Arolygiaeth Gofal Iechyd Cymru

Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Coed Du Hall, Mold.

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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 receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

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 Coed Du Hall, Mold on the evening of 11th February and the days of 12th and 13th February 2019. The following sites and wards were visited during this inspection:

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

Our team, for the inspection comprised of one HIW inspector, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one lay reviewer. The inspection was led by the 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. We found the service was going through a period of transition with the appointment of a new registered manager and assistant manager.

On the whole the hospital provided a positive therapeutic environment for its patients, displaying an emphasis on recovery.

The registered provider is required to review its processes around Mental Health Act administration. This has started with the appointment of the assistant manager who will lead this area.

This is what we found the service did well:

- Patients clinical notes were of a very high standard
- The hospital environment was maintained to a very high standard and felt very homely
- There was a strong management structure with established governance arrangements that provided safe and clinically effective care
- Staff interacted with patients respectfully which created a very pleasant environment

This is what we recommend the service could improve:

- Staff awareness and practice around patient confidentiality
- Mental Health Act administration processes need to be improved
- Recruitment of registered nurses to vacant posts

We identified regulatory breaches during this inspection regarding – During the inspection we found a section of patient notes containing personal information had been left in a communal area within the hospital. This is a regulatory breach.

The registered provider must ensure that all staff understand and follow the correct procedures for recording and storage of patients' clinical notes, in order to maintain patient confidentiality.

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

Coed Du hall is registered to provide an independent Mental Health rehabilitation service at Coed Du Hall, Mold.

The service has 22 bedrooms 4 of which are step down flats.

The setting is a mixed gender. At the time of inspection, there were 18 patients.

The service was first registered on 1 April 2002.

The service employs a staff team which includes an interim registered manager and an assistant manager, 5 registered mental health nurses and a registered learning disability nurse. In addition to this the service utilises 1 RNMH and 1 RNLD on a bank basis. There is also an occupational therapist with 3 OT technicians, 2 senior support workers with a team of 14 full time support workers and 9 bank support workers, 2 Chefs and a house keeper. The multi-disciplinary team includes a Consultant Psychiatrist, clinical psychologist, a psychology assistant, a counselling therapist and a learning disability specialist practitioner.

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 found that patients at Coed Du Hall were positive about the service and believed they were receiving good care

The service was in a rural location which lends itself to therapeutic rehabilitative environment.

We spoke with patients across all the wards at Coed Du Hall. On the whole patients made positive comments about the care they received and told us that they were treated with respect by staff.

Health promotion, protection and improvement

There was a range of health promotion, protection and improvement information and initiatives available to the patients at the hospital which assisted in maintaining and improving patients' wellbeing. This included information on healthy eating, smoking cessation and personal hygiene. This information was in various formats including easy read.

Staff completed health promotion checks on patient admission.

Dignity and respect

We observed that ward staff, senior management and auxiliary staff interacted and engaged with patients appropriately and treated patients with dignity and respect. Staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients.

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

During the inspection there was a serious incident that caused significant upset to both patients and staff, we saw staff deal with this incident in a professional manner. Every member of staff at the hospital that day made themselves

available to support the patients who were affected by this incident, long after its conclusion.

Patients had their own bedrooms that they could access throughout the day. The bedrooms provided patients with a good standard of privacy and dignity. Patients were able to lock their bedroom doors to prevent other patients entering; staff could override the locks if required.

We observed a number of bedrooms and it was evident that patients were able to personalise 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 or aerosols were stored securely within the hospital wards and patients would then request access to them when needed.

All bedrooms were en-suite and decorated to a high standard. The four step down flats also had a larger footprint with a kitchen area for the patient to prepare their own meals, promoting independent living. At the time of our visit none of the step down flats were being used in a structured way to facilitate rehabilitation.

There were numerous communal areas throughout the hospital. These could be accessed by all patients on the wards. These were all well maintained with comfortable seating providing pleasant environments for patients to socialise or take some time out if needed. There were also suitable rooms for patients to meet ward staff and other healthcare professionals in private.

The hospital is set within very spacious grounds surrounded by woodland and fields which adds to the pleasant calm environment.

Patient information and consent

There was a range of up-to-date information available within the hospital. Notice boards on the wards provided detailed and relevant information for patients.

The information on display included patient activities, statutory information, information on the Mental Health Act and advocacy provision and how to raise a complaint, including contact details for Healthcare Inspectorate Wales.

There was information about how patients could access local services such as the dentist. Also information from patient feedback outlining what issues had been raised and what the hospital and staff were doing about it.

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.

The Hospital had a daily planning meeting first thing every morning to arrange the activities, within the hospital and the community, alongside other activities and meetings, such as care planning meetings, tribunals and medical appointments. All incidents and concerns were also discussed and actions for the day agreed.

The hospital had a monthly patient forum where patients had the opportunity to provide feedback on the care that they receive at the hospital and discuss any developments or concerns. We were informed that this was a relatively new process and ways of attracting as many patients as possible to the event were being discussed.

The hospital held regular MDT meetings where patients or their elected representative meet with the clinical team to discuss their care and future care planning.

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

Care planning and provision

There was a clear focus on rehabilitation with individualised patient care that was supported by least restrictive practices, both in care planning and ward or hospital practices.

Each patient had their own individual weekly activity planner, this included individual and group sessions, based within the hospital and the community. These were discussed in the morning meeting to ensure all activities were carried out as planned. If not, the reasons were explored and new arrangements made.

The hospital had a wide range of well-maintained facilities to support the provision of therapies and activities. The occupational therapy team undertook assessments of patients' abilities and what therapies, support and activities would be beneficial to assist the patient's recovery.

There was a therapy kitchen with two areas for learning and practicing cooking skills. We saw evidence of patients offering to cook meals for staff as part of their daily activity routine.

Equality, diversity and human rights

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

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 procedures in place at Coed Du Hall. The policy provides a structure for dealing with all patients' complaints for services within the hospital.

Information was also available to inform relatives and carers, including on how to provide feedback, in the hospital foyer area.

Delivery of safe and effective care

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

We were satisfied that the service provided a very high standard of patient centred care. There was a clear focus on recovery and rehabilitation.

Managing risk and health and safety

The hospital provided individualised patient care that was supported by least restrictive practices, both in care planning and hospital or ward practices. There were personal emergency evacuation plans in place for each patient which were very thorough.

There were processes in place to manage and review risks and maintain health and safety at the hospital. A quarterly risk audit was carried out for the whole hospital, this included a ligature audit.

There was an assistance alarm system that covered the whole hospital. Screens at numerous locations directed staff to the location where the alarm had been activated. We saw evidence during the inspection that this system worked effectively.

Overall, the hospital was well maintained which upheld the safety of patients, staff and visitors. Staff were able to report environmental issues to the registered manager who maintained a log of issues and work required and completed. In addition, senior managers undertook regular audits of the hospital to review the environment.

The furniture, fixtures and fittings at the hospital were appropriate for the patient group. The nursing office window was partially covered with information posters. Whilst this was information displayed for the benefit of patients, it minimised the observation out of the nurse offices. That said we saw that the staff spent a large majority of their time out on the ward with patients.

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. Each incident is

reviewed by the registered manager at the morning meeting and discussed with the responsible clinician and other key team members.

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 the registered manager.

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. The incident reporting system and reporting schedules ensured that incidents were recorded, reviewed and monitored to assist in the provision of safe care at Coed Du Hall.

Examples of these reports were made available to inspectors and provided detailed and easy to understand breakdowns of the types of incidents recorded.

Improvement needed

The registered provider must ensure the windows of the nurse stations are clear of paperwork and posters to allow clear observation of patients.

Infection prevention and control (IPC) and decontamination

The registered provider employs dedicated housekeeping staff for Coed Du Hall. The communal bathrooms, showers and toilets were clean, tidy and clutter free. There was access to hand washing and drying facilities in all ward-kitchen and bathing areas.

Cleaning equipment was stored and organised appropriately in locked cupboards. Generally, throughout the inspection, we observed the hospital to be visibly clean and clutter free

Ward staff confirmed that they had appropriate stock of Personal Protective Equipment (PPE); these were stored in the domestic cupboards and clinical rooms.

There were hand hygiene gel dispensers at numerous points throughout the hospital and all the wards. However, all but one of these were empty. This was brought to the attention of the registered manager.

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.

Designated plastic bins were used for the safe storage and disposal of medical sharps, for example, hypodermic needles. These were stored safely.

Improvement needed

The registered provider must ensure that hand gel dispensers contain the appropriate hand sanitiser

Nutrition

Patients were supported to meet their eating and drinking needs.

We found that patients were provided with a choice of meals. We saw a varied menu and patients told us that they had a choice of what to eat. The menu was displayed clearly on all wards. Patients could also make specific requests with the kitchen to change meals. These requests were accommodated wherever possible. The kitchen employed two full time chefs and had won numerous awards for the quality and variety of the food made available for patients.

Drinks and fresh fruit were available throughout the day and patients had secure storage for their own snacks. Most patients told us that they enjoyed the food and felt that it was of very good quality.

As part of their individual recovery programmes, patients had access to a number of kitchens on the wards to make their own meals and snacks. The kitchen staff worked closely with the clinical team, and took part in the morning meeting. This allowed the clinical team to direct the kitchen towards certain types of food for particular patients as part of their recovery.

We checked a sample of food charts and weight charts for those patients requiring them, these were completed appropriately.

Medicines management

Overall medicines management at the hospital was safe and effective. The medication was stored securely within cupboards and medication fridges that were locked. Medication trolleys were not in use at the time of the inspection. There was evidence that there were regular temperature checks of the

medication fridge and clinic room temperature to ensure that medication was stored at the manufacturer's advised temperature.

We reviewed samples of Medication Administration Record (MAR) charts. All the MAR Charts reviewed contained the patient name and their mental health act legal status. MAR charts were consistently signed and dated when medication was prescribed and administered. When medication was refused by patient this was recorded appropriately.

There were no controlled drugs held at Coed Du Hall.

There was a monthly audit undertaken by the senior nurse to assist the management, prescribing and administration of medication at the hospital. Drugs liable to misuse were being recorded in a controlled drugs book which made it difficult to monitor stocks and use. During the inspection a discrepancy was found in the stock level held and what the records stated.

This was brought to the attention of the registered manager and the medication was found within the appropriate clinical area having fallen from the medication box.

Staff had access to all relevant medicine management policies at the hospital, these were displayed within the medication room. Staff also had access to the current British National Formulary (BNF)[1].

Improvement needed

The registered provider must introduce a more robust system of drugs management. A weekly audit is recommended with consideration to be given to a six monthly pharmacy led audit.

Safeguarding children and safeguarding vulnerable adults

[1] British National Formulary is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about individual medicines.

There were established processes in place to ensure that staff on both wards safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

The General Manager monitored the training completion rates with regards to safeguarding children and safeguarding vulnerable adults to ensure staff compliance with mandatory training.

We examined a number of safeguarding referrals. It is evident that the process was thorough and used correctly involving appropriate authorities where necessary.

Medical devices, equipment and diagnostic systems

There was a weekly audit of resuscitation equipment; staff had documented when these had occurred to ensure that all the necessary equipment was present.

During the inspection we witnessed the resuscitation equipment being utilised. The staff response to its use was very prompt demonstrating that staff knew, where everything was when required.

Safe and clinically effective care

We found that arrangements were in place to promote safe and effective care to patients. There was consistency in staff practice across the whole unit. There was an emphasis on least restrictive practice and patient recovery.

The daily meeting provided assurance that the care provided to patients evolved according to individual needs.

Records management

Patient records were held in a paper format. These were found to be of an excellent standard; very well indexed and clear to the reader.

We were told that there is a monthly audit of the patient care records by the registered manager to ensure quality. Areas on non-compliance are identified for individual staff members and addressed with an action plan.

During the inspection we found a section of patient notes containing personal information had been left in a communal area within the hospital. This is a regulatory breach.

Improvement needed

In order to maintain patient confidentiality the registered provider must ensure that all staff understand and follow the correct procedures for recording and storage of patients' clinical notes.

Mental Health Act Monitoring

We reviewed the statutory detention documents of six patients across three wards, which included Ash Beech and Cedar.

All patient detentions were found to be legal according to the legislation and well documented. There was one member of staff who carried out the Mental Health Act Administrators role alongside the duties of assistant registered manager. This member of staff has started at the unit very recently. All the required documentation was held on site and of a high standard. The documents were easy to navigate through the patient statutory folder. It was pleasing to hear of the high level of training the registered provider was investing in their Mental Health Act Administrator. Also the purchase of reference materials pertinent to this role.

Some areas of improvement required were identified which are listed below.

- Certificates under section 58 of the act that no longer authorise treatment need to be marked as cancelled.
- No record that the report of the SOAD visit had been communicated to the patient by the responsible clinician.
- No record of the statutory consultees discussion with the SOAD.
- No record that the patient has been informed of their rights about treatment for their mental health.
- Section 17 leave forms that have expired have not been marked cancelled in the statutory folder.
- No record that medical recommendations have been scrutinized for accuracy by someone with clinical expertise.
- No record that the patient received a copy of their detention papers or declined them from the Responsible Clinician.

- No record that the patient has received a copy of the statutory renewal report.

Improvement needed

The registered provider must ensure that measures are set in place so that practices within the hospital are compliant with Mental Health Act requirements, and there is documented evidence to support this.

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

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

There was evidence that care co-ordinators had been identified for the patients. The Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed.

Individual Care and Treatment Plans drew on the patient's strengths and focused on recovery, rehabilitation and independence. These were developed with members of the multi-disciplinary team and utilised evidence based practice. However, the Care and Treatment Plans did not evidence recording of good physical health monitoring and health promotion including recording of the Body Mass Index.

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.

Patients confirmed that they were encouraged to be involved in developing their care with a focus on discharge to a less restrictive environment. There was evidence of discharge planning where appropriate for patients on that pathway.

There was evidence within the care plans of unmet needs being identified and fully recorded.

We found that blood sugar levels were not recorded as being checked or refused by the patient. The provider must ensure both these matters are documented within the care plans of the individual patients

Improvement needed

The registered provider must ensure that where necessary blood sugar levels are checked and recorded. Also where the patient has refused the measurement to be taken.

The registered provider must ensure care and treatment plans contain evidence of good physical health monitoring and health promotion including recording of the Body Mass Index.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our inspection, staff confirmed that there were three patients subject to Deprivation of Liberty Safeguards (DoLS) authorisations. The interim Registered Manager confirmed that staff were up to date with Mental Capacity Act / Deprivation of Liberty Safeguards training.

Capacity assessments had been carried out and recorded appropriately in the care plan by the responsible clinician.

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 found evidence of a very good management structure with strong structured leadership and a positive relationship with staff and patients.

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 evolving 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. There have been recent changes in the senior management structure, the new appointees to these roles have a clear and structured overview of their roles within the organisation.

Through conversations with staff, observing multi-disciplinary team engagement and reviewing patient records there was evidence of strong multi-disciplinary team-working at Coed Du Hall. 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 is of concern that during the night time visit, the inspection team were able to access open areas of the hospital through an open door and remain unchallenged for over fifteen minutes. This was addressed with the registered manager.

It was positive that, throughout the inspection, the staff and particularly the registered manager at Coed Du Hall were receptive to our views, findings and recommendations.

Improvement needed

The registered provider must ensure that they give due consideration to the security of the building, service users and staff, especially during night time hours.

Dealing with concerns and managing incidents

We found there were established processes in place for dealing with concerns and managing incidents at the hospital.

It was evident that the registered manager monitored concerns and incidents locally at Coed Du Hall, these were discussed daily. There was a review system in place to provide additional oversight and understand lessons learnt from incidents.

Workforce planning, training and organisational development

We reviewed the staffing establishment at Coed Du Hall with that stated within their Statement of Purpose. The service was carrying 0.5 registered nurse vacancy that the registered provider was proactively attempting to recruit to.

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 and offered over-time. The registered provider also utilised agency registered nurses; reviewing staff rotas it was evident that generally the registered provider engaged agency nurses that worked at the hospital on a regular basis and who were familiar with working at the hospital and the patient group which assisted with the continuity of care for patients.

There was also a robust induction process in place where staff were not permitted onto the wards until this had been completed.

We reviewed the mandatory training statistics for staff at Coed Du Hall and found that completion rates were very high. The electronic system provided the registered manager with individual staff compliance details.

The registered provider has implemented processes for supervision so that staff record formal and informal supervision for inclusion on their annual performance development review (PDR). The full PDR process is still at the introductory stage but will be taken forward by the new registered manager

Improvement needed

The registered provider must continue the proactive recruitment campaign in order to fill the vacancies at the hospital in order to provide consistency in care for the service users.

Workforce recruitment and employment practices

Staff explained the recruitment processes that were in place at Coed Du Hall. 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 checks were undertaken and professional qualifications checked.

Staff were required to complete a structured induction programme prior to working at Coed Du Hall.

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.

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, measurable, 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			

Appendix B – Improvement plan

Service: Coed Du Hall Independent Hopstial

Ward/unit(s): Ash, Beech and Cedar

Date of inspection: 11, 12, 13 February 2019

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				
	3. Health promotion, protection and improvement			
	10. Dignity and respect			
	9. Patient information and consent			
	18. Communicating effectively			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	8. Care planning and provision			
	2. Equality, diversity and human rights			
	5. Citizen engagement and feedback			
Delivery of safe and effective care				
The registered provider must ensure the windows of the nurse stations are clear of paperwork and posters to allow clear observation of patients.	22. Managing risk and health and safety 12. Environment 4. Emergency Planning Arrangements	All documents obscuring the windows in the Nurses station 15/04/2019 have been removed and memo sent to staff reminding them of importance of observation via nurse station 2 Notice board have been purchased to house patient information and positioned close to Nurse Station	Neil Wattret Neil Wattret	Compliant as of 23/04/2019 Notice boards in place 23/04/2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that hand gel dispensers contain the appropriate hand sanitiser	13. Infection prevention and control (IPC) and decontamination	The service has introduced a daily clinical walkabout to be completed by Hospital Manager and/or Assistant Manager – Part of this walkabout requires the checking of environment including the availability of cleaning materials and PPE In addition, the service is actively recruiting a second housekeeper to assist in the delivery of safe and effective care in respect to infection control measures	Neil Wattret Sarah Muirhead – Assistant Manager Neil Wattret	On-going review Second housekeeper to be in place by end of may 2019
	14. Nutrition			
The registered provider must introduce a more robust system of drugs management. A weekly audit is recommended with consideration to be given to a six monthly pharmacy led audit.	15. Medicines management	A weekly medication audit has been introduced to be completed by the Senior Nurse and/or Hospital Manager this audit includes a reconciliation of all medications held In addition, the service has commissioned a Hospital Pharmacy	Neil Wattret – Hospital Manager and Alison McCallum – Senior Nurse	New medication audit to be reviewed as part of clinical governance

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Service to complete a 6 month audit with action plan		meeting 3rd mat 2019
	11. Safeguarding children and safeguarding vulnerable adults			
	17. Blood management			
	16. Medical devices, equipment and diagnostic systems			
	7. Safe and clinically effective care			
	6. Participating in quality improvement activities 21. Research, Development and Innovation			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	19. Information management and communications technology			
In order to maintain patient confidentiality the registered provider must ensure that all staff understand and follow the correct procedures for recording and storage of patients' clinical notes. The registered provider must ensure that measures are set in place so that practices within the hospital are compliant with Mental Health Act requirements, and there is documented evidence to support this . The registered provider must ensure that where necessary blood sugar levels are checked and	20. Records management	Staff have been instructed not to keep any clinical documentation on wards including diet and fluid charts. These are to be held in clinical files kept in the Nurse Station The Hospital has reviewed practices in regards to monitoring Mental Health Act documentation and has increased the frequency of audit to a monthly basis. Audits will be conducted by the Assistant manager. In addition, the Assistant manager will continue to be supported to receive training in this area This is being monitored via the weekly clinic audit. All staff are to receive medicines management training via	Neil Wattret and Alison McCallum Sarah Muirhead – Assistant Manager Alison McCallum –Senior Nurse	Compliant as of 23rd April 2019 To be compliant as of 3rd May 2019 To be compliant as

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
recorded. Also where the patient has refused the measurement to be taken.		Hospital Pharmacy Services on 13th May 2019 Staff have been reminded of need to record refusal within the medication file with reasons for refusal recorded. These charts are to be made available within MDT review		of 3rd may 2019
The registered provider must ensure care and treatment plans contain evidence of good physical health monitoring and health promotion including recording of the Body Mass Index.		All physical health documentation has been reviewed to ensure all physical health conditions are identified care planned and reviewed All care plans are reviewed and updated on a monthly basis for all patients All patients who require BMI monitoring is completed on a monthly basis by named nurse on the physical health monitoring form	Dr G Tanti Consultant Psychiatrist, Gordon Nelson – Therapist , Catherine White – Occupational Therapist	To be compliant as of 30th April 2019
Quality of management and leadership				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that they give due consideration to the security of the building, service users and staff, especially during night time hours.	1 Governance and accountability framework	Discussion has taken place with estates department as to best method of ensuring that front door is locked at all times and entry cannot be gained by visitors or other parties Night staff have also been instructed to carry out security check of all external doors to ensure that all doors are either locked or alarmed at commencement of shift and carried out throughout the night	Neil Wattret	30th April 2019
	23 Dealing with concerns and managing incidents			
The registered provider must continue the proactive recruitment campaign in order to fill the vacancies at the hospital in order to provide consistency in care for the service users.	25. Workforce planning, training and organisational development	Service continues to recruit staffing via various job vacancy websites. Staff vacancies are reviewed monthly as part of clinical governance arrangements as well as reviewing use of agency staffing	Neil Wattret	To be reviewed monthly as part of Clinical Governance arrangements

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	24. Workforce recruitment and employment practices			

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): Neil Wattret

Job role: Hospital Manager

Date: 23rd April 2019