worker vacancies which the registered provider was recruiting, with 2 staff nurses due to commence employment the month following our inspection.

To cover any shortfalls in fulfilling the staffing rota that may occur due to vacancies, the registered provider had a staff bank system in place along with the use of agency staff. Staff rotas evidenced 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.

It was positive to note that the hospital director had developed a Ty Catrin Workforce (Employee Retention) Plan. This documented priorities of the organisation in developing and maintaining its workforce along with proposals and initiatives that had been developed or planned.

We reviewed the mandatory training, supervision and annual appraisal statistics for staff at the hospital and found that completion rates were generally high. The electronic system provided the senior managers with details of the courses completion rates and individual staff compliance details. An area that needed improvement in compliance across all wards was Prevention and Management of Violence and Aggression (PMVA) Breakaway Training, however the electronic system highlighted that a large proportion of staff whose refresher training was due had been allocated a training date.

Improvement needed

The registered provider must ensure that staff complete their mandatory training, including Prevention and Management of Violence and Aggression (PMVA) Breakaway Training.

Workforce recruitment and employment practices

Staff explained the recruitment processes that were in place at Ty Catrin. It was evident 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 Barring Service (DBS) checks were undertaken and professional qualifications checked.

All staff received an induction prior to commencing work on the wards at the hospital. Permanent staff files held certificate of induction following the completion of their corporate induction. Agency staff completed an induction at the hospital prior to starting their shift, the completion of the induction was signed off by a member of staff and Ty Catrin and the agency staff member, these were then filed with the human resources team.

DBS checks were completed after each three year period of employment and systems were in place to monitor professional registrations are up to date.

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: Ty Catrin

Wards: all wards

Date of inspection: 22 - 24 April 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 display information on health promotion, protection and improvement throughout ward and communal areas within the hospital.	3. Health promotion, protection and improvement	Liaison between; Practice Nurse, Sports Therapist & Patients re relevant Health Promotion information required. Health promotion Information will be displayed on the designated information boards and be gender specific.	Jayne Gardner (Practice Nurse) / Sophie Arnold (Sports Therapist) / Elin Thomas (Senior Occupational Therapist) / Bethan Bater (Occupational Therapist)	IMMEDIATE Completed: 29/05/18 15/06/18

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must consider how to provide additional physical health provision available at Ty Catrin to support the practice nurse.	3. Health promotion, protection and improvement	Review of the Practice Nurse role and what currently falls within their job description/remit Review frequency and consistency of Clinics Review of RC support for Practice Nurse and shared physical heath workload Triage Protocol Review	Therisa Galazka (Registered Manager) / Jayne Gardner (Practice Nurse) Dr Phil Huckle (Consultant Forensic Psychiatrist) / Jayne Gardner (Practice Nurse) / Dr Dilum Jayawickrama (Consultant Forensic Psychiatrist)	30/06/18 30/06/18 30/06/18 30/06/18

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Review of Trained First Aiders on site and how they are utilised to support Practice Nurse Review number of staff trained in BLS and ILS	Victoria Wheeler (Practice Development Nurse)	IMMEDIATE Completed 06/06/18 IMMEDIATE Completed 06/06/18
		Consider Wound Management training for staff Devise Training programme for Phlebotomy and deliver Devise Training programme for ECG and deliver	Jayne Gardner (Practice Nurse) / Gail Blackman (Practice Nurse at Ty Cwm Rhondda)	31/07/18 31/07/18 31/07/18

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider should review the furniture and décor of the child visitor room.	3. Health promotion, protection and improvement	Review of visiting area with maintenance. Agree décor plans and timeline for completion. Patients will be involved in the décor of the room. External privacy film to window	Therisa Galazka (Registered Manager) / Peter Jones (SSM / Maintenance)	IMMEDIATE Completed 07/06/18 30/06/18 30/06/18
The registered provider is requested to provide an update on the refurbishment of the hospital gym, including timescales.	3. Health promotion, protection and improvement	Agree estates floor plans for refurbishment of Gym. Confirm with central estates a timeframe for completion	Peter Jones (SSM / Maintenance)	IMMEDIATE Completed 15/05/18 Sept 2018
The registered provider must ensure all bedroom door locks are functioning.	10. Dignity and respect	Bedroom door lock audit completed following incident of patient obstructing / damaging bedroom lock	Peter Jones (SSM / Maintenance) / Stuart Mayne (Security & TMVA Lead)	IMMEDIATE Completed 8/04/18

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Quarterly Fire Door checks will incorporate the bedroom Door Lock audit	Peter Jones (SSM / Maintenance)	From July 18
The registered provider must ensure all bedroom door observation panels are operational.	10. Dignity and respect	Obtained quote regarding replacement of complete door – to include anti-barricade fixtures and fittings. Submit request via the monthly CAPEX (Capital Expenditure). Actions thereafter will be based on CAPEX outcome.	Peter Jones (SSM / Maintenance) Therisa Galazka (Registered Manager)	IMMEDIATE Completed 31/05/18 IMMEDIATE Completed 07/06/18
The registered provider must ensure a long term remedy for the ant infestation to prevent future issues.	10. Dignity and respect	Ant `infestation` is a seasonal occurrence, specifically relating to warmer weather conditions. Management via insecticide product every two weeks during summer months. Advise patients not to store perishable items on bedrooms generally – reinforced via Community Meetings	Peter Jones (SSM / Maintenance) Ward Managers	31/05/18 ONGOING

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that there is information displayed which includes statutory information, information on the Mental Health Act and advocacy provision, how to raise a complaint and information on Healthcare Inspectorate Wales.	9. Patient information and consent	Review of current information displayed in clinical areas. Confirm information to be displayed on each ward and ensure this is maintained.	Ward Managers Ward Managers	15/06/18 15/06/18
The registered provider should consider displaying Information about the hospital, activity programme and local community facilities.	9. Patient information and consent	Review current information being displayed with a view of updating and /or replacing.	Ward Managers	15/06/18
The registered provider should review their automatic advocacy referral processes to ensure that patients have the opportunity to receive advocacy input.	9. Patient information and consent	Admission checklist to be amended to include automatic referral to Advocacy on admission to Ty Catrin. Patient information boards clearly display information relating to advocacy services and means of contact and support. Patients will be routinely asked if they require advocacy support for all patient meetings (as a minimum) and this will	Andrew Balmforth (Director of Clinical Services) Ward Managers Ward Managers	IMMEDIATE 15/06/18 IMMEDIATE

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		be clearly documented in care notes.		
Delivery of safe and effective care				
The registered provider must review their policy of CCTV use to ensure that it follows the Information Commissioner's Office guidance set out in their 2017 CCTV Code of Practice.	22. Managing risk and health and safety 12. Environment	Review Priory CCTV Policy (Revised 23 May 2018) with QIF (Quality Improvement Facilitator). Findings: Policy is cross referenced with other relevant policies including: • Data Protection • Management of Data Security Breach • Complaints • Incident Management, Investigation & Reporting • Privacy Impact Assessment The Policy references the Information Commissioner's Office Guidance 2014. This is not the most recent version of		IMMEDIATE Completed 06/06/18

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		which is June 2017. Escalate HIW recommendations to David Watts (Director of Risk Management) re; review in line with the Information Commissioner's Office Guidance 2017.	Therisa Galazka (Registered Manager)	08/06/18
The registered provider must ensure that all staff are aware of fire evacuation procedures and there are no restrictions in place that would contravene fire safety regulations and the registered provider's policy.	22. Managing risk and health and safety 12. Environment 4. Emergency Planning Arrangements	Display Floor Plans on each floor with Fire Evacuation Procedure as supporting evidence. Display Fire Evacuation notices at each stair well and external fire door. NOTE: Most recent fire drill (18/05/18) evidenced that all staff evacuated the building appropriately and as per evacuation procedure. Fire Drills (day/night) are performed every quarter.	Peter Jones (SSM / Maintenance) Peter Jones (SSM / Maintenance) Peter Jones (SSM / Maintenance)	20/06/18 20/06/18 Next due: Aug/Sept 18

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that stains and marks are promptly removed.	13. Infection prevention and control (IPC) and decontaminati on	Stain block and redecorate the relevant areas. NOTE: Patient responsible behaviour is challenging with regular/frequent episodes of throwing drinks at walls and ceilings.	Peter Jones (SSM / Maintenance)	11/06/18
The registered provider must provide an update on the establishment of the catering team at Ty Catrin.	14. Nutrition	Ty Catrin Catering Staffing Model: • 1 FTE Head Chef /Manager • 2 FTE Chefs • 2 FTE Kitchen Asst Establishment at time of Inspection; • 1 FTE Chef • 1 PTE Kitchen Asst Catrin have successfully recruited; 2 FTE Chefs • 1 already in employment • 1 completed induction we:	Therisa Galazka (Registered Manager) / Hayley Sellers (HR Advisor)	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		01/06/18 1 FTE Kitchen Assistant Interviews held: 02/05/18 Offer accepted and awaiting HR compliance checks/Induction		Completed
The registered provider must ensure that all Controlled Drugs are accounted for in line with relevant legislation.	15. Medicines management	ASHTONS provide an external audit service and live report on a weekly basis identifying any prescribing and/or administrating errors. All Controlled Drugs must be administered via a two nurse procedure. Reinforce to all registered nurses and ensure refresher medication assessments are completed as necessary. Nurse in Charge is responsible for ensuring all medication administration is undertaken in line with NMC guidance and Priory Medicines Management policies. Random weekly clinic checks to be conducted by Ward Managers.	ASHTONS Ward Managers / Andrew Balmforth (Director of Clinical Services) Ward Managers	ONGOING IMMEDIATE IMMEDIATE

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that Controlled Drug cupboards have appropriate shelving to remain organised.	15. Medicines management	Following completion of the new clinics, additional shelving was identified as a requirement for the Controlled Drugs cupboards.	Therisa Galazka (Registered Manager) / Peter Jones (SSM / Maintenance)	IMMEDIATE Completed 27/05/18
The registered provider must ensure that there is a standardised emergency equipment audit checklist across the hospital.	16. Medical devices, equipment and diagnostic systems	Checklist received and amendments/ additions to be confirmed before re-issuing to all wards	Andrew Balmforth (Director of Clinical Services) / Paul Stewart Davies (Charge Nurse)	15/06/18
The registered provider must ensure that access to original mental health act statutory documentation is available at any time.	20. Records management	Original documents will be held securely with the Mental Health Act Manager. These documents are accessible by Senior Management Team members in the absence of the Mental Health Act Manager An electronic copy of the Mental Health Act Statutory Documentation will be uploaded to Care noted for reference purposes.	John Harris (MHA & Referrals Manager) / Therisa Galazka (Registered Manager) John Harris (MHA & Referrals Manager)	n/a 31/08/18

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider is required to ensure that there are sufficient staff resources with appropriate knowledge to fulfil the registered provider's statutory responsibilities of the Act and that practice follows the guidance set out in the Mental Health Act 1983 Code of Practice for Wales, Revised 2016.	Mental Health Act 1983	A review of staff resources was undertaken and agreed with the Mental Health Act Manager in 2016. Further discussion and review will be raised with the Regional Operational Director to establish staffing model for 2018-2019.	Cerys Morris (Operational Director) / Warren Irving (Managing Director) / Therisa Galazka (Registered Manager) / Daniel Whitfield (Finance Director)	31/07/18
The registered provider must ensure that there is an appropriate system in place to prevent any conflict of interest of Hospital Manager Hearing panel members.	Mental Health Act 1983	With immediate effect; all panel members requested to hold a Managers Hearing will be requested to disclose any relationship history with the identified individuals as to avoid any conflict of interest. This information with not be held at site or recorded. It will be used only for the identified Hearing only and disposed of in line with 2018 GDPR Legislation.	John Harris (MHA & Referrals Manager)	IMMEDIATE

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that copies of the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 are available in English and Welsh.	Mental Health Act 1983	The Mental health Code of Practice 1983 is on all Wards. The revised 2016 edition is ordered in both Welsh & English for all Clinical areas and reception.	Therisa Galazka (Registered Manager) / John Harris (MHA & Referrals Manager)	IMMEDIATE Completed 06/06/18
The registered provider must ensure that patient risk assessments evidence and inform the clinical judgement of the outcome.	Mental Health (Wales) Measure 2010	A shared understanding of Risk (Low – High) is clearly documented in the Clinical & Risk Assessment Policy. This is referenced and supports formulation and outcome of risk. The Risk Assessment has been discussed at Regional Service Line forums	n/a	n/a
The registered provider must ensure that the care coordinator is clearly documented for all patients with a CTP.	Mental Health (Wales) Measure 2010	Review all CTP documentation and electronic patient profiles to ensure care coordinator is detailed	SW	IMMEDIATE
The registered provider must ensure that there is dietician input to Ty Catrin when required.	Mental Health (Wales) Measure 2010	Dietician appointed and awaiting confirmation of HR and Finance processes.	Therisa Galazka (Registered Manager)	30/06/18

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that the Medication and Other Treatment CTP domain is completed for patients who are receiving medication.	Mental Health (Wales) Measure 2010	Discussion with Multi-disciplinary Team (MDT) regarding Care & Treatment Planning. All domains of CTP to be fully completed for all patients. MDT Meeting proposed to review all existing care plans and to address the immediate action. Care and Treatment Planning Week will continue as planned to review all domains	Therisa Galazka (Registered Manager) MDT MDT	IMMEDIATE Completed 06/06/18 11/06/18 30/06/18
The registered provider must ensure that any unmet needs are recorded in patients' CTPs.	Mental Health (Wales) Measure 2010	Unmet needs are currently captured via the patients' individual timetables of which data is collated via the compliance in charge dashboards. To further capture unmet needs direct in care notes. Discussion to establish how best to implement this at site.	MDT	11/06/18
The registered provider must ensure that patient's involvement in their care is clearly documented.	Mental Health (Wales) Measure 2010	Discussion with MDT regarding Care & Treatment Planning. Patients' involvement to be clearly documented and consistent for all.	Therisa Galazka (Registered Manager)	IMMEDIATE Completed 06/06/18

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		MDT Meeting proposed to review all existing care plans and to address the immediate action. Care and Treatment Planning Week will continue as planned to review all domains.	MDT MDT	11/06/18 30/06/18
The registered provider must ensure that family and/or carer involvement in their care is clearly documented in patient records.	Mental Health (Wales) Measure 2010	Discussion with MDT regarding Care & Treatment Planning. Carer / Family involvement and comments re: plans to be clearly documented. *Involvement is with patient consent only* MDT Meeting proposed to review all existing care plans and to address the immediate action. Care and Treatment Planning Week will continue as planned to review all domains.	Therisa Galazka (Registered Manager) MDT Rhys Bradley (Social worker) / Jim Crinion (Social worker) / Stephen McNicholas (Social worker)	IMMEDIATE Completed 06/06/18 11/06/18 30/06/18

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that clinical entries are detailed, particularly in reference to patients' mental state.	Mental Health (Wales) Measure 2010	Priory perform a monthly Quality Walk Round re: Documentation. Additions to the audit will now include a quality check of Care note entries for previous 4 weeks and alert the MDT to any substandard entries for further action. Provide staff with guidance re: good practice for report writing. Randomly audit clinical entries for quality assurance and address concerns as necessary	Daniel Stubbings (Clinical Psychologist) Andrew Balmforth (Director of Clinical Services) Ward Managers	30/06/18 30/06/18 IMMEDIATE
Quality of management and leadership				
The registered provider must ensure that staff complete their mandatory training, including Prevention and Management of Violence and Aggression (PMVA) Breakaway Training.	25. Workforce planning, training and organisational development	Staff Training is reported against weekly and compliance benchmarked against other Priory services.	Victoria Wheeler (Practice Development Nurse) / Therisa Galazka (Registered Manager)	ONGOING

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Hospital Director to ensure all staff are compliant with Prevention & Management of Violence and Aggression training including Breakaway techniques.	Victoria Wheeler (Practice Development Nurse) / Stuart Mayne (Security & TMVA Lead)	ONGOING
		Forthcoming Training dates confirmed as: 20th & 21st June 25th & 26th July 5th & 6th September 26th & 27th September 10th & 11th October 1st & 2nd November 29th & 30th November 6th & 7th December 12th & 13th December	Stuart Mayne (Security & TMVA Lead) / Sam Carr (Senior HCW) / Kelly Dance (Senior HCW)	13/12/18

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): **THERISA GALAZKA**

Job role: **HOSPITAL DIRECTOR / REGISTERED MANAGER**

Date: **29 JUNE 2018**