Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Priory Hospital Church Village

Parkcare Homes (No.2) Ltd

Inspection date:

15 – 17 November 2021

Publication date: 18 February 2022

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Digital ISBN 978-1-80391-710-8

Contents

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 Priory Church Village on the evening of 15 November 2021and following days of 16 and 17. The following sites and wards were visited during this inspection:

- Priory Hospital Church Village - Main building

Our team, for the inspection comprised of one HIW inspector, who led the inspection, one clinical peer reviewer and one Mental Health Act reviewer.

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

We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed that staff interacted with patients respectfully throughout the inspection.

There were establish governance and accountability processes in place. However, areas of improvement identified during the inspection highlighted that the capacity of the workforce at the hospital is stretched.

Staff we spoke with expressed their concerns around staffing and a fatigued workforce. The limited availability and inconsistency of ward staff has resulted in staff focusing on the day to day management of the care provision at the hospital.

There is currently a lack of clear long term rehabilitative focus at the hospital. The Priory Group needs to support the hospital in its future workforce planning arrangements to enable the service to provide holistic rehabilitative care to its patients.

This is what we found the service did well:

- Staff interacted and engaged with patients respectfully
- Medicines management was safe and effective
- Care and Treatment plans were completed in line with the Welsh Measure
- Monitoring the use of the Mental Health Act

This is what we recommend the service could improve:

- Arrangements around infection prevention and control
- Stabilising and strengthening the workforce at the hospital
- Focus on a more holistic approach to rehabilitative care

There were no areas of non-compliance identified at this inspection that required immediate corrective action.

3. What we found

Background of the service

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

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

The service employees a staff team including a Hospital Director, a Director of Clinical Services along with mental health and learning disability registered nursing staff and healthcare assistants. The multi-disciplinary team includes a psychiatrist, a psychologist and a psychology assistant, an occupational therapist and an occupational therapy assistant. The hospital employs a team of administrative, catering, domestic and maintenance staff.

The service was first registered on 13 May 2013.

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 staff interacting and engaging with patients appropriately, and we observed staff treating patients with dignity and respect.

The hospital offered a range of therapeutic and social activities within the hospital and the local community. However, we found that these have been impacted upon due to lack of staffing resources.

Health promotion, protection and improvement

As part of the rehabilitative approach to care the hospital focused on accessing services and facilities within the local community with the aim of improving patients' independence.

It was confirmed that patients were able to access GP, dental services and other physical healthcare professionals in the community. Each patient had an individualised 'Keeping Healthy' care plan and physical health monitoring was undertaken, however improvements with these were identified and are detailed later in the report.

There was a range of community based activities that patients could attend, either escorted by staff or unescorted depending upon individual patient's risks and capabilities. These included social and recreational activities as well as developing an individual's Activities of Daily Living (ADL)[1] skills.

[1] Activities of Daily Living are tasks of everyday life. These activities include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet. Instrumental

Each patient had a weekly planner of their own activities that linked with the hospital wide activity schedule. The individual planner was based on the patient's assessed needs and interests.

Staff spoke of options that they offer patients based on their preferences and care needs. We did observe that some patients had been out on leave from the hospital, which including shopping for personal items. Whilst there were facilities and opportunities to undertake structured activities within the hospital, during the inspection we did not observe these happening frequently.

We were informed that due to staffing pressures activities, particularly within the community, were occasionally postponed or cancelled; this impacts negatively upon patients care and rehabilitation.

Patients were able to access, and make their own, hot and cold drinks in the dining room. The hospital also had an ADL kitchen, however it was acknowledged that the ADL kitchen was not utilised by patients as much as it could be. Encouraging and enabling patients to regularly make their own meals would enable patients to practice daily skills within a rehabilitation environment in preparation for discharge to a less secure environment.

Patients had access to an enclosed garden area that they could access for fresh air. However, the space was rather bare and uninviting, the outdoor space could be used to enhance patients' physical and mental wellbeing. The registered provider must consider how the outdoor space could be developed to encourage patients to use this area.

Improvement needed

The registered provider must review the prevision of therapeutic and social activities that are on offer at the hospital, both within the hospital and in the community.

The registered provider must ensure that the staffing establishment enables therapeutic and social activities to be undertaken as part of the hospital's rehabilitative focus.

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activities of daily living are activities related to independent living and include preparing meals, managing money, shopping, doing housework, and using a telephone.

The registered provider must consider options to develop the outside areas of the hospital to benefit the wellbeing of patients.

Dignity and respect

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

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

Within the main building each patient had their own en-suite bedroom with toilet, sink and a shower. Patients were able to lock their bedroom doors to prevent other patients entering; staff could override the locks if required. There were two bedrooms within Garth View and the patients had access to one shared bathroom and toilet within this area. At the time of the inspection Garth View was not being used by patients.

We observed a number of bedrooms and it was evident that patients were able to have personal items within their rooms. Patients had storage for their possessions within their rooms. Any items that were considered a risk to patient safety, such as razors, aerosols, etc. were stored securely and accessed by staff.

However, some storage areas within patient bedrooms were difficult to reach, these included high shelving within wardrobes, and for some patients the low level storage areas were difficult to access.

We also noted that within some patient bedrooms that the mattress of the bed had been removed from the bed base and placed directly on the floor. Staff and patients informed us that some patients had done this to enable them to be able to see their bedroom TV whilst lying down because the location of the fixed bed base did not allow for ease of watching TV.

Through our discussions with staff and patients we were informed that for some of the patients the bed within their room was not large enough to enable them to be able to sleep comfortably. Patient records did not contain an assessment of the bed requirements based on the individual patient's health needs and/or physique. These must be completed as part of a full occupational therapy assessment prior to admission to the hospital to ensure that the patient has the

most appropriate bed (along with other furnishings and enabling equipment) ready for the patient's arrival to the hospital. Healthy sleep pattern is vital; issues effecting sleep will impact upon the patient's wellbeing and recovery.

A number of patients commented upon their mattress being uncomfortable to sleep on, stating it can feel sticky. When observed some of the bedrooms we noted that some mattresses did not have the cover correctly fitted. Staff should ensure that patients are supported, where required, as part of Activities of Daily Living to ensure that their beds are correctly made to help prevent disruptive sleep.

We also noted that some patient bedrooms had unpleasant odours which it was suspected came from personal hygiene and cleanliness of bedrooms and items within. Again, as part of Activities of Daily Living staff should support patients when necessary in maintaining and learning personal hygiene skills.

It is essential that each patient's ability to undertake various aspects of Activities of Daily Living are assessed, monitored regularly and supported where required.

Improvement needed

The registered provider must review the configuration of the bedrooms to ensure that they are practical for the patient group, including:

- Appropriately accessible storage space
- Appropriately positioned bed

The registered provider must ensure that patients are assessed to ensure they have an appropriately sized bed to enable healthy sleep pattern as part of their occupational therapy assessment prior to admission to the hospital. This must also be undertaken for the patients currently at the hospital.

The registered provider must ensure patients are supported in aspects of Activities of Daily Living as required.

Patient information and consent

There was some information on display which was available for patients that included activities, health promotion and safeguarding information. However, some of this information was out of date.

There was information displayed on how to raise a concern. There was also Priory Group information that informed patients of their rights in regards to the

Mental Health Act. However, as the service is a hospital and registered with HIW it incorrectly made reference to Care Inspectorate Wales (CIW).

Whilst independent advocacy information was displayed on the ward, it was obscured by the door frames of the secure display, therefore it was difficult to read.

There was some information displayed that would assist patients with a learning disability understand the information, however this could be available for more of the information that was displayed, including the hospital's weekly activity plan.

A programme of review should be in place to ensure that information is relevant, correct and up to date.

Improvement needed

The registered provider must ensure that information that is displayed throughout the hospital is relevant, correct and up to date.

The registered provider must ensure that information that is displayed is in an accessible format for the patient group.

Communicating effectively

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

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

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

Care planning and provision

We found that patient records evidenced individualised care; this was based on the individual's needs and risks. However we found that there were improvements required in these areas which are stated later in the report.

The situation of limited availability and inconsistency of ward staff over recent months has resulted in staff focusing on the day to day management of the care provision at the hospital. There is currently a lack of clear long term rehabilitative focus and a more holistic approach to care planning and provision is required.

Equality, diversity and human rights

Staff practice was aligned to established hospital policies and systems which supported patients' equality, diversity and rights to be maintained. Patients could also access the independent advocacy.

There was great improvement in the availability and organisation of the statutory the Mental Health Act (the Act) documentation at the hospital. Relevant documentation was available to staff and was stored securely.

During a meeting we attended we heard conversations between staff around a specific patient and their capacity to manage their own finances. A capacity assessment around the patient's ability to manage their finances had not been completed. Therefore there was no reason why the patient could not access their money and spend it as they wished, and therefore staff should not have questioned whether the patient should have their money.

Improvement needed

The registered provider must ensure that staff practice is in adherence to the Mental Capacity Act.

Citizen engagement and feedback

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

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

Delivery of safe and effective care

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

The hospital environment was equipped with suitable furniture, fixtures and fittings for the patient group; however there were significant areas of maintenance that required prioritising.

Improvements are required in the infection prevention and control arrangement at the hospital, with a particular focus on carpeted areas and soft furnishings.

Clear governance, operational and monitoring arrangements are required for the de-escalation room. The de-escalation room would also benefit from more therapeutic feel and being less clinical in appearance.

Patient's Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and outcomes being recorded.

Whilst care plan documentation was individualised and clearly written, improvements are required to ensure that physical health and nutritional needs are assessed, recorded and monitored.

There was significant improvements in the management and monitoring of the Mental Health Act at the hospital since our previous inspection.

Managing risk and health and safety

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

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

The furniture, fixtures and fittings at the hospital were appropriate for the patient group. However, there were outstanding maintenance requests that impacted upon the patient group. The quiet room which can be accessed by patients was locked off and out of use due to blood stained carpet, this needs to be addressed as a priority to enable this room to be used again.

It was also noted that one bedroom window was damaged on the outside and required the pane of glass to be replaced, this had been reported but not completed.

Access to the hospital building was either via steps from the car park or via a ramp which provided appropriate access for persons with mobility difficulties. The hospital entrance was secured to prevent unauthorised access. Non-patient areas within the hospital were secured to prevent patients gaining access to these. Whilst there were arrangements for staff to have keys, we were informed that on occasions there are insufficient keys for all the staff to have a set each. All staff must have access to the specific keys they require for their role. There is also a risk a staff member may need to immediately access an area, such as a locked patient bedroom, and any delay could cause harm to a patient. Staff had access to a number of ligature cutters in case of an emergency, these were stored securely.

The hospital had recently established de-escalation room which replaced one of the bedrooms in the main building. The registered provider had developed a local procedure for its use taking guidance from the Priory Group's policies for Short Term Specific Restrictive Interventions, and Seclusion. The local procedure states that the Priory Church Village does not use seclusion, and states the strategies that can be used within the service. The local procedure also states that staff must always accompany a patient within the room.

We observed the de-escalation room which had a door release to open from within; the room was secured from the outside to prevent patients accessing the room, either when unoccupied or whilst staff are supporting a patient within the area. The room was equipped with a range of furnishing that could assist with de-escalation and restraint if required.

The de-escalation room was only to be used to manage a patient incident, so all use of this room would be documented within the Priory incident reporting system. However, at the time of our inspection there was no easy way to identify, from the incident records, when the room had been used, for how long, with which patient and which staff. This needs to be developed so that there is a clear log of usage that can be used to review and monitoring whether the room is being used appropriately.

The de-escalation room itself had a clinical feel as the walls were a plain colour. Staff we spoke with had suggested some ideas on how they could make the de-escalation room feel more therapeutic but as yet a decision on this had not been reached.

The registered provider must ensure that there is clear governance and understanding by both staff and patients at the hospital regarding the purpose of the de-escalation room. This is vital for staff who are unfamiliar with the service and those patients who may not easily understand the purpose of the de-escalation room and may misinterpret its function, particularly if they've had previous experiences of similar arrangements in other services that used seclusion.

The register provider must also ensure that each patients' care record has an individualised plan on how this room is to be used if required for that patient. The individualised management plan must include the patient's views and wishes.

It is also noted that the review date on the local procedure stated the same as its issue date, this needs to be corrected to the correct timeframe.

Improvement needed

The registered provider must ensure that the quiet room is made fit for patients and accessible.

The registered provider must ensure that the damaged bedroom window is replaced.

The registered provider must ensure that all staff on shift have the appropriate set of keys required for their role.

The registered provider must ensure that there is clear governance and clarity of purpose for the de-escalation room.

The register provider must ensure that each patients' care record has an individualised plan on how the de-escalation room is to be used if required for that patient; this must include the patient's views and wishes.

Infection prevention and control (IPC) and decontamination

The registered provider employs dedicated housekeeping staff for the hospital. Cleaning equipment was stored and organised appropriately. There were hand hygiene products available in relevant areas of the hospital; these were accompanied by appropriate signage. Staff also had access to Personal

Protective Equipment (PPE) when required. Within the secured clinic room appropriate bins were available to dispose of medical sharp items, these were not over filled.

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

Whilst the hospital appeared mainly clutter free and on the whole clean, throughout the inspection there were areas of improvement identified. As stated earlier there was a carpet with blood stains within the quiet room, which had been closed off to prevent patients accessing this. However other areas of the hospital were carpeted and were observed to be unclean or stained, staff reported that they could not manage to effectively clean some of the marks. The registered provider must review the flooring throughout the hospital and ensure that it is suitable to meet the required IPC standards.

There was seating within the reception area of the hospital that was also stained, the registered provider must review this to ensure that this meets the required IPC standards.

We saw evidence to confirm that the hospital conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands of the COVID-19 pandemic. Staff we spoke to were aware of infection control obligations. The registered provider had COVID-19 documentation to support staff and ensure that staff remained compliant with policies and procedures.

There were areas of the hospital that lacked ventilation, including communal areas. It was noted that throughout the inspection the hospital was very warm and the air felt stale; this was of particularly apparent on the first night of the inspection. The control of airflow within buildings is important to manage airborne containments and associated infections.

On arrival at hospital visitors were required to show proof of recent negative Lateral Flow Test (LFT) or complete one on arrival. We identified a number of areas for infection control improvements with regards to undertaking LFT on arrival. A visitor could use the toilet within the reception area or within their vehicle if they wished. The LFT kit was available within the reception area, however the liquid agent used for the tests was not a single use sachets but a bottle for multiple tests. This means many people will handle this item and therefore a risk of cross contamination if a person subsequently tests positive for COVID-19.

Whilst there was hand gel available, this was in a bottle and flowed too freely as there was evidence of spillage on the table and surrounding floor area. On the first evening there was no PPE available for visitors attending, however masks and gloves were available on subsequent days.

There was a bin to dispose of used LFT items, however this required replacing as the pedal operation was not working and the lid hinge was broken and therefore the lid would not remain in place to keep the bin closed.

Staff undertake sepsis training and through our discussions with staff they evidenced knowledge in this area, including identifying signs of sepsis and an appropriate escalation process. There was no sepsis information displayed in the hospital, the registered provider should consider displaying this to remind and aid staff in the identifying and management of sepsis.

Improvement needed

The registered provider must ensure the flooring throughout the hospital meets the required IPC standards.

The registered provider must ensure the furniture within the reception area meets the required IPC standards.

The registered provider must review the current arrangements of onsite LFT for visitors to ensure that risks of cross contamination when undertaking LFT are minimised as far as practically possible.

Nutrition

The hospital had a four-week menu that altered seasonally. However, we were informed that this was not currently being followed. Whilst this was partly due to supply issues, the main reason stated was that the hospital had only one cook employed with the other cook post being vacant. In addition to this the hospital were unable to source regular agency cook to provide cover.

During the inspection we heard of the contingency plan that had recently been put in place with the use of current suitably qualified staff to help address the current deficit. However this is unlikely to be sustainable long term and a permanent resolution needs to be found.

Whilst there was evidence of a focus on providing healthy eating and balanced diet, on reviewing patient records and speaking to staff it we were not assured that nutrition, along with activities, was being considered in the wider care

provision at the hospital. It is important that these are included along with health promotion to develop and support holistic rehabilitative care at the hospital.

Improvement needed

The registered provider must ensure that arrangements are in place to provide an appropriate level of long term cook provision at the hospital.

The registered provider must ensure that individual patient nutritional needs are clearly incorporated in to care plans.

Medicines management

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

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

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

The clinic room itself was very small but well organised. However the door from the clinic room opened on to the main communal corridor of the patient area, therefore if a staff member and patient were discussing personal matters this could be overheard by other patients within the area impacting upon their privacy. The registered provider should consider the location of the clinic room or the location of the clinic room door to afford greater privacy to patients.

We reviewed a sample of Medication Administration Record (MAR charts). All the MAR Charts reviewed contained the patients name and their Mental Health Act legal status. Charts were consistently signed and dated when medication is prescribed and administered or the reason recorded when medication was not administered.

There was no pain tools to assess pain needs and management in use, these help patients identify how much pain they are experiencing and for staff to document this within patient records for monitoring and review.

We reviewed the use of PRN[2] medication, this was documented on the MAR Charts, however the reasons why PRN medication was administered was not always stated. The registered provider must ensure that there is a record of why PRN medication was administered within the patient record. There should also be a regular monitoring and review of PRN medication to identify if there are any trends in its use or changes required to regular medication.

Improvement needed

The registered provider must ensure that patients are afforded privacy whilst attending at the clinic door.

The registered provider must ensure that standardised pain tools to assess pain needs and management are used.

The registered provider must ensure that the reason(s) why PRN medication was administered is clearly documented.

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.

The staff training compliance rates suggested that staff were aware of the required processes. However, our discussions with staff highlighted that some were uncertain on how to refer to external organisations; they provided how they would ascertain this but they were not familiar with the organisations and/or processes that they could use.

Improvement needed

The registered provider must ensure staff are knowledgeable on how to refer safeguarding concerns to external organisations.

[2] Pro Re Nata (PRN) which is the administration of medication is not regularly scheduled, e.g. daily. Instead, the medication is taken as needed.

Safe and clinically effective care

Overall we found that there were governance arrangements in place that helped ensure that staff at the hospital provided safe and clinically effective care for patients.

However, we have identified areas of improvement in a number of areas throughout the report. It is clear that limited availability and inconsistency of ward staff has impacted upon these processes.

Records management

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

Mental Health Act Monitoring

We reviewed the statutory detention documents of two patients at the hospital and spoke with the mental health act administrator to discuss the monitoring and audit arrangements in place.

The organisation and availability of the statutory documentation and associated records was vastly improved since our previous inspection. This enabled us to gain assurance that detentions were compliant with the Act and overall followed the guidance of the Mental Health Act Code of Practice for Wales, 2016 (the Code).

It was evident that detentions had been applied and renewed within the requirements of the Act and copies of legal detention papers were available to ward staff at the hospital. There were clear records of patients being informed of their statutory rights regularly throughout their detention.

The renewal of detention was correctly applied on statutory forms and clearly documented within patient records. It was also evident that those patients'

detentions were reviewed by the Mental Health Review Tribunal and at Hospital Manager Hearings [3], when applicable or required.

Medication was provided to patients in line with Section 58 of the Act, Consent to Treatment. Consent to treatment certificates were kept with the corresponding electronic medication record. 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 leave had been authorised by the responsible clinician on Section 17 Leave authorisation forms, these were up-to-date and well recorded. Whilst there was record of the patient's involvement in decision around their leave, there was no record to state whether the patient had received a copy of their leave form.

Improvement needed

The registered provider must ensure that there is a record of whether the patient had received a copy of their leave form.

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

We reviewed the care plans of one patient in detail and specific areas of a number of other patients at the hospital.

We found that patients' Care and Treatment Plans (CTP) reflected the domains of the Welsh Measure with measurable objectives and outcomes being recorded. CTPs also included the views of the patient.

It was noted that for one patient the CTP did not reflect their current care plans and circumstances around the patient, therefore the CTP had become outdated and was only being updated annually. There was also no record that updating

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

the CTP was considered on reflection of the patient's progress and significant changes whilst at the hospital since the previous review and update of the CTP.

Whilst the patient risks had been identified and rated low, medium or high, there was no record of how the risk rating had been calculated. Therefore it was not evident that the risks were based on standardised clinical risk analysis.

There were 'Keeping Healthy' care plans in place for patients. However the patient's record we reviewed had minimal planning around weight management, exercise and nutrition. The patient's Malnutrition Universal Screening Tool (MUST)[4] score had only been completed five times since over two years.

Within one set of patient records reviewed it was identified that the patient had a diagnosis of epilepsy and receives medication for this, however there was no care plan in place to manage and monitor the patient's epilepsy diagnosis.

All patients had detailed Positive Behavioural Support (PBS) plans in place which directed staff how best to support each individual patient.

Improvement needed

The registered provider must ensure that patients' Care and Treatment Plans correctly reflect the individual patient's current situation.

The registered provider must ensure that physical health needs are identified, care planned and monitored as required.

[4] MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. NHS Wales: Malnutrition Universal Screening Tool

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 observed a committed staff team who had a good understanding of the needs of the patients at the hospital.

There were establish governance and accountability processes in place. However, areas of improvement identified during the inspection highlights the capacity of the workforce at the hospital is stretched.

This was demonstrated in the difficulty the hospital faces with fulfilling its required staffing rota with regular staff. Staff we spoke with expressed their concerns around staffing and how that impacted upon the provision of rehabilitative care.

The Priory Group needs to support the hospital in its future workforce planning arrangements to enable the service to provide holistic rehabilitative care to its 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 established governance structure which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

However, we have identified areas of improvement in a number of areas throughout the report. It is clear that limited availability and inconsistency of ward staff has impacted upon these processes. This reaffirms why it is essential that the development of the de-esculation room must have clear and strong governance arrangements to ensure its safe and transparent use.

It was clear from our discussions with the hospital director and reviewing documentation and processes that they have clear responsibilities and focus for the hospital's operation. Their commitment to these responsibilities was clearly displayed and it was evident that these required all of their capacity at the hospital.

During our discussions with staff we were informed that there are periods over the last year when there was is a lack of ward visibility of senior hospital staff. The interim Director of Clinical Services had commenced their role during November 2021 and, as stated, the hospital director had clear priorities focussing on overall hospital operation and Priory Group organisation corporate and governance activities. The registered provider needs to consider how the links between senior managers and ward staff at the hospital can be strengthened.

It was positive to note that links have been developed and strengthened between the two other local Priory Group Hospitals; Ty Catrin and Ty Cwm Rhondda. This includes providing joint Senior Management On Call and Meidcal On Call rotas across the three hospitals.

It was also positive that, throughout the inspection, the all staff at the hospital were receptive to our views, findings and recommendations.

Improvement needed

The registered provider needs to consider how the links between senior managers and ward staff at the hospital can be strengthened.

Dealing with concerns and managing incidents

As stated earlier in the report, there were established processes in place for dealing with concerns at the hospital. There was also a process for capturing compliments to enable these to also be shared and learnt from.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system that included the name of patient(s) and staff involved, a description, location, time and length of the incident. Any use of restraint was documented.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed.

Workforce planning, training and organisational development

We spoke with and observed a committed team of staff at the hospital, which included the multidisciplinary team members, registered nurses, healthcare assistants, administrative and axillary staff.

The service employees a staff team including a Hospital Director, a Director of Clinical Services along with nursing and healthcare assistants. The multi-disciplinary team includes a psychiatrist, a psychologist and a psychology assistant, an occupational therapist and an occupational therapy assistant.

A number of posts within the multi-disciplinary team had been recently recruited to, the Director of Clinical Services had recently commenced their role as an interim appointment whilst the post is recruited to substantively. Whilst the psychologist was not permanent they were working at the hospital on a long term sessional basis two days a week. It was noted that the multi-disciplinary team spoke openly and respectfully of each other and were in the process of developing in to a cohesive team.

We reviewed staff rotas to consider how the service provided a team of staff to provide rehabilitation care and support the patients at the hospital as a locked rehab service.

The registered provider's statement of purpose states that two registered nurse would be rostered during the day shift, if this is not possible then healthcare assistant will be rostered to provide additional cover on the ward. The Director of Clinical Services will be available as a second qualified nurse for advice and support. The statement of purpose specified that during the night shift that there would be one registered nurse; however it was positive to hear that the registered provider aimed to roster two registered nurses to provide additional expertise and cover for breaks during the night shift.

On reviewing the staff rotas for the last 12 weeks it was evident that the registered provider was not able to provide two registered nurses per shift on a frequent basis. This had also occurred during some of the day shifts during the weekend when the Director of Clinical Services would not typically be available at the hospital to fill in as a second qualified nurse for advice and support. Therefore we are not assured that the registered provider is ensuring the skill mix at the hospital is at the required level to meet the clinical needs of the patient group at all times.

On commencing their role during November 2021 the interim Director of Clinical Services took responsibility to compile the full ward rota for the hospital. Prior to

this there was a disjointed approach to setting the ward rotas, with the registered nurse rota and healthcare assistant rotas being devised by separate personnel within the hospital. We were informed that this had in some part caused the uncertainty with staff of knowing who the staff team on shift would be and how many agency staff, particularly unfamiliar agency staff, would be working.

To cover any shortfalls in fulfilling the staffing rota that may occur due to vacancies or sickness, the registered provider utilised their own staff or agency staff. It was evident that where possible the use of agency staff was of regular individuals who were familiar with working at the hospital and the patient group however this was not always the case.

Staff we spoke with raised their concerns about the requirement to use agency staff, and stated that they often felt concerned for the safety of the patients and themselves. We heard from staff that they have had to raise concerns about individual agency staff numbers. The uncertainty of the quality or competence of agency staff was demonstrated on the first evening of our inspection where we observed one member of agency staff neglecting their duties whilst on shift and had to be removed from their shift. The registered provider notified the agency provider of the concerns raised.

The Registered Manager described the hospital's future workforce planning arrangements to fill any vacant positions, and in addition, the consideration being given to the ward staff establishment with the provision of senior roles for both registered nurses and healthcare assistants that would be aimed at experienced staff in those professions. The intention of this would be to increase the skill mix and experience of the ward staff at the hospital and provide progression opportunities within the hospital; historically a number of experienced staff have departed to accept more senior roles in other settings due to the lack of progression opportunities available at Priory Church Village.

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

During our conversations with staff, whilst evidencing commitment to the patients and their colleagues they often raised concerns with us regarding staff fatigue.

The hospital employs a team of administrative, catering, domestic and maintenance staff. As stated earlier at the time of the inspection there was a cook vacancy that requires to be appointed to.

Improvement needed

The registered provider must keep HIW informed of the hospital's workforce planning arrangements to ensure consistent staff team to provide support and rehabilitative care for patients.

The registered provider must ensure arrangements are in place to monitor and prevent staff fatigue.

Workforce recruitment and employment practices

The Priory Group's central recruitment processes were in place at the hospital. Prior to employment staff references were received, Disclosure and Baring Service (DBS) checks were undertaken and professional qualifications checked.

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	Not applicable	Not applicable	Not applicable

Appendix B – Improvement plan

Service: Priory Church Village

Date of inspection: 15 – 17 November 2021

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 review the prevision of therapeutic and social activities that are on offer at the hospital, both within the hospital and in the community.	3. Health promotion, protection and improvement	A full review of activity provision at the hospital will be completed, to include an additional focus on increasing time patients spend preparing their own meals	Emily James, Occupational Therapist	28/02/2022
The registered provider must ensure that the staffing establishment enables therapeutic and social activities to be undertaken as part of the hospital's rehabilitative focus.	3. Health promotion, protection and improvement	When at full staffing complement, the site has the correct number of staff in the nursing and OT department to allow for suitable activities on site and in the community. A number of vacant positions is currently impacting on the ability to undertake the full programme at all times. However, the service is in the process of recruiting into vacant roles, which will	Diana Tyrrell, Hospital Director	31/03/2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		ensure a full range of activities can resume uninterrupted. A number of staff have accepted positions, and are currently going through pre-employment checks and processes before being compliant to start.		
The registered provider must consider options to develop the outside areas of the hospital to benefit the wellbeing of patients.	3. Health promotion, protection and improvement	This will be discussed with patients and staff during patients and staff feedback forums, in order to get their views and ideas. Future plans will then be discussed with the relevant departments within the organisation and necessary requests made.	Diana Tyrrell, Hospital Director	31/05/2022
The registered provider must review the configuration of the bedrooms to ensure that they are practical for the patient group, including: • Appropriately accessible storage space • Appropriately positioned bed	10. Dignity and respect	A meeting was held with Priory Estates on 15/12/2021 to discuss. A contactor visit has been requested to provide quotes to move fixed TV cabinets so all patients are able to see the TV from their beds. Currently all patients do have a chair in their bedrooms, so are able to sit in from of the TV should they wish to	Diana Tyrrell, Hospital Director	30/06/2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		watch it. The issue with locked storage being too high will also be discussed. Once a quote has been received, a request for the works to be completed will be made via Priory Estates.		
The registered provider must ensure that patients are assessed to ensure they have an appropriately sized bed to enable healthy sleep pattern as part of their occupational therapy assessment prior to admission to the hospital. This must also be undertaken for the patients currently at the hospital.	10. Dignity and respect	The Occupational Therapist will be involved in future pre admission assessment for any patients with bariatric needs. A meeting was held with Priory Estates on 15/12/2021 to discuss. A contactor visit has been requested to provide quotes to replace all beds with ¾ beds. Once a quote has been received, a request for the works to be completed will be made via Priory Estates.	Emily James. Occupational Therapist Diana Tyrrell, Hospital Director	31/12/2021 30/06/2022
The registered provider must ensure patients are supported in aspects of Activities of Daily Living as required.	10. Dignity and respect	All patients are offered support with Activities of Daily living as required, but may refuse staff intervention. The team will work closely with external care teams to provide a full MDT	Luke Humphreys, Interim Director of Clinical Services	28/02/2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		approach when patients refuse interventions. Specific care plans around ADL refusal will be developed for relevant patients		
The registered provider must ensure that information that is displayed throughout the hospital is relevant, correct and up to date.	9. Patient information and consent	A full review of all notice boards an displayed information to be undertaken, and outdated information replaced	Diana Tyrrell, Hospital Director	31/01/2022
The registered provider must ensure that information that is displayed is in an accessible format for the patient group.	9. Patient information and consent	A full review of all notice boards and displayed information to be undertaken, to ensure all available information is in an easy read format.	Diana Tyrrell, Hospital Director	31/01/2022
Delivery of safe and effective care				
The registered provider must ensure that the quiet room is made fit for patients and accessible.	22. Managing risk and health and safety 12. Environment	A the time of the inspection, a request had been made for replacement floor covering and the area locked off due to being unsuitable for patient use. The floor covering is due to be replaced on 6th & 7th January 2022	Diana Tyrrell, Hospital Director	31/01/2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that the damaged bedroom window is replaced.	22. Managing risk and health and safety 12. Environment	The damaged pane has now been replaced.	Diana Tyrrell, Hospital Director	Completed 16/12/2021
The registered provider must ensure that all staff on shift have the appropriate set of keys required for their role.	22. Managing risk and health and safety 12. Environment	There are currently sufficient keys for all staff, with additional bedroom keys available. A full review of key management processes is in the process of being carried out. Site are considering a new key tracker system to better manage keys are site.	Diana Tyrrell, Hospital Director	30/04/2022
The registered provider must ensure that there is clear governance and clarity of purpose for the de-escalation room.	22. Managing risk and health and safety 12. Environment	The service currently has a local procedure in place, and the correct use of the descalation room has been communicated to all regular and block booked agency staff. The service also completed a staff questionnaire to ensure staff understand its use, shortly after its introduction.		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		A spreadsheet will be introduced in order to monitor if the room is being used correctly. This will be discussed at every Clinical Governance meeting from January 2022 Induction booklet for agency staff will be updated to include information on correct use of descalation room.	Diana Tyrrell, Hospital Director Diana Tyrrell, Hospital Director	31/01/2022 31/01/2022
The register provider must ensure that each patients' care record has an individualised plan on how the de-escalation room is to be used if required for that patient; this must include the patient's views and wishes.	22. Managing risk and health and safety 12. Environment	All care plans to be reviewed to include this information, which will be reviewed at each Multidisciplinary Meeting as part of regular care plan reviews.	Luke Humphreys, Interim Director of Clinical Services	15/02/2022
The registered provider must ensure the flooring throughout the hospital meets the required IPC standards.	13. Infection prevention and control (IPC) and decontamination	Flooring in the Lounge and Clinic Room will be replaced with vinyl flooring on 6th & 7th January 2022. A CAPEX request has been made to purchase an industrial steam cleaner for the carpet on the ward corridors, to enable effective cleaning.	Diana Tyrrell. Hospital Director	31/03/2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure the furniture within the reception area meets the required IPC standards.	13. Infection prevention and control (IPC) and decontamination	Priory Interior Team has been contacted on 23/12/2022 to request a replacement sofa for reception area.	Diana Tyrrell, Hospital Director	31/03/2022
The registered provider must review the current arrangements of onsite LFT for visitors to ensure that risks of cross contamination when undertaking LFT are minimised as far as practically possible.	13. Infection prevention and control (IPC) and decontamination	LFT's are currently provided to the site by the DHSC online ordering service (Salesforce). Contact was made on 25/11/2021 requesting individual single use sachets of test solution. A response was received from a Policy & Delivery Advisor in Welsh Government advising we should not be using the tests for visitors. This has been queried, and a response chased 23/12/2021 In the meantime, disposable gloves, hand sanitiser and disinfectant wipes are in place on reception, so bottles can be wiped between use. The broken bin in reception has been replaced.	Diana Tyrrell. Hospital Director	28/02/2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that arrangements are in place to provide an appropriate level of long term cook provision at the hospital.	14. Nutrition	Agency provision for the weekend has now been sourced. Recruitment of a permanent chef remains a focus for the site, which is being supported by regular recruitment calls with Priory resourcing colleagues.	Diana Tyrrell, Hospital Director	31/03/2022
The registered provider must ensure that individual patient nutritional needs are clearly incorporated in to care plans.	14. Nutrition	Full review of care plans to take place, and will incorporate nutritional needs	Luke Humphreys, Interim Director of Clinical Services	15/02/2022
The registered provider must ensure that patients are afforded privacy whilst attending at the clinic door.	15. Medicines management	A meeting was held with Priory Estates on 15/12/2021 to discuss. A potential solution has been found, and a contractor requested to attend the service to provide quotes. Once received the work will be requested via Priory Estates, and if approved a request will be made to complete the works within the given timeframe.	Diana Tyrrell, Hospital Director	31/12/2022
The registered provider must ensure that standardised pain tools to assess pain needs and management are used.	15. Medicines management	The site will investigate available options and introduce the scale most appropriate for the service. The service is currently	Luke Humphreys, Interim Director of Clinical Services.	31/01/2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		considering introduction of the Abbey Pain Scale		
The registered provider must ensure that the reason(s) why PRN medication was administered is clearly documented.	15. Medicines management	Nursing staff will be reminded of their responsibilities in regards to this during clinical supervision, and monitoring via documentation quality walk rounds The service will introduce Priory Healthcare As Required (PRN) Medication Protocol for all patients. This form is used to monitor PRN use and is reviewed monthly	Luke Humphreys, Interim Director of Clinical Services. Luke Humphreys, Interim Director of Clinical Services.	31/01/2022 31/01/2022
The registered provider must ensure staff are knowledgeable on how to refer safeguarding concerns to external organisations.	11. Safeguarding children and safeguarding vulnerable adults	The service has a local safeguarding procedure outlining how to report safeguarding concerns, which is displayed in the nurse's office. All staff also have access to the Priory Intranet, which contains a separate Safeguarding Hub or information and resources. The local safeguarding procedure to be recirculated to all staff, and asked to sign in acknowledgement of understanding.	Luke Humphreys, Interim Director of Clinical Services	15/01/2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Additional training will be offered to any staff as required.		
The registered provider must ensure that there is a record whether the patient had received a copy of their leave form.	Mental Health Act 20. Records management	This will be included in Multidisciplinary Meeting minutes for all patients going forward.	Dr Zahir Ahmed	15/01/2022
The registered provider must ensure that patients' Care and Treatment Plans correctly reflect the individual patient's current situation.	Mental Health (Wales) Measure 20. Records management	All plans will be reviewed for accuracy and amended as required	Luke Humphreys, Interim Director of Clinical Services	28/02/2022
The registered provider must ensure that physical health needs are identified, care planned and monitored as required.	Mental Health (Wales) Measure 20. Records management	Full review of care plans to take place, and will incorporate physical health needs	Luke Humphreys, Interim Director of Clinical Services	15/02/2022
Quality of management and leadership				
The registered provider needs to consider how the links between senior managers and ward staff at the hospital can be strengthened.	1 Governance and accountability framework	A Business Case has been submitted, which includes the provision for progression routes. This would enable the employment of Charges Nurses,	Diana Tyrrell, Hospital Director	30/04/2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		which would provide a link between senior management and ward staff.		
The registered provider must keep HIW informed of the hospital's workforce planning arrangements to ensure consistent staff team to provide support and rehabilitative care for patients.	25. Workforce planning, training and organisational development	A copy of the hospitals workforce plan will be submitted to HIW on a monthly basis from January 2022, until no longer required to do so by HIW	Diana Tyrrell, Hospital Director	31/01/2022
The registered provider must ensure arrangements are in place to monitor and prevent staff fatigue.	25. Workforce planning, training and organisational development	This will be discussed with individual staff during management supervision. Nursing rota standards are in place, which limits the number of shifts a staff member should do in a row. Rotas will be reviewed and devised in line with these standards. The service has managed to recruit a number of new staff into vacant posts, which should have a positive impact on staff fatigue and well being. The site has a programme of wellbeing initiatives, which will be renewed for 2022.	Luke Humphreys, Interim Director of Clinical Services Diana Tyrrell, Hospital Director	28/02/2022 31/01/2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Staff will be reminded of well-being support on offer, including Employee Helpline, and Wellbeing Apps		

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

Service representative

Name (print): Diana Tyrrell

Job role: Hospital Director

Date: 23/12/2021