Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

St David's 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 St David's Independent Hospital on 15, 16 and 17 December 2017. This is our second inspection of the service this year and was prompted by staff working at the hospital raising significant concerns with HIW.

Mental Health Care (St David's) UK – St David's Independent Hospital

St David's Independent Hospital is an Independent Hospital and is registered to provide rehabilitation treatment to male adults over the age of 18 (eighteen) years with a borderline to moderate learning disability, whether or not they are detained under the Mental Health Act 1983 (The Act).

The hospital is registered to accommodate 15 patients overnight at any one time.

How did we do this?

The team comprised of one member of HIW staff who was accompanied by a peer reviewer.

The review was carried out over a night/early morning and two days and focussed specifically on:

- Care plans and risk assessments
- Staffing including; the use of agency
- Induction and training
- Patient observations
- Safeguarding
- Governance and audit
- Moral amongst the staff
- Culture

2. Summary of our inspection

Overall we were not assured that the registered provider had adequate systems and processes in place to ensure patients were receiving effective care. Of particular concern was the finding that observations were not being undertaken effectively for patients who were on enhanced observational levels. In addition we found that for one patient there was no risk assessments or a plan of care in place, this it not acceptable.

We also identified a lack of documented induction for the significant number of agency staff being utilised at the hospital which meant we could not be assured that they had the necessary qualifications skills and experience to work with the patient group.

In addition, HIW had not been informed in relation to a number of incidents that were reportable under Regulation 31 of the Independent Health Care (Wales) Regulations 2011 and some of these were significant events.

Many of the issues raised in this report relate to a failure of governance. If the governance process had been working effectively these issues should have been identified and acted upon before the inspection had taken place.

One of the most concerning issues identified at the visit was the culture of negativity and the approach and attitude by some staff.

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

- Some good examples of patient information in a clear and appropriate format
- Comprehensive records for the administration of the Mental Health Act
- There were some examples of staff dedication to the patients

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

- The service is not compliant with Regulation 15 (1) (a) (b) and (c) regarding the quality of treatment and other services
- The service is not compliant with Regulation 20 (1) (a) and (b) regarding ensuring at all times suitably qualified, skilled and experienced person are working at the establishment including those employed on a temporary basis

- The service is not compliant with Regulation 15 (1) (a) and (b) regarding ensuring that patients are appropriately observed and this is recorded in line with their risk assessments and plans of care.

These are serious issues and resulted in the issuing of a non-compliance notice to the service in relation to the above.

In addition this report identifies further non-compliance issues as detailed below;

- The service is not complaint with Regulation 31 regarding notification of events

- The service is non-compliant with Regulation 19 (1) (b) regarding effective governance processes in place to manage risks relating to the health, welfare and safety of patients.

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 are very concerning and have resulted in the service being designated 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 the required improvements are made. We are also in regular contact with the commissioners of patients at the hospital.

3. What we found

Quality of Patient Experience

We observed a range of interactions that varied considerably, some not very appropriate in content.

Patients had activity plans and attended Coed Bach within the grounds of St David's which provided a range of activities and therapies.

Patients had access to a range of information in a clear and appropriate format.

We spoke with a number of patients to ensure that the patients' perspective is at the heart of our approach to inspection. In addition, we spoke to a range of staff from different disciplines including senior members of the organisation.

Dignity and respect

During the inspection staff interaction with patients varied considerably in terms of its appropriateness. Whilst the Inspectors did not hear any derogatory or abusive interaction there were some interactions that could have been more patient focused such as staff stating *"I am on"* in relation to patient observations. In addition, when a member of staff was orientating a new member of staff they stated that the men in St David's would be in prison if *"there were no Mental Health Act",* this is clearly not appropriate

Each patient had their own bedroom and the degree of personalisation varied depending on the behaviour and risk assessment of the individual patient

Improvement needed

The registered provider must ensure that staff communicate with patients and with each other in a caring and professional manner.

Delivery of Safe and Effective Care

There were some systems in place and a range of policies and procedures to underpin them. However it was evident that these systems had failed in relation to effective and consistent patient observations for a significant number of patients. In addition, there was a complete lack of any documented risk assessments and care plans for a recently admitted patient which the service had failed to identify for themselves.

Due the lack of any documentation for agency staff we could not be assured that they were suitable skilled, knowledgeable or experience to care for the patient group.

Overall this meant that we could not be assured that the registered provider was able to provide patients with safe and effective care.

Managing risks and promoting health and safety

Access to the hospital was via a locked door and a bell was provided to enter the premises.

The Inspector chose five random names of agency staff, who had recently worked at the hospital, and requested that the interim manager provide copies of the completed induction documentation in order to check that they had the appropriate knowledge, skills and experience. Some very limited information about skills and competence was produced for three of the agency staff but this was very basic and not satisfactory. For the remaining two agency staff no information at all was available. In addition, with regards to induction paperwork, the Inspector was informed that the interim manager was not able to find the agency file and therefore no information was available for any inductions of the agency staff. Given the extensive weekly use of agency staff that was between 269 and 710 hours a week this was very concerning.

In the absence of any completed induction documentation, we cannot be assured that key aspects of the operation of the hospital have been cascaded to the agency staff; this could have significant implications for patient and staff safety.

In addition, the absence of evidence to demonstrate that staff had the necessary skills, knowledge and experience means that the registered provider could not provide any assurance that these agency staff members were equipped to care for patients in a safe and effective manner.

Improvement needed

The registered provider must ensure that all personnel working at the hospital have the necessary skills, knowledge and experience to care for the patients in a safe manner.

The registered provider must ensure that all checks on staff are documented and available for inspection.

The registered provider must ensure that the induction process for all staff is recorded and documentation made available for inspection.

Effective care

The hospital had a combination of paper and electronic records. We examined 2 sets of patient records

Patient A was admitted to St David's on the 9 December 2019. HIW's Inspector examined the care file on the 16 December 2019 and no risk assessments or care plans were available in the patient file. The file consisted of some historical information, some clinical entry notes, a pre-admission assessment that had been undertaken in May 2019 and a few templates around risk that had not been completed for the individual patient. In addition, the Inspector requested that the interim manager check the electronic notes for any additional information. The only electronic information that was available for the patient were some risk management plans that had been completed in relation to a care home placement some 11 months earlier.

The patient was a complex individual who was detained under the Mental Health Act, was on 1:1 enhanced observations and exhibited a range of challenging behaviours.

The lack of any care plans meant that there was no framework for the delivery of effective care, for example when the patient was on 1:1 observations there were no guidelines for the member of staff responsible for undertaking this level of observation. In addition, there were risks detailed within the clinical entries but no risk management plan had been formulated to address these. Some of these risks included; inappropriate sexual behaviour and excessive fluid intake.

Without any care plans and risk assessments staff did not have a framework to guide them and enable them to deliver safe and effective care.

We also found that the other individual patient care files contained a large amount of information which made it difficult for the inspectors to locate review dates and current plans. Therefore, when agency and/or bank staff were working at the hospital and were not familiar with the documentation they would experience similar issues and

have difficulty accessing the information they needed to care for the patient effectively. The registered manager must review the appropriateness of such a large amount of information being included and ensure that key documentation is easier to locate.

Improvement needed

The registered provider must ensure that there are comprehensive risk assessments and care plans in place for all patients.

The registered provider must review their governance processes to ensure that any patients without appropriate risk assessments and care plans are identified promptly.

The registered provider must review the appropriateness of such a large amount of information being included in patient care files and ensure that key documentation is easier to locate.

There were a significant number of occasions when there was no documentation to confirm that patients had received the required level of 1:1 observations.

At approximately 23:30hrs on the 15 December 2019 Inspectors requested copies of the observational records for the patients on 1:1 observations. These records were reviewed and the following gaps identified for observations in place earlier in the day:

- Patient A - No observations recorded since 21:00hrs
- Patient B - gaps between 20:00hrs – 23:00hrs
- Patient C - No observations since 21:00hrs
- Patient D - No observations since 20:00hrs
- Patient E - No observations since 20:00hrs
- Patient F - No observations since 20:00hrs

A similar review was undertaken on 17 December 2019 at 11:09hrs and the following gaps were identified:

- Patients A, B and G - observation forms blank
- Patient C - one entry only at 10:55hrs
- Patient F - one entry only at 08:45hrs

In addition, during staff interviews, staff told HIW's peer reviewer that on a number of occasions they would leave their 1:1 observations to assist other patients. This practice presents a significant risk to the welfare and safety of both patients who have been assessed as requiring enhanced observation and other patients being cared for at the hospital. It was also evident that staff went from one direct patient observation to another throughout their shift.

Improvement needed

The registered provider must ensure that observational records for all patients are maintained and fully complete at all times.

Quality of Management and Leadership

Through discussions with a range of disciplines of staff and observations it was very evident that moral amongst the care staff group was low and many of them felt exhausted. The negative culture within the hospital was also of some concern.

During the visit we were given copies of a range of governance and quality reports but it was difficult to appreciate how these processes were having a positive impact and initiating change for the service.

Governance and accountability framework

There were a range of systems and processes in place in relation to governance and audit. However, the systems were not working in relation to improving all aspects of the service and addressing the areas identified earlier in this report. A specific example of this is that on the 30 August 2019 and again on the 1 November 2019 it was identified that there was a lack of a documented induction for agency staff. This matter still persisted during this inspection and we could not find any evidence that action had been taken to address the issue.

It was also surprising to find that in the “Local Led Clinical Quality Governance” report dated 22 November 2019 for the review period October 2019 there were no reference made with regards to agency induction even though the audit mentioned above had highlighted the issue.

Improvement needed

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.

Dealing with concerns and managing incidents

It was very evident that there were a significant amount of incidents resulting in injury to patients that had not been reported to HIW in line with regulation 31 of the Independent Health Care (Wales) Regulations 2011; some of these were serious incidents. On the “Safeguarding Notification Tracker” there was a column to indicate whether an HIW referral was required. Since October 2018 until December 2019 there were only 6 occasions when according to the tracker HIW had been notified. However, upon further consideration of the incidents it was apparent that significantly more of these incidents were required to be reported to HIW under the serious injury category.

Improvement needed

The registered provider must review all incidents and ensure that HIW is appropriately informed of incidents resulting in serious injury to patients.

Workforce recruitment and employment practices

During the inspection we were told that the service had a total of 8 staff vacancies and that there were currently a higher than usual number of patients requiring enhanced observation; 7 patients were on a 1:1 observation at the time of the inspection. It is vital that the registered provider has a robust action plan in place to address these deficits as a matter of priority.

Improvement needed

The registered provider must put an action plan in place to address the deficits in staffing numbers.

Wider organisational issues

During the visit we spoke with a range of staff. A number of themes were identified during the interview process. Many of the care staff stated that they felt exhausted and burnt out and moral was noted to be poor. Additionally of concern to the inspectors was the issues identified at the visit in relation to the culture of negativity and the approach and attitude shown by some staff towards patients. A recommendation regarding this has been made earlier in the report.

4. What next?

Following the visit HIW held a service of concern review meeting where it decided, due to the findings of the visit, that a non compliance notice should be issued and that St David's Hospital would be designated a Service of Concern. In addition, due to the serious concerns identified within this report a decision was made to issue an "Urgent Decision to Impose an Additional Condition"; the effect of which was to stop the provider admitting any new patients to the hospital until HIW are satisfied that any new admissions would not be exposed to the risk of harm.

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.

Appendix A – Improvement plan

Service: St David's Independent Hospital

Date of inspection: 15, 16 and 17 December 2019

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

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Patient Experience				
The registered provider must ensure that staff communicate with patients and with each other in a caring and professional manner.	Regulation 16 (1) Regulation 18 (1) and (2)	With immediate effect all senior personnel, when navigating communal areas, are to be vigilant in observing care delivery and opportunities to share best practices. They will identify and challenge poor standards of care and any lack of professionalism demonstrated by staff, with particular focus on communication / interaction between staff and patients. Experienced nursing staff have been made available to the service from other MHC locations to support the sharing of best practice and model high standards of	All	Immediate

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		care. The Learning & Development Manager has refreshed the training programme for St Davids Hospital to focus more specifically on key components of care that reinforce the culture, behaviours and standards required to deliver high quality care. The programme moving forward focuses on the following training elements; • Person Centred Care • Positive Behavioural Support • Active Support • Communication Skills • Dignity in Care • Autism Mandatory training compliance will not be compromised with these changes. Dates for the above will be available from 19 February 2020 through to 10 November 2020.	Margaret Shannon, Learning & Developed Manager	Feb – Nov 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		A Dignity Champion was trained in late Summer 2019 however the role had never been reinforced within the service. Internal adverts will be raised in February for two additional Dignity Champions. These roles will support staff education and the promotion of dignity in care on a daily basis.	Christine Ashton Hofer, Dignity Champion in post. (Additional persons to be identified)	20 February 2020
		Staff supervision processes are under review to place more emphasis on clinical / care delivery. A draft template for supervision has been proposed for review by the service at the next Clinical Governance forum (18 February 2020) that incorporates the 6 c's of care approach; care, compassion, courage, communication, commitment and competence. If approved this will be introduced to the service with immediate effect. This process will assist in 1:1 education and support of staff, help gain	Christian Bradford, Interim Registered Manager.	28 February 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		knowledge and understanding, as well as assist in the management of performance.		
		Staff communication and interaction with patients has been added to the agenda of the Patient Meeting for February 2020. Our interactions will be discussed openly and any lessons learning to be shared via staff meetings and local level Clinical Governance. Advocacy support will be invited to attend the meeting to support any patients as required.	Wendy Goulbourn, Senior Social Worker.	28 February 2020
		Until further notice, Dignity in Care will be added to the Staff Meeting agenda as a standard agenda item until further notice. The focus of this agenda item will be to encourage staff to discuss improvements that can be made in relation to care delivery and patient experience. Any actions or lessons learning will be reviewed in the local level Clinical Governance Forum and shared with the	Christian Bradford, Interim Registered Manager.	Immediate

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		MHC People Wellbeing Committee. Unannounced day and night visits to the service will continue and will be carried out by the Quality Team, Regulation and Compliance Officer and Lay Visitor Scheme. All have been briefed in relation to feedback from H.I.W. and areas of concern / focus moving forward. Standards of care, communication and professionalism will remain a focus of these visits. A series of workshops with the staff team will take place to define the values and culture expected within the service. These values and behaviours will then embedded in the service through leadership and behavioural modelling and the alignment of systems and processes, such as patient observation and engagement, team meetings, staff supervision and appraisal etc. to assist in the facilitation of a sustainable change in	Gemma O'Malley, Quality Lead. Andrew MacGlashan, Executive Operations Director / Christian Bradford, Interim Hospital Manager.	Immediate 30 April 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		culture moving forward. The company handbook will be re-issued to all staff at St Davids Hospital.	Molly Davies, Recruitment Admin	14 February 2020
Delivery of safe and effective care				
The registered provider must ensure that all personnel working at the hospital have the necessary skills, knowledge and experience to care for the patients in a safe manner.	Regulation 20 (1) and (2)	As of 04 February 2020 training compliance at St Davids Hospital is as follows; Mandatory training – 88% Specialist training - 66%. A training programme has been devised by the Learning & Development Manager to further support the service that will run from 19 February – 10 November 2020. Up to 24/01/20 - 95% of Agency staff are MAPA or MVA trained. 41% are Advanced MAPA trained. Further MAPA training is booked to run 26 March 2020. Twelve agency staff attended advanced MAPA training on 27 December 2019, this training was provided by MHC to ensure all staff on duty were suitably	Margaret Shannon, Learning & Development Manager.	Feb – Nov 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		trained. Further to this training a meeting took place on 24 December 2019 to discuss expectations in relation to the quality of staff. Further training for agency staff in relation to MAPA training has been scheduled for 05 February 2020. The staff rota is reviewed on a daily basis to ensure there are adequate numbers of staff, as well as suitably trained and experienced staff. The Interim Registered Manager takes a lead on this on a day to day basis. Any identified shortfalls in staffing are covered using Bank Staff or Agency staffing. Ongoing recruitment continues with 9.5 FTE staff undergoing pre-employment checks / induction processes. The next two week company induction commences 10 February 2020 in which it is anticipated most of the staff going through the on-boarding process will attend.	Christian Bradford, Interim Registered Manager.	Immediate

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		A recruitment event took place 31/01/20 to support ongoing recruitment of new staff to St Davids Hospital. This event included an interview workshop and engaging activities with OT/SALT/Patients. Adverts are live for the Registered Manager vacancy and Interim Deputy Manager post at present both internal and external to the organisation. The appointment of the new Registered Manager to the Hospital is key in the development of the service and achieving sustainable change. The advert closes 21 February 2020. A robust selection process will take place to ensure the best candidate can be identified.	Executive Team	28 February 2020
The registered provider must ensure that all checks on staff are documented and available for inspection.		All staff are subject to pre-employment checks to ensure a safe and robust recruitment process. These checks include enhanced DBS checks and	Denise Jones, Service Administrator.	28 February 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that the induction process for all staff is recorded and documentation made available for inspection.		reference checks. All information in relation to pre-employment checks is stored in the individual staff member's personnel file as well as the electronic HR solution 'Snowdrop'. A personnel file audit was carried out on a sample of the files on 07 January 2020. A full follow up audit has been scheduled to be carried out throughout February 2020 which will be carried out by the service Administrator. Any actions will be addressed via the Management team Close supervision and management of agency staffing has been an ongoing issue for the service, as identified by H.I.W during the inspection. Post inspection a number of improvements have been made to ensure all agency staff are suitably trained and experienced to be working at St Davids Hospital. 94% of Agency Profiles are available within the 'Agency File' within the Nursing Office. Of these staff, evidence is now	Christian Bradford, Interim Hospital Manager.	14 February 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		available to demonstrate 60% have completed a St Davids Hospital specific in house induction. The target is for all agency staff to have completed an induction and evidence be on file by Friday 14 February 2020. The refreshed system ensures any new agency staff members profile is provided prior to commencing work and on day of arrival a local induction is completed and stored with the profile within the 'Agency File' in the Nursing Office. The nurse in charge will lead the staff team in ensuring appropriate induction. On a daily basis, the Nurse in Charge checks and signs the duty planner to confirm all agency staff on shift have a profile and induction in place / complete. The agency staff profile record and duty planners are then audited by the Interim	Nurse in Charge Nurse in Charge	Immediate Immediate

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Hospital Manager on a weekly basis to ensure processes are embedded. This is scrutinised at random intervals by the Quality Team and Responsible Individual. All feedback will be shared with Interim Hospital Manager who is accountable for compliance of this process within the service.	Christian Bradford, Interim Hospital Manager.	28 February 2020
The registered provider must ensure that there are comprehensive risk assessments and care plans in place for all patients.	Regulation 15 (1) (a) and (b) Regulation 19 (1) Regulation 23	A full file audit is 50% complete for all patients identifying approximately 188 corrective actions thus far, in relation to content and quality. The full file audit will be completed by 14 February 2020. Patient Files have also been audited/reviewed on an announced and unannounced basis by a number of external stakeholders, over multiple visits including; • NHS Wales • NHS England	MHC Quality Team	14 February 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		• Care Coordinators from Local Health Boards, Local Authorities • CCGs Various professional guidance and support has been shared by internal staff and external stakeholders to improve care and risk planning within the service. The support and advice has been welcomed by the team. All feedback from these visits has been discussed at a local level via the Clinical Governance Forum and also at central operational meetings. Some commissioners have been sitting in the daily morning incident review meetings to further support the service. All care and risk plans will continue to be reviewed via the MDT process. Future patient file audits have been prescribed quarterly, to be carried out by MHC Quality team, unannounced, to support	St Davids MDT / MHC Quality Team	Immediate

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must review their governance processes to ensure that any		St Davids Hospital. Results will be reviewed at the local level Clinical Governance meeting. NHS England, via a Quality & Transforming Care meeting have suggested implementing a 24 hour and 72 hour care plan and this is under consideration at present. Prior to any admission to the service, the MDT at St David's Independent Hospital will ensure all pre-admission information (Service Delivery plan) is available to staff to familiarise themselves with. There will be a pre-admission meeting in which care plans and risks assessments are agreed and made available to staff prior to admission. All care plans and risk assessments are in place. As part of the processes described above, these plans are under	Dr A. Dean, Executive Medical Director. Dr J. Nash, Consultant Psychiatrist	28 February 2020 As required.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
patients without appropriate risk assessments and care plans are identified promptly. The registered provider must review the appropriateness of such a large amount of information being included in patient care files and ensure that key documentation is easier to locate.		close scrutiny by internal and external stakeholders. The patient file audit is identifying a number of areas for improvements. These improvements are reviewed as part of the weekly MDT review and updates are made accordingly. As described above, the file audit will be completed by 14 February 2020, and all improvements will be made to the care plans and risk assessments by 20 March 2020. As part of the File audit described above consideration will be given to ensure only current and relevant information is held within the Patient File and that the file is indexed appropriately.	Dr J. Nash, Consultant Psychiatrist. MHC Quality Team / St David's MDT	20 March 2020 28 February 2020
The registered provider must ensure that observational records for all patients are maintained and fully complete at all times.	Regulation 15 (1) (b)	At present the Observation forms utilised are under review. NHS Wales have offered to review the templates upon completion in which we will be accepting the support offered. Forms to be	Neil Wattret, Clinical Nurse Specialist / Christian Bradford,	01 March 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		reviewed, revised and implemented by 01 March 2020. Current observation records are completed with a system in place to ensure these are monitored daily and signed off as fully complete by Nurse in charge (NIC) of duty. MHC Quality Team carries out random audits of this process, day and night, to ensure standards are maintained. These systems have been checked on numerous occasions to date with inconsistencies still identified as of 24/01/2020. This was immediately brought to the attention of the Interim Hospital Manager. Further guidance and support for staff on how to complete observation records has been provided at a local level by the Interim Hospital Manager.	Interim Hospital Manager. Nurse in Charge Christian Bradford, Interim Hospital Manager.	Immediate Immediate

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Observation records have also been audited by a number of external stakeholders post HIW's inspection, these include; • NHS Wales • NHS England • Care Coordinators from Local Health Boards, Local Authorities • CCGs All feedback from these visits has been discussed at a local level via the Clinical Governance Forum. Regular checks by Senior Nurses, Interim Hospital Manager and Quality Team to ensure staff are vigilant and aware of expectations in relation to Observation records continue on a daily basis. These checks are to ensure that staff are aware of the expectations within St David's Independent Hospital. Any feedback from these	Jill Broom & Heroldine Davids, Senior Nurses.	Immediate / Ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		checks/observations will be reviewed and discussed in an individual's supervision to support personal development. A draft observation and engagement audit tool has been implemented within the service which serves to test staff members understanding of what effective observation and engagement looks like at the various different observation levels. This is used on an ad-hoc basis at present, however the aim is to use the tool with all staff working in St Davids Independent Hospital by 31 March 20202. The MHC Observation Policy will also be reviewed and local level training in the reviewed policy to be made available for all grades of staff including non-ward based staff. The whole team at the	Christian Bradford, Interim Hospital Manager. MHC Quality team / Learning & Development team.	31 March 2020 30 April 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		hospital will be aware of the purpose and function of carrying out observational checks correctly to contribute to patient safety and wellbeing. All staff will be competently trained to raise any anomalies in observations to the attention of the Nurse in Charge and Registered Manager. A fortnightly audit process has been implemented to track progress, any issues identified will be addressed on an individualised basis through staff supervisions. In addition to supervision and support, training in key areas has been identified; • PCP • PBS • Active Support As agreed with HIW, the Responsible Individual, Dr Anthony Dean, will notify of all discharges from the service as they	Dr A. Dean, Executive	As required.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		happen.	Medical Director/RI	
Quality of Management and Leadership				
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 19 (1)	The MHC Quality team has been working with the Service to improve the Local Level Clinical Governance Forum held at St Davids Hospital on a monthly basis. The service is keen to strengthen local level ownership of the Clinical Governance forum due to areas of concern identified to date and over dependence on external systems of support. The Interim Registered Manager is reviewing all areas of responsibility in the Hospital to ensure data for all the relevant forums is reviewed via the local level Clinical Governance Forum. This meeting is crucial in ensuring the identification of any issues, ensuring regular review, ongoing monitoring and	Christian Bradford, Interim Registered Manager.	31 March 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		the completion of corrective action is taken in a timely manner. Data to be reviewed at the Clinical Governance Forum will be collated from the following sources: • RIVO data– Live electronic governance record, reporting and notification system. This captures data in relation to Incidents, Accidents, AAWN Medication, Physical Intervention, Involvement of Emergency services, Medication Errors, Complaints, Compliments, Concerns, Whistleblowing, Infectious Outbreaks and audit scores. • Incident Review Meetings & RCAs (Daily) • MDT Minutes (Weekly). • Audit scores (Monthly) • Staff Meetings (monthly) • Patient Meeting (monthly) • Risk Register (Quarterly)		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale

		• Internal Regulation & Compliance Inspection (Annual)
		• HIW Inspection Feedback
		• Stakeholder Feedback Questionnaires (As Required)
		  ○ Friends and Family
		  ○ Professionals
		  ○ Staff
		  ○ Patients
		• Learning & Development Data Sets
		• Continuous Improvement Plan
		
		Themes and trends from the local level governance meetings at St Davids Hospital is then shared and analysed via MHC's Quality Governance Framework at one of the following committees;
		
		• Safety & Risk Committee
		• Medicines Management Committee
		• Information Governance Committee		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		• Workforce Wellbeing Committee • Peoples Wellbeing Committee • Safeguarding Committee • Finance Committee • Professional Standards Committee On a bi-monthly basis the service attends an Internal Service Review (ISR) forum in which the Registered Manager presents a service update in relation to care and service delivery including all key Performance Indicators to the Responsible Individual, Executive Team and various Heads of Department. This process is a safeguard to ensure that the data captured throughout the organisation reflects the information presented / shared by the Registered Manager and the reality of the patient / staff experience on a day to day basis. This process is in its infancy but as it continues to establish itself, the greater it will be of support and improve the performance of the Hospital.	Andrew MacGlashan, Executive Operations Director.	17 February 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		The services next ISR is 17 February 2020. A review of the governance framework, arrangements and subsequent processes has commenced post H.I.W inspection of St Davids Hospital by the Executive team with the involvement of key individuals throughout the organisation. This is a review of the entire Framework, not isolated to St Davids Hospital, but lessons learning will be shared throughout with St Davids to make local level improvements and the review will use the examples flagged by H.I.W at St David's Independent Hospital to test effectiveness. This will be reviewed at the MHC Board in March 2020	Ryan Sandick, Executive Director of Quality.	28 February 2020
The registered provider must review all incidents and ensure that HIW is appropriately informed of all incidents resulting in serious injury to	Regulation 31 (1) (b)	All incidents have been reviewed dating back to October 2018. This resulted in 52 notifications to H.I.W on 03 February	Christian Bradford, Interim	7 February 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
patients.		2020. There may have been risk of duplicating historical notifications by taking this approach however it ensures full transparency and regulatory compliance moving forward. All regulatory notifications and safeguarding referrals were up to date as of 03 February 2020. To prevent non-compliance in this area moving forward responsibilities of key individuals have been reviewed and duties allocated to ensure consistency and rigour in approach. The Senior Social Worker will complete all local Safeguarding referrals with immediate effect. In the absence of the Senior Social Worker the responsibility will be held by the Hospital Management team (Registered Manager or Deputy Manager) moving forward. The Interim and Registered Manager is to take responsibility for the submission of all regulatory notifications to H.I.W with immediate effect. In the absence of the	Registered Manager. Wendy Goulbourn, Senior Social Worker Christian Bradford, Interim	Immediate/As required. Immediate/As required.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Registered Manager, moving forward this responsibility will be carried out by the Hospital Deputy Manager. In the rare and unforeseen absence of both members of the Hospital Management team the MHA Manager will submit the required regulatory notifications. Processes in place to monitor and safeguard this have been reviewed and all safeguarding alerts and regulatory notifications are reviewed in the time scheduled for the daily incident review meeting as necessary. The Registered Manager, Senior Social Worker and Responsible Clinician all attend this forum. In addition, themes and trends in the data will be reviewed at the local level Clinical Governance Forum as an additional safeguard to compliance, as well as a forum for learning lessons and identifying quality improvements. This forum takes place on a monthly basis.	Registered Manager.	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		All Serious Untoward Events (SUI) that occur at St David's Independent Hospital will be reviewed weekly by the Executive Team (Dr Anthony Dean Executive Medical Director, Andrew MacGlashan Executive Operations Director, Ryan Sandick Executive Quality Director), on a weekly basis via the Operations Meeting that takes place on a Monday afternoon at 1pm. All data in relation to SUI across all MHC services is presented at this forum by the Quality Lead. Any specific feedback and actions for St David's Independent Hospital will be discussed with the current Interim Hospital Manager (CB) with immediate effect.		
The registered provider must put an action plan in place to address the deficits in staffing numbers.	Regulation 20 (1) (a)	Additional support to assist with rota management has been provided to the service with immediate effect and this is reviewed on a weekly basis to ensure effectiveness. This support has been provided from resources outside of the hospital and monitors the rota to ensure		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		staffing levels are maintained at the prescribed levels at all times. If staffing shortfalls are identified these are been covered by Bank staff and Agency staff. These shifts are proactively covered when and where possible. **Update 04 February 2020**; There is still fluctuation in staffing levels due to sickness, annual leave and fluctuation in the prescribed patient observation levels. As a part of this process the MHC Sickness / Absence policy will be reviewed. This review is scheduled to take place 06 February 2020 with support of Croner Professional Services. The new policy will be launched by 28 February 2020. Recruitment continues for the hospital and as of 04 February 2020 there are 9.5 FTEs going through the recruitment/induction process. Induction	MHC Quality Team	28 February 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		commences 10 February 2020 and is a protected two week process. It is anticipated, reviewing all contributing factors, a full staff compliment will be achieved by 01 May 2020. All recruitment needs of the service will be reviewed weekly by the Executive Team (Dr Anthony Dean Executive Medical Director, Andrew MacGlashan Executive Operations Director, Ryan Sandick Executive Quality Director), on a weekly basis via the Operations Meeting that take place on a Monday afternoon at 1pm. All feedback and actions will be discussed with the Interim Hospital Manager. An update will be provided to HIW by the Interim Hospital Manager at the end of each month in relation to vacancies carried at the service. As previously agreed with HIW, the Responsible Individual, Dr Anthony Dean, will notify of all discharges from the	Christian Bradford, Interim Registered Manager. Dr A. Dean, Executive	Monthly As required.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		service as they happen as this is also a significant contributing factor to the number of staff required at the service at any given time.	Medical Director/RI	