Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Focussed Review: Staffing, Governance, Patient Incidents and Risk Management Arrangements (Unannounced)

Ty-Grosvenor Independent Hospital

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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 focussed inspection of Ty Grosvenor Independent Hospital on the 4, 5 and 6 October 2020. This service was previously inspected in July 2020 where we focussed predominantly on Brenig Ward. The purpose of this visit was to follow up on the actions the hospital had put in place following the July inspection and to ensure the improvements and learning had been transferred to Alwen Ward.

Ty Grosvenor – Elysium Healthcare Ltd

Ty Grosvenor is an Independent Hospital and is registered to provide rehabilitation treatment to either male or females in single gender wards to a maximum of 34 (thirty four) adults between 18 (eighteen) and 65 (sixty five) years of age who are diagnosed with a mental disorder and who may be liable to be detained under the Mental Health Act 1983.

How did we do this?

The team comprised of two members of HIW staff and a peer reviewer (who was the nominated Mental Health Act reviewer) who visited the hospital. This arrangement was due to the Coronavirus pandemic and the need to reduce the number of people attending the hospital to minimise any risk to patients and staff at Ty Grosvenor.

The review was carried out over a night/early morning and one other full day and one other half day and focussed specifically on:

- care plans and risk assessments
- patient observations
- staffing including; the use of agency
- safeguarding/Incidents/patient concerns
- governance and audit.

2. Summary of our inspection

Overall we remain not assured that the registered provider had adequate systems and processes in place to ensure patients were receiving effective and safe care.

Following up on actions from our previous visit, we noted Brenig ward had made some improvements in relation to patient care plans and risk assessments. However, the learning had not filtered to Alwen ward, where we identified similar failings as those we found in July.

Issues regarding care plans found in July 2020 were again identified on this inspection. Care plans for some patients with identified risks did not have sufficient detail in them to ensure these were being managed appropriately.

Some of the care plan audits reviewed were of a poor quality because they lacked detail. They did not have deadline dates documented and where actions/outcomes had been identified, there was no evidence they had been completed.

The documentation for actual staffing numbers had improved and it was evident that since our last visit, the vast majority of shifts had a night time coordinator and/or additional staff available.

Overall, our review of the statutory documentation of the Mental Health Act process verified that the patients were legally detained. However, actions and issues arising from this process do not form part of the hospital's governance framework.

Concerns about a lack of staff meetings, supervision and some lapsed staff appraisals were raised as areas requiring improvement.

Again, many of the issues raised in this report relate to the failure of an effective audit and governance framework. If the audit and governance process had been working effectively these issues should have been identified and acted upon.

Our inspection found that there were some areas of noteworthy practice, these are set out below:

- Following our previous inspection, the documentation for actual staffing numbers was readily available and on the majority of occasions a night time coordinator and/or additional staff were available
- Due to COVID-19, none of the Mental Health Act review tribunals and/or Mental Health Act mangers review panels were cancelled. Video calling was used to ensure these took place
- Advocacy services were very complimentary of the Mental Health Act Administrator (MHA) and her work in ensuring patients' rights were provided
- Following our previous inspection a physical health nurse lead has been appointed
- The patients we spoke with were positive about the staff, their care at the hospital and the environment
- There were a good range of therapies, recreational and social activities offered to the patients.

However, we identified the service was not compliant in a number of areas detailed below;

- A review of the care plan audits highlighted a lack of sufficient detail, some sections were incomplete, deadline dates and some identified actions had not been completed
- A review of care and treatment plans highlighted a number of concerns, some of which were identified in our last inspection. Specifically, some care plans lacked explicit detail concerning how identified risks need to be managed and wound care was poorly documented in terms of how staff should monitor wounds for improvement/deterioration
- There was a lack of evidence to confirm team meetings were taking place on a regular basis
- Staff supervisions were not routinely being conducted and documented and the system used to record these was not up to date
- There were a number of staff who had not had an annual appraisal

These are serious issues, some of which were identified in our previous inspection and resulted in the issuing of a non-compliance notice to the service.

At the time of publication of this report HIW has received sufficient assurance that appropriate action has or will be taken to address the improvements required.

The findings of this inspection remain very concerning for HIW and have resulted in the service still being a Service of Concern as described in our enforcement procedure. This means the hospital is under the highest level of scrutiny and HIW will be monitoring the service very closely to ensure that all required improvements are made and embedded within hospital practices to ensure sustainability. As a result of our findings we issued a notice of decision to impose a condition preventing new admissions at Ty Grosvenor. We remain in regular contact with the commissioners of patients at the hospital.

3. What we found

Quality of Patient Experience

We observed staff interacting and engaging with patients appropriately and treating patients with dignity and respect. The patients we spoke with commented positively on their relationships and interactions with staff.

Patients had a range of suitable activities and therapies available to them both within the hospital and the community.

We spoke with patients during the visit, to ensure that the patients' perspective is at the heart of our approach to inspection.

Health promotion, protection and improvement

Ty Grosvenor had a range of facilities to support the provision of therapies and activities. Patients were engaged and supported in undertaking Activities of Daily Living that promoted recovery and rehabilitation, such as preparing meals and other domestic activities. Patients also have access to the Real Work Opportunities[1] initiative led by the occupational therapy team.

Both wards had an occupational therapy kitchen which patients could use to prepare meals. In addition, both wards also had a laundry room with a washing machine and tumble drier. These facilities enable patients to learn and maintain skills in these areas during their time at the hospital.

Both wards had cardio-gym equipment that patients were able to use to take part in exercise within the hospital. Patients were being supported, where applicable, to take part in a range of therapeutic and leisure activities, with many patients using Section

[1] Real work opportunities are ward based roles such as ward librarian, administrative assistant, and assistant housekeeper.

17 Leave[2] from hospital to access the local community. These activities were facilitated in line with the COVID-19 local lockdown arrangements.

Both wards had a large communal area separated in to a lounge and dining area which provided space for patients to relax when not involved in activities. At the time of our visit each ward was waiting for additional chairs and tables for the dining areas.

There were garden areas for each ward which patients residing in the flats could also access.

Each ward had an occupational therapy room that provided a suitable place for staff-led activities and therapies. Patients also had access to a range of books, games and other activities on the wards, including a pool table. There was computer and internet access available on both wards; this was restricted and monitored for each patient based on individual risk assessments.

There was information displayed at the hospital for patients which included details on HIW and how to contact us, how to raise a complaint and external organisations including independent advocacy.

Dignity and respect

We observed staff interacting and engaging with patients appropriately and treating patients with dignity and respect. We heard staff speaking with patients in calm tones throughout our visit. We observed staff being respectful toward patients; when patients approached staff members, they were met with polite and responsive, caring attitudes. The patients we spoke with told us they were treated with dignity and respect at the hospital. In addition, the staff we spoke with were enthusiastic about their roles and ensured they supported and cared for the patients appropriately.

All patients had their own bedroom which they could access throughout the day. Patients were able to lock their own bedrooms which staff could over-ride if required. Patients told us that they were able to personalise their bedrooms and had sufficient storage for their personal possessions. The degree of personalisation was dependant on the behaviour and risk assessment of each patient.

[2] Section 17 of the Mental Health Act is the authorisation of a detained patient's leave from hospital.

The hospital had suitable rooms for patients to meet ward staff and other healthcare professionals in private. The hospital had a visitor room for patients to meet with their family and friends. A gazebo had also been set up within the hospital grounds during the pandemic to allow patients to meet with relatives.

Communicating effectively

Both wards had daily morning meetings to arrange the activities within the hospital and the community, alongside other activities and meetings, such as care planning meetings, medical appointments and tribunals.

Each ward had a weekly patient meeting which gave an opportunity for patients 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, their families and carers were also included in some meetings.

Delivery of Safe and Effective Care

Following up on our findings from July 2020, we found some aspects of the patient care documentation and risk assessments had improved. However, there were still areas that required improvement to ensure patients were receiving safe and effective care.

We identified a lack of detail in patient documentation for wound care and how identified risk items are to be managed when a patient requires them. The lack of completeness in these areas does not support the continuity, quality and safety of patient care.

We found the hospital environment was equipped with suitable furniture, fixtures and fittings for the patient group.

Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation. We have recommended that copies of the Code of Practice are available on each ward and that Mental Health Act audits form part of the hospital's clinical governance process.

Managing risks and promoting health and safety

Access to the hospital was direct from the hospital car park and street which provided suitable access for people who may have mobility difficulties. Visitors were required to enter the hospital via a reception area and intercom system. This helps to deter unauthorised persons from entering the building. Access through the hospital was restricted to maintain the safety of patients, staff and visitors.

Staff wore personal alarms which they could use to call for assistance when necessary. There were also nurse call points around the hospital and within patient bedrooms that were within reach of the beds, this ensures patients can summon assistance if required.

The hospital appeared well maintained and suitably furnished. The furniture, fixtures and fittings at the hospital were appropriate for the patient group. At the time of our inspection, additional tables and chairs were being acquired for both wards to replace items that had been previously damaged.

Staff told us the hospital had a dedicated maintenance staff member who was responsive to any issues or concerns staff raised regarding maintenance throughout the hospital.

Infection prevention and control (IPC) and decontamination

Throughout the inspection we observed the hospital to be visibly clean and free from clutter. As a result of the COVID-19 pandemic staff told us that cleaning schedules had increased to hourly. Staff had access to appropriate personal protective equipment (PPE) and cleaning equipment.

There were hand hygiene products available in relevant areas around the hospital. Rooms had been configured to enable safe numbers of people into the area and these numbers were displayed on the outside of the doors.

Safe and clinically effective care

Following our inspection in July 2020, we found some aspects of the patient care documentation and the addressing of patient risks had improved on Brenig ward. However, there were still areas that required improvement.

Of the care plan documentation we reviewed on Brenig ward, the following observations were made:

- Patient A was reviewed in July 2020 and we identified that the patient had injured themselves on occasions using various objects (iPad and glasses). There was no risk assessment/specific care plan in place to manage this known risk. In October 2020, we found that the care plan documentation for Patient A had been updated, however, there was still a lack of specific detail of how this known risk is to be managed.

- In July 2020 we identified that there was no wound care plan in place for Patient B. On 4 October 2020, Patient B had a wound on her arm which she inserted an object into. Steri strips were applied to the wound after the insertion, but there was no description of the wound in the clinical notes. There was also no description of the dressing applied as a result and it was not evident if the wound had been assessed by an appropriate person with specialist skills in wound care.

- Without a comprehensive care plan for Patient B, staff were not able to effectively monitor any progress or deterioration in the wound in a timely manner and there was no guidance for staff in terms of the dressings to be utilised.

In addition to reviewing patient care notes on Brenig ward, we also looked at care and risk documentation on Alwen ward.

We found that a patient required level 3 observations in terms of bathroom access because of their self-injurious/suicidal behaviour. When the patient is using the bathroom, all items need to be removed and staff must obtain verbal contact with the patient from outside the door.

Staff told us that they dispense shower gel etc. into small medicine pots for the patient to us. However, the care plan did not make this clear. The care plan also did not describe the risk regarding other personal hygiene items, such as a toothbrush and toothpaste. These areas require extra detail to adequately guide staff and support them to manage the associated risks when the patient is using the bathroom facilities.

The issues identified in this section present an increased risk of harm to patients. We could not be assured that care was being provided in a manner that ensures the welfare and safety of the patient. The absence of specific detail in the care plans and risk assessments outlined above meant that staff did not have a framework to guide them and enable them to deliver safe and effective care.

Improvement needed

The registered provider must ensure that there are comprehensive risk assessments and care plans in place that provide specific and sufficient detail that enable staff to clearly provide continuity in the delivery of safe and effective care.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients across Alwen and Brenig wards. We also reviewed the governance and audit processes for monitoring the use of the Mental Health Act (MHA) at the hospital.

The three sets of statutory documentation reviewed verified that the patients were legally detained. It was evident that detentions had been renewed within the requirements of the Act. The renewal of detention was correctly applied on statutory forms and copies of legal detention papers were available.

It was documented within patient records that they had been informed of their rights in line with Section 132[3] of the Act. Records evidenced that appeals against the detentions were held within the required timescales. At the time of the visit, Section 132 documentation was not kept on the MHA records. However, the Mental Health Act administrator addressed this at the time and agreed to integrate this practice as part of the MHA record keeping process in future.

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

All patient leave had been authorised by the responsible clinician on Section 17 Leave authorisation forms. Section 17 Leave clearly stated the conditions of leave, i.e. escorted or unescorted, location and duration. However, we identified that Section 17 leave forms were not held within the MHA records. Section 17 forms need to be held in the MHA records as well as in the patients' notes on the ward. The Mental Health Act administrator addressed this issue at the time of the inspection.

We recommended that copies of the Code of Practice are obtained and kept on each ward. At the time of our visit, one statutory consultee form was missing from the records being reviewed. The Mental Health Act Administrator confirmed she would find this. Therefore we require confirmation that the missing statutory consultee form has been obtained.

A MHA audit had been completed in February 2020 and a number of areas were identified within the document as requiring improvement. Many of the issues had been addressed, but some were still in progress/outstanding. Staff said as a result of COVID-19 and the need to work from home, finalising the actions had been disrupted. We recommended that actions arising from the audit are captured in an action plan that will easily track the progress of the actions and identify the person/s responsible. In addition, this information needs to form part of the hospital's clinical governance programme to ensure completion and accountability.

[3] Section 132 – Managers have a duty to provide information to detained patients in accordance with the Mental health Act 1983

Improvement needed

The registered provider must ensure copies of the Code of Practice are located on Alwen and Brenig wards

The registered provider must confirm that the missing statutory consultee form has been obtained for the records

The registered provider must ensure that actions arising from MHA audits are included in the clinical governance meetings to evidence progress and accountability of the actions identified

Quality of Management and Leadership

There had been some improvement following our last visit with regards to ensuring staffing numbers were sufficient on Brenig and Alwen wards.

A programme of mandatory training is in place for staff and they told us they had received a range of training.

There was a lack of team meetings taking place as well as staff supervision. Data provided showed some staff had not received an annual appraisal.

However, it was evident that issues identified in July 2020 regarding audit and governance had not been fully resolved. Some of the care plan audits reviewed highlighted poor and incomplete entries. As a result of these findings, we could not be assured that the registered provider's audit systems were effectively assessing and monitoring quality, nor that they were robust in their ability to identify, assess and manage risks relating to the health, welfare and safety of patients.

Governance and accountability framework

HIW were not assured that the governance framework had improved following our inspection in July 2020.

We reviewed a sample of patient care plan audits for both Brenig and Alwen wards. It was evident from the content that some of these were of a poor quality and standard. We did note that the ward manager on Brenig ward had recognised the lack of detail and had devised an action plan to improve these, which we noted as proactive.

On Alwen ward, not all care plan audits had been completed, with 10 out of 13 audits completed. We found that a care plan audit had not been undertaken for a patient, despite them being the most challenging patient on the ward.

In addition, four out of 10 audits had many areas/sections assessed as 'no', meaning that the standard was not met. The audit form required a rationale for this outcome.

Despite the need for this detail, the entries were poor and limited throughout the documents, with the action to address the failings missing.

Within this sample of audits we identified that neither a 'yes' nor 'no' outcome against the standard had been recorded. Therefore where the detail/rationale was limited, it was hard to understand what outcome or action was required as a result of the audit.

There was no deadline dates recorded in four out of 10 care plan audits. Therefore, where action/improvement had been identified there was no evidence that the appropriate action had been undertaken and/or when it should have been completed.

One care plan audit had been completed on 10 August 2020. There were actions identified in the audit that had still not been resolved when we reviewed the patient's care plan during this inspection.

As a result of these findings, we could not be assured that the registered provider's audit systems were effectively assessing and monitoring quality, nor that they were robust in their ability to identify, assess and manage risks relating to the health, welfare and safety of patients.

During the inspection we received no evidence of additional audits undertaken other than the care plan audits referred to above. Despite requesting this information, the registered manager was unable to provide documentation to demonstrate that a robust governance framework was in place for the hospital.

Improvement needed

The registered provider must review the completed audits of patient care plans for both wards to ensure they are completed fully and that actions and dates are clearly evidenced

The registered provider must ensure that care plan audits for all patients on both wards are completed.

The registered provider must review the governance arrangements across the hospital to ensure that they are effective at identifying issues of concern and tracking the completion of corrective action.

Workforce recruitment and employment practices

There was a clear organisational structure for the hospital, which provided clear lines of management and accountability. Our concerns in July regarding staffing numbers and the lack of a night time coordinator had significantly improved.

The documentation for actual staffing numbers was readily available and allowed HIW to fully review the information. It was evident that for the vast majority of shifts, additional staff and/or a night time coordinator was on duty. This was also the general consensus from the staff we spoke to, that staffing numbers had improved over the past few months.

Workforce planning, training and organisational development

The hospital had a programme of mandatory training in place. The staff we spoke to said they had received a range of training and during the visit we noted that training was taking place.

From discussions with staff it was evident that there had not been any staff meetings for a considerable period. There were no minutes of staff meetings for 2020. It is important that regular staff meetings take place and that these are documented to ensure all staff are aware of any actions/issues arising.

A review of staff supervision data showed that some had taken place in August 2020. However, staff supervision was not routinely being undertaken. In addition, the spreadsheet used to capture supervision dates was not up to date. A routine programme of documented staff supervision needs to be established and accurate records must be kept to clearly document the frequency of these sessions.

In addition, staff appraisals were not routinely being undertaken. This had not improved since our last visit and needs to be urgently addressed in line with the registered provider's policy.

Improvement needed

The registered provider must ensure that all staff receive appropriate supervision which is documented. The system used to record this information must be reviewed and updated to ensure accurate dates are recorded

The registered provider must review the appraisal process and ensure all out of date staff appraisals are conducted. An accurate record needs to be kept to enable staff to have an annual appraisal

The registered provider must ensure that regular staff team meetings take place. These must be documented to enable any employee who is unable to attend to stay informed of all actions/issues.

4. What next?

Following the visit HIW held a service of concern review meeting where it decided, due to the findings of the follow up visit, that a non-compliance notice should be issued and that Ty Grosvenor would remain a Service of Concern. In addition, due to the serious concerns identified within this report, a decision was made to issue a notice of decision to impose a condition preventing new admissions at Ty Grosvenor until HIW are satisfied that our concerns have been actioned.

The areas for improvement identified in this report and the non-compliance notice are presented in the improvement plan that can be found at Appendix A. This includes details of action being taken by the provider to address the issues raised. At the time of publishing this report HIW is sufficiently assured that that appropriate action is being taken but we will be monitoring the service closely to ensure improvements are embedded within hospital practices and are sustained permanently.

Appendix A – Improvement plan

Service: Ty Grosvenor Independent Hospital

Date of inspection: 4, 5 and 6 October 2020.

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
Patient Experience				
No issues identified at this inspection				
Delivery of safe and effective care				
The registered provider must ensure that there are comprehensive risk assessments and care plans in place that provide specific and sufficient detail that enable staff to clearly provide continuity in the delivery of safe and effective care.	Regulation 15 (1) (a), (b) and (c) & 19 (1) (a) and (b)	The registered provider will take immediate action to review the care plans and risk assessments of those patients on enhanced and supportive level 3 observations and implement any changes where required. The registered provider will ensure that all patient records will have risk assessments and care plans appropriate to their individual needs. In order to achieve this an appropriately experienced registered nurse will undertake an audit of all clinical records.	Claire Cawley	Completed 2nd November 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		The audit will include reference to specific risk assessments to ensure the appropriateness of that assessment on a case by case basis. The audit will identify any areas in need of improvement and action immediately taken to address these areas. Any care plans that do not clearly describe the actions needed to ensure the delivery of safe and effective care for these individuals will be amended accordingly. The registered provider will ensure that additional training on Care Planning will be delivered to all Registered Nurses at Ty Grosvenor. This training will be delivered in November by the Learning and Development team from Elysium. Subsequent training will be delivered to ensure all staff are updated and further refresher training will be delivered when required. The registered provider will take action to add additional scrutiny of the quality and appropriateness of care plans and risk assessments for specific patients. To deliver this a review of all the care plans	Claire Cawley Louise Burrows	26th November 2020 11th November 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		by the MDT will be undertaken for those patients on Enhanced Level 3 observations throughout the week.		
The registered provider must ensure copies of the Code of Practice are located on Alwen and Brenig wards	The Code of Practice for Wales, introduction & Chapter 1	To ensure both Alwen and Brenig wards have a copy of the Code of Practice on the wards and all staff have been made aware of this change	Christie McAteer	Completed 09/11/20
The registered provider must confirm that the missing statutory consultee form has been obtained for the records	The Code of Practice for Wales 25.26	The MHA Administrator to obtain the missing statutory consultee form and add to the records.	Angela Lalek	Completed 09/11/20
The registered provider must ensure that actions arising from MHA audits are included in the clinical governance meetings to evidence progress and accountability of the actions identified	Regulation 19 (1) (a) and (b)	The MHA administrator will attend the clinical governance meeting to present any audits, identifying any actions needing to be addressed. If unable to attend in person a report to be submitted for consideration.	Louise Burrows	To commence from November 2020 CG meeting
Quality of Management and Leadership				
The registered provider must review the completed audits of patient care plans for both wards to ensure they are completed fully and that actions and dates are clearly evidenced	Regulation 19 (1) (a) and (b)	All Care Plan audits created to date will be reviewed by the Quality Assurance Lead for Wales to ensure they meet this requirement.	Claire Cawley	Completed 2nd November 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Any actions identified to improve the effectiveness and robustness of the care plan will be implemented in conjunction with the nursing team. Identified actions within the care plan audit will be included within the care plans for each patient by the identified responsible person. The Quality Assurance Lead for Wales will then audit the completed care plans weekly to ensure the action has been completed.		
The registered provider must ensure that care plan audits for all patients on both wards are completed	Regulation 20 (1) (a)	The registered provider will monitor the care plan audits weekly to ensure completeness. In the event of any plans being incomplete the registered provider will ensure changes are made by the registered nurse as soon as practicably possible.	Claire Cawley	Weekly from October 26th 2020
The registered provider must review the governance arrangements across the hospital to ensure that they are effective at identifying issues of concern and tracking the completion of corrective action.	Regulation 20 (2) (a)	An audit of the local governance structures will be undertaken by the Elysium quality team. The outcome will be shared with HIW and the senior management team with an action plan devised based on the outcome. In addition to the corporate governance structures the registered provider will introduce a weekly	Gareth Taylor Gareth Taylor	November 30th 2020 Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		governance call with members of the local and regional senior team to monitor progress. As required additional actions will be put in place to address any areas requiring improvement. A local audit schedule will be developed to address these identified areas. The outcome of the audits will be reviewed in the weekly governance structure. As a minimum the key areas will initially include risk management plans, care plans and incidents.	Claire Cawley	November 30th 2020
The registered provider must ensure that all staff receive appropriate supervision which is documented. The system used to record this information must be reviewed and updated to ensure accurate dates are recorded	Regulation 20 (2) (a)	The registered provider will undertake a full review of the supervision system the result of which will ensure that all staff receive appropriate supervision. A system of recording will be put in place to ensure accurate records are maintained.	Louise Burrows	November 23rd 2020
The registered provider must review the appraisal process and ensure all out of date staff appraisals are conducted. An accurate record needs to be kept to enable staff to have an annual appraisal	Regulation 20 (2) (a)	The registered provider will review the appraisal process and complete any outstanding appraisals. A record will be maintained by the HR department and a system will be introduced to ensure appraisals are diarised. An annual audit of completed appraisals will be conducted by the HR department and presented to Clinical Governance.	Louise Burrows	November 30th 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that regular staff team meetings take place. These must be documented to enable any employee who is unable to attend to stay informed of all actions/issues.	Regulation 9 (1) (g)	Whole service staff meetings will be introduced on a fortnightly basis. Representatives from all areas of the hospital will be invited to attend and minutes of the meeting will be taken and shared across the hospital both electronically and in hard copy.	Louise Burrows	November 23rd 2020

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): Louise Burrows

Job role: Hospital Director

Date: 20/11/20