Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Priory Hospital Cardiff

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Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities

Contents

1. What we did 5

2. Summary of inspection 6

3. What we found 10

- Quality of Patient Experience 10
- Delivery of Safe and Effective Care 15
- Quality of Management and Leadership 26

4. Next steps 31

Appendix A – Summary of concerns resolved during the inspection 32

Appendix B – Immediate improvement plan 33

Appendix C – Improvement plan 34

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Priory Hospital Cardiff on 08, 09 and 10 January 2024.

The following hospital wards were reviewed during this inspection:

- Maple – a two bedded, low secure ward, which was providing care for one patient at the time of our inspection
- Willow - a one bedded, low secure ward, which was providing care for one patient at the time of our inspection
- Elm – a one bedded, low secure ward, which was providing care for one patient at the time of our inspection.

Our team for the inspection comprised of two HIW Healthcare Inspectors and three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer). The inspection was led by a HIW Senior Healthcare Inspector.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of one questionnaire was completed by patients, and 25 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Staff interacted and engaged with patients appropriately and treated patients with dignity and respect. All patients had their own ward, ensuite bedroom and garden area, which provided a high standard of privacy. Each patient had a dedicated staff team and their own programme of care that reflected their individual needs and risks. We found patients were provided with suitable therapeutic activities, facilities and equipment to support and maintain their health and wellbeing.

A wide range of patient information was available or displayed for the patients on each ward. However, we saw inconsistencies in how patient information was displayed in the hospital and noted that some patient information was not provided in an accessible format to aid understanding. We also found little evidence that patient information was provided or readily available in any language other than English. We were told that patients could engage and provide feedback on the provision of care at the hospital, but we found limited evidence to demonstrate that feedback was being routinely captured, actioned and fed back to patients.

This is what we recommend the service can improve:

- The service must review the consistency and accessibility of the patient information displayed and provided throughout the hospital, to support patient awareness and understanding
- The service should review how it will approach the need to communicate and provide information in languages other than English if required
- The service should do more to ensure patients are kept informed of the outcomes of their feedback and any changes or improvements implemented as a result.

This is what the service did well:

- The hospital's Bespoke Therapeutic Placement (BTP) services provided a tailored programme of care, treatment and activities for each individual patient
- Staff demonstrated suitable regard for patient equality, diversity and human rights
- Patients had weekly access to a mental health advocate who took an active involvement in their care.

Delivery of Safe and Effective Care

Overall summary:
We found staff were committed to providing safe and effective care in the hospital. Overall, we were assured that the service had processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors. Robust procedures were in place for the safe management of medicines. Patient care plans and Positive Behaviour Support plans were being maintained to a good standard. Overall mandatory staff training compliance was generally high, but some improvements were required in respect of Safeguarding and Basic Life Support training compliance. We found suitable infection prevention and control (IPC) arrangements in place at the hospital.

Comprehensive 'quality walk round' environmental and documentation audits were being conducted to identify and rectify any risks or issues. However, we noted examples which indicated that the findings were not being routinely reviewed and monitored to ensure any follow up actions were undertaken as a result of issues identified.

Staff compliance with mandatory Reducing Restrictive Intervention Breakaway Training (RRI) was suitably high and we noted that restrictive practices were being used as a last resort. However, we noted a high number of recent incidents of physical intervention, many of which involved patients assaulting staff. During the inspection we observed that staff had identified a requirement for additional RRI training and improved governance oversight of patient safety incidents. We were told this was in the process of being implemented for staff.

We found a robust system of audit and governance oversight in respect of patient Mental Health Act records and monitoring. The statutory documentation we saw verified that the patients were appropriately legally detained.

This is what we recommend the service can improve:

- The service must ensure actions identified during quality walk rounds are routinely reviewed, monitored and addressed
- The service must continue to improve staff mandatory Safeguarding and Basic Life Support training compliance
- Additional RRI training must be implemented to support staff in their roles and ensure the safety of staff and patients as matter of priority
- The service must conduct further discussions with staff to improve the support systems in place for staff following patient safety incidents

- The service must strengthen the leadership and management systems within the hospital to ensure effective governance oversight of patient safety incidents.

This is what the service did well:

- Medication side effects were measured using the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS), which we identified as an example of good practice
- We saw strong evidence that patients were involved in the care planning process and in decisions about their medications
- All staff were compliant with their mandatory Safe Handling of Medicines training.

Quality of Management and Leadership

Overall summary:
The majority of staff who completed HIW questionnaires provided positive feedback about working at the hospital. Most staff told us that they feel supported in their roles and satisfied with their senior management.

We found an effective governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care which supported improvements and shared learning from incidents and serious untoward events. There were regular staff meetings for staff to raise any issues and provide feedback on their experience of working in the hospital. We found appropriate processes in place for senior staff to monitor compliance with mandatory training and noted high staff compliance with clinical and managerial supervisions. A wide range of policies and procedures were available to help staff undertake their duties and responsibilities, though we found some were past their review dates.

Staffing levels were appropriate to maintain patient safety at the time of our inspection. However, we noted a high number of permanent staffing vacancies in the hospital, including twelve nursing staff vacancies.

We were informed that the service had dedicated quality improvement leads who visited the hospital on a quarterly basis. However, we found that a formal inspection of the hospital had not yet been conducted in accordance with Regulation 28 of The Independent Health Care (Wales) Regulations 2011.

This is what we recommend the service can improve:

- The registered provider must continue to progress the ongoing recruitment to vacant posts in the hospital
- The service must review any policies which are past review dates to support staff in their roles
- The registered provider must ensure the hospital is visited in accordance with Regulation 28 of The Independent Health Care (Wales) Regulations 2011 and provide HIW with a copy of the report when complete.

This is what the service did well:

- Staff were receptive to our views, findings and recommendations throughout the inspection
- The service had a dedicated workforce coordinator who maintained continuous oversight of the hospital staffing levels
- Overall staff compliance with mandatory training courses was high at 94 per cent.

3. What we found

Quality of Patient Experience

We invited patients, family and carers to complete HIW questionnaires to obtain their views on the service provided at the hospital. We also spoke with patients on the wards when appropriate to do so, however, some patients lacked capacity to participate in our questionnaire process. At the time of our inspection there were three patients being cared for in the hospital, one of whom was admitted on the first day of our inspection. We received only one completed patient questionnaire, therefore, the sample size is too small to draw robust conclusions and identify themes or trends.

However, the patient who did respond provided positive feedback and rated the care and service provided at the hospital as very good. They told us that staff treated them with dignity and respect, and that they felt safe in the hospital. They agreed that staff provided care and treatment to them when needed.

Health promotion, protection and improvement
The hospital had good processes in place to help protect and promote the physical health of patients. We reviewed the records of all three patients and saw evidence that patients received appropriate physical assessments in addition to their mental health care. Patients had physical health care plans which documented regular health screening and regular review of their goals and progress. Long term health conditions were supported and managed appropriately. Patients were able to access GP, dental services and other physical health professionals as required.

We found patients were provided with suitable activities, facilities and equipment to support and maintain their health and wellbeing. Each ward had an outside garden area and a spacious main lounge with a TV, games and activities for patient use. The hospital's communal patient areas included a Social Club and Arts and Crafts Centre which provided a pool table, table tennis and art therapy equipment. Patients could also access the hospital's fitness suite, sensory room and occupational therapy kitchen with the support of staff.

We found that the hospital's Bespoke Therapeutic Placement (BTP) services provided a tailored programme of care, treatment and activities for each individual patient. The multidisciplinary team (MDT) included a dedicated psychologist, a full-time occupational therapist (OT) and two occupational therapy assistants to support the provision of therapies and activities.

Dignity and respect
The registered provider's Statement of Purpose outlined how hospital staff supported patients to maintain their privacy and dignity. We observed staff treating patients with respect and supporting patients in a dignified and sensitive manner throughout the inspection. It was clear that good professional relationships had been developed to support patient health and wellbeing.

Each individual patient had a dedicated staff team to support their care and treatment throughout the day. All patients had their own entire ward, ensuite bedroom and garden area, which provided a high standard of privacy. We observed that patients were able to store possessions, personalise and decorate their ward as desired. We were told that patients could lock their rooms subject to individual risk assessment, but staff could override the locks if necessary.

There were suitable areas where patients could congregate and socialise in the hospital, but we were told that this very rarely occurred due to the individual care requirements and preferences of the patient group. Staff confirmed that patients were supported to engage in group activities when appropriate.

There appeared to be an appropriate mix of gendered staff working on the wards throughout the inspection. Almost all staff members who completed a questionnaire agreed that the privacy and dignity of patients is maintained during their time at the hospital.

Patient information and consent
The hospital had a written statement of purpose that met the requirements of the regulations. A wide range of patient information was available or displayed for the patients on each ward, including information on advocacy services and how patients could contact HIW.

We saw evidence that easy read versions of documents had been created to aid understanding for patients, including care plans, activity timetables and therapeutic interventions. Patients were also provided with an easy read patient guide which contained detailed and practical information to support understanding of relevant aspects of their care. However, we found inconsistencies in how patient information was displayed in the hospital and noted that some patient information was not provided in an accessible format to support their understanding. For example, no patient information regarding the complaints process was displayed on Elm ward, an easy read version of the complaints process was displayed on Willow ward, while a full, inaccessible version was displayed on Maple ward. This meant we were not assured that patients were being clearly signposted to the complaints process. Additionally, we found that information about accessing a legal representative was displayed only on Willow Ward, where

it could only be viewed by one patient. We further noted that the Mutual Expectations board on Willow Ward was not displayed in an accessible format.

The service must review the consistency and accessibility of the patient information displayed and provided throughout the hospital to support patient awareness and understanding.

At the time of our inspection, we noted that some of the hospital's patient information boards were empty, including the 'Getting to Know You' and Infection Prevention and Control boards. We discussed this matter with staff who explained that they were in the process of completing the boards and this action would soon be finalised.

Communicating effectively

We witnessed staff treating patients with respect and kindness throughout the inspection. We saw that staff took the time to speak with patients to understand their needs or any concerns the patients raised. All but one staff member who completed a questionnaire agreed that patients were informed and involved in decisions about their care.

Daily handover and multidisciplinary meetings were held to discuss patient care requirements, upcoming activities within the hospital and other relevant information, such as medical appointments. The service used digital technology as a tool to support effective communication in order to ensure timely patient care.

Suitable visiting arrangements were in place for patients to meet family and carers at the hospital. A telephone was available for patients to use in private if required. Patients had access to their own mobile phones, subject to individual risk assessment.

During the inspection we found little evidence that patient information was provided or readily available in any language other than English. We were told that patient information could be provided in Welsh on request but that translation services were not available to the hospital as standard practice. We discussed this matter with staff who advised that there were no Welsh speaking staff nor patients in the hospital, but the situation would be reviewed and appropriately addressed if a Welsh speaking patient was admitted.

The service should review how it will approach the need to communicate and provide information in languages other than English if required.

Care planning and provision
During the inspection we reviewed the Care and Treatment Plans of all three patients. The plans were person centred and each patient had a programme of care that reflected the needs and risks of the individual patients. We saw evidence that patients had been involved in the development of their care plans wherever possible. More findings on the care plans can be found in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Daily Senior Management Team (SMT) meetings were held each morning to discuss individual patient care requirements and any concerns, issues or incidents that had taken place the day before. We attended a SMT meeting during the inspection and saw that staff demonstrated a good level of understanding of the patients they were caring for, and that discussions focused on what was best for the individual patient.

We found patients were supported to make their own decisions wherever possible. We observed patients making their own food and clothing choices throughout the inspection. Patients were supported to carry out every day personal tasks to promote their independence, including preparing their own drinks and snacks and using the therapy kitchen and laundry facilities whilst supervised. It was positive to note that the hospital was supported by a dedicated social worker who assisted patients and family/carers with discharge planning arrangements and engagement with community-based services.

Equality, diversity and human rights
During the inspection we found that all three patients were detained at the hospital under the Mental Health Act (the Act). The legal documentation we reviewed was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code). We saw good evidence that patients were regularly reminded of their legal status and rights under the Act. Patients had access to an Independent Mental Health Advocate who can provide information and support with any issues they may have regarding their care.

The hospital had policies in place to help ensure that patients' equality and diversity were respected. It was positive to note that staff compliance with mandatory Diversity and Inclusion training was high at 97 per cent.

Reasonable adjustments were in place so that everyone could access and use services on an equal basis. The Care and Treatment Plans (CTPs) we reviewed evidenced that the social, cultural and spiritual needs of patients had been considered. Suitable visiting arrangements were in place for patients to meet visitors at the hospital.

During our discussions with staff, they demonstrated suitable regard for upholding patient rights and provided examples which evidenced their respect for individual patient preferences. At the time of our inspection, we observed that one transgender patient was being cared for in the hospital. Staff showed consideration and respect for the patient's care requirements and personal wishes by using the patient's preferred pronouns and by ensuring an appropriate mix of gendered staff were available to support the patient concerned.

Citizen engagement and feedback

We found there was no dedicated patient meeting process and were told that this was due to the care requirements of the patient group and the low number of patients being cared for in the hospital. We were told that patients could engage and provide informal feedback on the provision of care at the hospital during their daily interactions with staff.

During our discussions with staff, they told us that the Priory Quality Improvement lead conducted formal patient surveys which were last undertaken in September 2023. We were informed that the survey results were recorded and shared across the wider Priory Hospital group in order to drive quality improvement.

We saw examples of actions which had been taken as a direct result of patient feedback which included changes made to the hospital's food provision arrangements. However, we found limited evidence which demonstrated that patient feedback was routinely captured, actioned and fed back to patients. The service's October 2023 quality walk round had identified a requirement for 'you said we did' boards to be ordered for the hospital but we noted this action had not been completed at the time of our inspection. We discussed this matter with staff who admitted that the matter had been accidentally overlooked and advised that robust action would be undertaken to rectify this issue. Following the inspection, we were informed that a 'you said we did' board had been installed in the hospital.

The service must do more to ensure patients are kept informed of the outcomes of their feedback and any changes or improvements implemented as a result.

We saw evidence that patient complaints were appropriately recorded via Datix and within the hospital's informal complaints book. We reviewed a sample of complaints which evidenced that these were recorded, investigated and supervised with in line with the registered provider's policy.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
We looked at the processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors at the hospital. Each ward provided a clean and comfortable environment for patients and the hospital was equipped with suitable furniture, fixtures and fittings for the patient group. Some suitable measures were in place, which included:

- The hospital entrances were accessible to everyone and were secured at all times throughout the inspection to prevent unauthorised access
- There were up-to-date ligature point risk assessments for each ward that detailed the actions taken to mitigate and reduce the risk of ligature
- Ligature cutters were appropriately stored in the nursing office for use in the event of a self-harm emergency
- A business continuity and emergency contingency plan was in place that set out the procedures to follow in the event of a major incident occurring at the hospital. These included events such as fire and severe weather conditions
- There were nurse call points within patient bedrooms so that patients could summon staff when required
- Staff wore personal alarms and radios which they could use to call for assistance if necessary. We were assured there were sufficient alarms available for all staff
- A range of up-to-date health and safety policies were available for staff.
- There were established processes and audits in place to manage risk, health and safety and infection control. A comprehensive health and safety inspection and audit had been undertaken in December 2023, by members of the corporate health and safety team at The Priory Group
- We found appropriate arrangements in place to ensure fire safety within the hospital. A fire risk assessment had been undertaken in August 2023 and during our inspection we witnessed ongoing actions were being completed to address the recommended improvements.

We saw evidence of comprehensive audits of hospital records and patient care plans to ensure compliance. Hospital staff conducted monthly environmental and documentation ‘quality walk rounds’ to identify and rectify any risks or issues. However, we noted that the quality walk round template did not include space to record the date of completion. Whilst we were assured that the completion date could be identified within the hospital’s electronic record system, the date was

not present when the document was printed, which could cause confusion for staff.

The quality walk round template must be updated to include space to record the date of completion.

We observed that issues identified during quality walk rounds were routinely discussed during clinical governance meetings in order to drive quality improvement. However, during the inspection we saw examples which indicated that the findings were not always reviewed and monitored to ensure actions were undertaken as a result of issues identified.

As previously outlined in this report, staff had failed to order 'you said we did' boards for the hospital following the findings of the October 2023 quality walk round. We also found that during the December 2023 quality walk round, staff had identified that the garden of Willow was not 'clean, hazard free and fit for use' due to there being 'no outside shelter area, chairs outside very wet due to rain'. However, no immediate action was taken in respect of this matter and no appropriate follow up actions were identified in the action plan within the quality walk round documentation.

The service must ensure actions identified during quality walk rounds are routinely reviewed, monitored and addressed.

Infection prevention and control (IPC) and decontamination

We found suitable infection prevention and control (IPC) arrangements in place at the hospital. The service had an appointed IPC lead who was supported by the hospital manager and corporate Priory IPC team. A range of up-to-date policies were available that detailed the various infection control procedures to keep staff and patients safe. Cleaning schedules were in place to promote regular and effective cleaning of the hospital. The training statistics provided by the registered provider indicated that overall compliance with mandatory Infection Control training was high at 96 per cent. Almost all staff who completed a HIW questionnaire agreed that the hospital implemented an effective infection control policy, there was an effective cleaning schedule in place, appropriate Personal Protective Equipment (PPE) was supplied, and that the environment allowed for effective infection control.

We saw examples of good practice in relation to infection prevention and control. PPE was readily available for staff, including Bite Pro bite resistant clothing which protected staff when managing challenging patient behaviours. The patient laundry facilities were in good order and we found daily lint removal checklists in place. Hand hygiene audits were appropriately completed, and we saw ample IPC

signage and facilities throughout the hospital. Daily food safety checks and monthly food safety audits were being undertaken on the hospital's main kitchen with no issues identified.

During the inspection we identified that some improvements were required to ensure effective IPC in relation to food management. We highlighted the following issues to staff:

- At the time of our inspection we found that the Elm and Willow patient fridges required general cleaning to ensure they were safe for patient use. We highlighted this issue to staff and the matter was suitably rectified during the inspection
- Daily Satellite Kitchen Safety Checklists were in place to ensure effective IPC within the patient kitchens, but we saw several gaps on Elm where the checklist was not completed. We further identified a pattern whereby the checks were not being completed during the weekends
- We found unlabelled cereal containers in the Willow kitchen so the date of opening and expiry could not be ascertained.

The service must:

- **Implement robust governance oversight to ensure Daily Satellite Kitchen Safety Checklists are routinely completed throughout the hospital**
- **Ensure patient foods are regularly checked and appropriately labelled so that the opening and expiry date can be viewed, to ensure patient safety.**

Nutrition
We saw evidence that the nutritional and hydration needs of each patient were being appropriately assessed, recorded and addressed. Patients were assessed on admission using the Malnutrition Universal Screening Tool (MUST) and received ongoing weight management checks during their stay. Care plans had been put in place to manage specific dietary needs where required.

Each ward had a kitchen which provided suitable facilities for patients to access hot and cold drinks and snacks throughout the day. Patients could store their own personal food as required. We viewed the hospital's four-week rotational menu and found patients were provided with a variety of meals in keeping with their nutritional and individual needs.

We saw evidence that patients were able to feed back their suggestions about the food at the hospital. The service had conducted a food and menu satisfaction survey in November 2023.

Medicines management
We reviewed the hospital's clinic arrangements and found robust procedures in place for the safe management of medicines. The three wards shared two clinic rooms which were both clean, tidy and well organised. Relevant policies, such as medicines management and controlled drugs, were available to all staff electronically and on display within the clinic rooms. However, we noted that the hospital's rapid tranquilisation policy was due for review in February 2023.

The registered provider must review the out-dated rapid tranquilisation policy to ensure the provision of clear and up to date guidance for staff.

Daily temperature checks of the medication fridges and clinic rooms were being completed to ensure that medication was stored at the manufacturer's advised temperature. Appropriate arrangements were in place for the storage and safe use of controlled drugs and drugs liable to misuse. Drugs were securely stored, and the records evidenced that stock was accounted for when administered and that stock checks were being undertaken.

Patient medications were supplied and monitored by external, independent pharmacy services which supported hospital compliance with medications management processes. We found appropriate internal and external auditing systems in place and received positive feedback from nursing staff regarding the pharmacy engagement with the hospital.

We reviewed the Medication Administration Records (MAR charts) for all three patients and found they were being maintained to a good standard. The MAR charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. Regular medication reviews were completed to ensure patient medications continued to be safe and appropriate. These included weekly medication reviews conducted by the hospital psychiatrist, and monthly multidisciplinary team (MDT) Individual Care Reviews (ICR).

We saw strong evidence that patients were involved in decisions about their medications wherever possible. We were told that patients routinely attended ICR meetings during which any updates or changes to their medication were discussed and recorded. During our discussions with staff, we were told that patient medication information was not routinely provided in easy read format, but this could be implemented as required.

The service should consider the routine provision of patient medication information in easy read format to support patient understanding of their medications.

Medication side effects were measured and appropriately escalated using the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS), which we identified as an example of good practice. Consent to treatment certificates were well completed and stored with the corresponding electronic medication record. We observed safe, sensitive and appropriate prescribing of medications in accordance with patient needs.

Staff we spoke with during the inspection demonstrated appropriate knowledge and understanding of the hospital's medications management procedures. We were told that all nursing staff had received training on the hospital's electronic medications management system. All staff were compliant with their mandatory Safe Handling of Medicines training.

Staff confirmed that any medication errors were recorded on the Datix system and that only one medication error had been reported in the hospital prior to our inspection. We found good systems in place to ensure medication errors were appropriately recorded, investigated and supervised, and any learning opportunities were shared with all staff.

Safeguarding children and safeguarding vulnerable adults
There were established processes in place to ensure that the hospital safeguarded vulnerable adults, with referrals to external agencies as and when required. A comprehensive safeguarding policy was in place and up to date, and a register of safeguarding incidents was being maintained. The hospital's management structure included an appointed safeguarding lead and three deputies who were supported by the senior management team to ensure the hospital's safeguarding responsibilities were met. We were told that staff attended monthly quality assurance forums where safeguarding concerns were discussed as a standing agenda item, to share trends and learning opportunities.

During our discussions with staff they demonstrated a good understanding of the risks and vulnerabilities of the patients being cared for in the hospital. We were assured that staff fully understood the hospital's safeguarding procedures and reporting arrangements. We saw evidence that safeguarding concerns were being recorded and referred to external safeguarding agencies in line with the registered provider's policy. We were informed that the hospital was developing good working relationships with the local authority safeguarding team to facilitate additional scrutiny of referrals made from the setting.

Training figures we viewed during the inspection indicated that overall staff compliance with mandatory Safeguarding Combined Adults, Children and Young People training was 76 per cent. We discussed this matter with senior staff who advised that three members of staff were already booked on to forthcoming courses and that additional courses would be arranged for staff to improve compliance.

The service must continue to improve staff mandatory Safeguarding training compliance.

Medical devices, equipment and diagnostic systems
There were regular audits at the hospital and staff had documented when these had occurred to ensure that the equipment was present and in date. We saw evidence of weekly checks being undertaken on the resuscitation and emergency equipment held in each clinic room.

Safe and clinically effective care
We found staff were committed to providing safe and effective care. The hospital had policies in place to help protect the safety and wellbeing of patients and staff. There was an established electronic system in place for recording, reviewing and monitoring patient safety incidents which incorporated a hierarchy of incident sign-off by the hospital manager and senior staff. During the inspection we reviewed a sample of Datix reports and found that they had been appropriately recorded and addressed in line with policy.

The hospital's comprehensive meeting processes evidenced that patient care requirements were routinely discussed, reviewed and addressed by the MDT. We were told that the hospital's dedicated psychologist provided additional clinical supervision to address the challenging care requirements of the patient group when necessary. The majority of staff who completed a questionnaire agreed that they were satisfied with the quality of care and support they give to patients, and that patient care was the hospital's top priority.

We observed suitably high staffing levels throughout the inspection, which supported the safe care of patients. Patient clinical observations were completed at a frequency determined by their care plans or as clinically indicated. Staff used the National Early Warning Score (NEWS) assessment tool to record patient physical observations and ensure the timely escalation of concerns.

The staff training programme was appropriately tailored to patient requirements, and we found good overall staff compliance with their mandatory training. Overall staff compliance with Immediate Life Support (ILS) training was appropriately high but we noted that staff compliance with Basic Life Support (BLS) training was 78

per cent. We discussed this matter with senior staff who advised that dates had already been booked for outstanding staff members to complete their BLS training in early 2024.

The service must continue to improve staff compliance with mandatory BLS Training.

During the inspection we noted safe and therapeutic staff responses to challenging patient behaviours. The hospital had recently implemented the 'Safewards' model, and the patient Care and Treatment Plans (CTP's) we viewed included personalised strategies for managing and preventing challenging behaviours. The principles of Positive Behavioural Support (PBS) were also being used as a method of de-escalation and prevention. Overall staff compliance with non-mandatory PBS training was 95 per cent. We reviewed the PBS plans for all three patients and found they were person-centred and regularly updated to support current patient needs.

We found patient therapeutic observation records were being appropriately and contemporaneously completed. Patient observation levels were discussed during daily meetings and recorded within handover documentation for ongoing staff awareness. We were told that staff would observe patients more frequently in line with policy if patients continued to present with increased risks.

The hospital's intensive care suites were used as a way to manage short periods of aggressive and disturbed behaviour from patients. During the inspection, we observed that one patient was being cared for within the intensive care suite. We found the documentation around the use of the intensive care suite was robust and fully compliant with hospital's Seclusion and Long Term Segregation policy. We saw evidence of an individualised exit strategy in place for each period of seclusion, which supported reintegration back into the main ward environment. We were assured through our discussions with staff that the use and time frame of each period of seclusion was justified and proportionate.

Staff showed understanding of the restrictive practices available to them as well as appropriate preventative measures which can reduce the need for restrictive responses to challenging behaviour. Overall staff compliance with mandatory Reducing Restrictive Intervention Breakaway Training (RRI) was high at 97 per cent. We saw evidence that restrictive practices were being used as a last resort, with thorough monitoring around therapeutic effect and risk, and diversionary tactics in place as a method of de-escalation. Staff demonstrated that incidents of restrictive practice were appropriately recorded and monitored via individual patient care records and Datix.

At the time of our inspection we noted that there had been 43 recorded incidents of physical intervention within the past three months, many of which had involved patients assaulting staff. We reviewed a sample of such incidents and saw they were appropriately recorded and addressed. Reflective supervision processes were in place and being undertaken to support staff and patients following patient safety incidents. The hospital's Safety Huddle and Team Incident Review processes ensured that all staff were given an opportunity to reflect and consider any learning or additional support required. We were informed that staff could access further additional support and aftercare via the Employee Assistance Programme and the Wellbeing Team. Senior staff advised that the service was also in the process of implementing 'drop in' sessions where staff could raise any concerns.

Whilst we found high RRI training compliance and robust processes in place to support staff following incidents, we noted that staff had repeatedly identified a requirement for additional, supplementary RRI training and support during the hospital's monthly Clinical Governance Committee meetings held over the three months prior to our inspection. The meeting minutes also identified a lack of leadership when restrictive practices were implemented, resulting in occasions when staff had been bitten and punched. We noted that staff felt that the issue was partly caused by a high usage of agency staff within the hospital.

We discussed this matter with senior staff who advised that the appointed Priory RRI lead had recently visited the hospital with a view to implementing workshops to provide additional training and support, but these had not yet commenced at the time of our inspection. We were told that in February 2024, an additional hospital staff member would be trained as an RRI instructor which would increase the training opportunities and availability of courses for staff.

The majority of staff members who responded to our questionnaire confirmed that they were content with the efforts of the organisation to keep them and patients safe. However, some expressed concern and dissatisfaction with the current RRI training and support systems in place within the hospital. They told us:

> *"RRI training is unsafe, we are being told to let go and move away from the patient every time when the patient goes to the floor. Staff are getting injured due to lack of techniques."*

> *"Frontline staff are often left to be assaulted with no support from management even when concerns are raised. Staff who do raise concerns are often ignored and no communication to why nothing has been changed. Ongoing situations are rarely communicated with frontline staff, leaving us feeling helpless. Management does, however, encourage all staff to report incidents such as assaults or racial abuse to the police".*

"Staff get hurt; patient is then allowed to go out in the community, how is this right".

"We are told to put patient into ICS, we are unable to get them there due to assaults. We are then told to shut the door and not allowed to talk to the patient. Untrained staff are running the shifts. It's unsafe on a daily basis."

"This is one of the most unsafe hospitals I work in. The team and staff are amazing and try their best however there is no leadership on the wards. Patients are assaulting staff several times a day and staff are unable to deal with the extreme violence and situations that occur. There is no plan and staff are saying they haven't got the correct training to deal with this. Patients are restrained face down on the floor daily."

The service must:

- **Implement additional RRI training to support staff in their roles and ensure the safety of staff and patients as a matter of priority**
- **Conduct further discussions with staff to improve the support systems in place for staff following patient safety incidents**
- **Strengthen the leadership and management systems within the hospital to ensure effective governance oversight of patient safety incidents.**

Records management

Patient records were being maintained electronically and were password protected to prevent unauthorised access and breaches in confidentiality. Where paper documentation was used, we found it to be suitably and securely stored. Confidential waste bins were located across the hospital site to ensure information was appropriately destroyed.

The patient records we reviewed during the inspection were well organised and easy to navigate through clearly marked sections. It was evident that nursing staff and MDT professionals were writing detailed and regular entries that provided up to date information on the patient and their care.

Further information on our findings in relation to patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Mental Health Act Monitoring
We reviewed the statutory detention documents of all three patients detained at the hospital. All records were found to be compliant with the Mental Health Act (MHA) and Code of Practice. The MHA documentation was well organised, easy to navigate and securely stored. The training figures we viewed evidenced high staff compliance with mandatory MHA and Mental Capacity Act (MCA) training at 92 and 95 per cent.

We found a robust system of audit and governance oversight in place in respect of the patient MHA records and monitoring. The hospital's MHA administrator demonstrated good governance oversight of patient MHA records to monitor compliance with national guidelines and review upcoming deadlines to ensure patient detentions remained lawful. It was positive to note that the MHA Administrator was a member of the All Wales Mental Health Act Administrators Forum which met regularly throughout the year to discuss issues and share learning across the service.

We found good processes in place to support patient rights. Patient rights information was clearly documented with an assessment of patient understanding, in accordance with Section 132 of the Act. We saw evidence that patient detention was reviewed within set timescales during hospital managers review panels and Mental Health Review Tribunals. We noted that patients were encouraged and supported to appeal against their detention through formal processes where required. Mental capacity assessments were fully completed and regularly reviewed and updated.

All patients had weekly access to a mental health advocate who provided information and support regarding any issues they may have. Staff told us the advocate took an active involvement in patient care and participated in hospital meetings, complaint investigations and safeguarding matters. We spoke with the advocate who confirmed that they received good support and communication from hospital staff.

We saw that Section 17 leave for patients was being suitably risk assessed and that the forms determined the conditions and outcomes of the leave for each patient. However, the Section 17 leave forms did not include a section where patients could sign to indicate their involvement, agreement and understanding in determining the conditions and objectives of their leave, nor that they had been offered a copy of the documentation.

Section 17 forms should be amended to include a section for recording patient agreement and signature.

We found medication was provided to patients in line with Section 58 of the MHA. Consent to treatment certificates were suitably stored with the corresponding MAR chart. However, during our examination of patient records we found limited evidence of entries made by the statutory consultees which fully documented their views on the medical treatment of patients authorised by the Second Opinion Appointed Doctor (SOAD). The brief entries we saw did not clearly detail the treatment options discussed, nor the decision-making process that had been undertaken in respect of patient medications.

The service must implement processes to ensure discussions between the statutory consultees and SOAD are routinely and fully recorded within patient records.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010. We reviewed all three patient CTPs and found they were well organised and easy to navigate. The care plans were completed to a high standard and the records reflected the domains of the Welsh MH measure.

We found a good standard of clinical record keeping which reflected the needs and risks of the patients. Within all the records there was evidence of comprehensive assessments including specific patient physical health care assessments and proportionate, evidence-based risk assessments. Patient presentation and progress was contemporaneously documented, and the nature of interventions were appropriate to the needs of the patient. The records demonstrated that CTPs were regularly reviewed and updated by the MDT.

We found strong evidence that patients, family and carers were involved in the care planning process wherever possible. The CTPs were person-centred and included a good level of patient specific detail. The records detailed the involvement of family and carers, advocacy, external agencies and community professionals where required.

The patient voice and their wishes were well reflected within the care planning documentation we viewed. Monthly Individual Care Reviews (ICRs) were held for each patient to ensure they were kept updated and to discuss their current needs and risks.

Quality of Management and Leadership

Staff Feedback

Staff responses to the HIW questionnaires were mostly positive, with the majority of staff members recommending the ward as a place to work and confirming that they would be happy with the standard of care provided for their friends or family.

The majority of staff members agreed that their current working pattern allowed for a good work-life balance. Most staff agreed that in general, their job was not detrimental to their health and that their organisation takes positive action on health and wellbeing.

Staff comments included the following:

> *"I'm very privileged to be working in this comparatively unique set-up, where patients have the appropriate number of caring staff present to meet their needs. And also there is a robust MDT at hand. And sufficient resources. I've seen great progress in individuals. I'm very happy about the patient care delivered here."*

> *"I feel that as a new service we have had some challenging times and that senior management have supported us and also came into work during the night hours. I also feel that this workplace is amazing at regular supervision which I feel help me to overcome any stress I encounter and can move on with support."*

> *"Management efficiency evidenced in smooth decision making… patients' welfare, security and confidentiality remain our topmost priorities. Clean and very hygienic environment with very good security. If I were a patient, Cardiff Priory will be my only choice."*

Governance and accountability framework

It was positive that throughout the inspection staff were receptive to our views, findings and recommendations. During the meetings we attended, staff demonstrated that they cared for the patients and staff and valued their views and opinions on how to make improvements. The majority of staff members who completed a questionnaire told us that their organisation was supportive and takes swift action to improve when necessary.

We found an effective governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care which supported improvements and shared learning from incidents and serious untoward

events. The MDT was well established, and we observed everyone working well together throughout the inspection. There were defined systems and processes in place to support the effective operation of the hospital to ensure it focussed on continuously maintaining standards and improving its services. However, we did find some improvements were required to ensure issues identified during hospital audits were appropriately actioned, as detailed previously in this report.

The staff members we spoke with during the inspection and most staff who completed our questionnaire provided positive feedback to us about their immediate line managers. The majority of staff agreed that their manager could be counted on to help with difficult tasks at work and that they asked for their opinion before making decisions that affected their area of work.

We were told that the service had dedicated quality improvement leads who visited the hospital on a quarterly basis and provided ongoing support to staff. However, we found that a formal inspection of the hospital had not yet been conducted in accordance with Regulation 28 of The Independent Health Care (Wales) Regulations 2011.

The service must:

- **Ensure the hospital is visited in accordance with Regulation 28 of The Independent Health Care (Wales) Regulations 2011**
- **Prepare a written report on the conduct of the establishment and provide HIW with a copy of the report when complete.**

Most staff members felt that senior management were visible and that communication between senior management and staff was effective. They told us:

> *"The service works really well due to the senior management being very present throughout the week. This is the only setting I have worked in that you can speak directly to your hospital director about your concerns and they are helping out on the ward."*

However, three of the 25 respondents disagreed. They told us:

> *"Communication between wards/managers is awful…it is frustrating when a change is made (e.g. on-site training), but we aren't told."*

The registered manager should reflect on this aspect of feedback and investigate whether improvements could be made in relation to communication between senior management and staff.

Dealing with concerns and managing incidents
There was an established electronic system in place for recording, reviewing and monitoring incidents. Regular incident reports were produced and reviewed at the hospital level, and at a corporate level, to help identify trends and patterns of behaviour.

Individual incidents were being discussed with members of the MDT and senior staff during daily morning meetings, monthly patient safety meetings and monthly clinical governance committee meetings. We saw that incidents, complaints and safeguarding concerns were dicussed as a standing agenda item during daily morning meetings, and any learning was shared with all staff.

Workforce planning, training and organisational development
We found staffing levels were appropriate to maintain patient safety within the hospital at the time of our inspection. Robust processes were in place to ensure the staffing levels and skill mix continued to be appropriate. Staff confirmed that the service had a dedicated workforce coordinator who maintained continous oversight of the hospital staffing levels. We were told that the rotas were completed three months in advance and reviewed daily to ensure the staffing levels were sufficient.

However, we noted a high number of permanent staffing vacancies in the hospital, including twelve vacancies for Registered Mental Health Nurses (RMNs). Senior staff advised that some of the vacant posts would soon be filled during the onboarding process and there were ongoing recruitment processes for the outstanding vacant posts. We noted a high usage of agency staff had been identified during recent clinical governance meetings and discussed this issue with staff. We were told that bank and agency staff were used to cover any nursing staff shortfalls and where agency staff were used, the hospital actively sought to book agency staff who were familiar with the hospital and the patient group wherever possible.

The registered provider must continue to progress the ongoing recruitment to vacant posts in the hospital.

We found appropriate processes in place for senior staff to monitor compliance with mandatory training. Senior staff confirmed there were processes in place to ensure bank and agency staff were suitably trained to work in the hospital. During the inspection we reviewed the mandatory training statistics for staff and found overall staff compliance with mandatory training courses was high at 94 per cent. However, some improvements were required in respect of the provision of supplementary RRI training and overall staff compliance with BLS and Safeguarding training courses, as previously outlined in this report. The majority of staff who

completed a questionnaire felt that there was enough staff for them to do their job properly and that they had received appropriate training to undertake their role.

We received the following comments from staff in the questionnaires, when they were asked what other training they would find useful:

> *"Additional restraint training."*
>
> *"Advanced Basic Healthcare Training."*
>
> *"Special Security Protection Orientation for Mental Health environments."*
>
> *"More RRI sessions due to low level of staff experience in this setting."*
>
> *"Learning difficulty and/or disability specialised training."*
>
> *"Areas such as security and also handling monies seems to have been left. In general, it feels like a lot has been learn as you go."*
>
> *"Further training on autism and learning disability to help support our current clients further."*

The service should consider this feedback to identify ways to improve the accessibility of training sessions and types of speciality training available for staff.

We noted that staff received monthly supervisions and found high staff compliance with clinical and managerial supervisions at 98 and 100 per cent. There were regular staff meetings for staff to raise and discuss any issues and provide feedback on their experience of working in the hospital.

Workforce recruitment and employment practices
A wide range of policies and procedures were available to help staff undertake their duties and responsibilities. We saw evidence that policies were generally being reviewed and updated on a regular basis. However, during the inspection we found some policies were out of date in addition to those not previously mentioned in this report. These included:

- Health and Safety Policy, Organisation and Arrangements – review date 10 August 2023
- Safer Recruitment and Selection – review date 7 December 2023.

The service must review any policies which are past review dates to support staff in their roles.

An appropriate staff recruitment, selection and appointment process was in place at the hospital. Prior to employment, external pre-employment checks were conducted which included enhanced Disclosure and Barring Service (DBS) checks. We were told that staff employment records were regularly reviewed to ensure that staff were fit to work at the hospital.

Staff confirmed that newly appointed permanent staff members received a week long period of induction at Llanarth Court, during which they were supernumerary to the usual staffing establishment at the hospital. They were then inducted to Priory Hospital Cardiff, where they completed further training and ward-based competencies under the guidance of an experienced staff member. Senior staff confirmed that during their six month probationary period, newly appointed staff received a mid-way review after three months, in addition to their ongoing supervison.

A whistleblowing policy was in place should staff wish to raise any concerns about issues at the hospital. Staff were able to contact a 'freedom to speak up' guardian to raise any issues in confidence. Almost all staff who completed a HIW questionnaire said that they would know how to report unsafe practice and a majority of staff confirmed that they would feel secure raising concerns about patient care or other issues at the hospital. The majority of staff agreed that the hospital takes positive action on health and well-being and that they were aware of the occupational health support available to them as an employee.

The majority of staff who completed a questionnaire confirmed that the hospital was supportive of equality and diversity and that all staff have fair and equal access to workplace opportunities. They told us:

> *"Cardiff Priory provides an even level playing ground for everyone."*
>
> *"Everyone is the same in the eyes of the management."*
>
> *"…There's been massive reduction in racial discrimination from patients and management are working to reduce this to bare minimum.*

4. Next steps

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 immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: 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.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

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
At the time of our inspection we found the Elm and Willow patient fridges required general cleaning to ensure they were safe for patient use.	The cleanliness of the fridges posed a potential health and safety risk.	We highlighted this issue to staff.	The matter was suitably rectified during the inspection in that both fridges were cleaned.

Appendix B - Immediate improvement plan

Service: Priory Hospital Cardiff

Date of inspection: 08 - 10 January 2024

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate non-compliance issues were identified on this inspection				

Appendix C - Improvement plan

Service: Priory Hospital Cardiff

Date of inspection: 08 - 10 January 2024

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	Standard/ Regulation	Service action	Responsible officer	Timescale
The service must review the consistency and accessibility of the patient information displayed and provided throughout the hospital, to support patient awareness and understanding.	Patient information and consent	Review of information on all three units to ensure consistency of information, including a review of easy-read and bilingual information to ensure the same information is provided across all 3 units. Site have created easy-read versions of care plans. Plan to implement these across site. Additional easy-read information has been sourced and will be displayed across units. Review of easy read/ bilingual information in therapeutic spaces.	Michelle Mason/ Christie Reames Michelle Mason Christie Reames	29.03.2024 29.03.2024 29.03.2024
The service should review how it will approach the need to communicate and provide	Communicating effectively	Site have identified and made contact with translation services - this service offers translation services for over 290 languages.	Christie Reames	21.02.2024 - Complete

information in languages other than English if required.		Site have identified 6 current staff members who are fluent in Welsh. Site have sent out a survey to staff to gain more information re: what languages staff team can speak and to what level. Site are ordering signs to include English, Welsh and Easy-Read pictures.	Christie Reames Christie Reames Michelle Mason	21.02.2024 - Complete 21.02.2024 - Complete 29.03.2024
The service must do more to ensure patients are kept informed of the outcomes of their feedback and any changes or improvements implemented as a result.	Citizen engagement and feedback	Site to order You Said, We Did board x 3 – to be displayed in the communal area of each unit. Ward Round document to be completed with patient prior to ICR has been devised and implemented at site: Ward Round feedback form devised and implemented at site.	Michelle Mason Michelle Mason Michelle Mason	29.03.2024 29.03.2024 29.03.2024
The quality walk round template must be updated to include space to record the date of completion.	Managing risk and health and safety	New quality walk round forms have been implemented.	Michelle Mason	12.01.2024 - Complete
The service must ensure actions identified during quality walk	Managing risk and health and safety	Charge Nurse has been given the lead in Quality Walk Rounds who will ensure actions are followed up.	Michelle Mason / Christie Reames	21.02.2024 - Complete

rounds are routinely reviewed, monitored and addressed.		Action Plan on QWR's to be used and pre-populated onto next month's audit until complete. QWR Action Plan to be raised in monthly clinical governance.	Christie Reames Christie Reames	29.03.2024 29.03.2024
The service must: • Implement robust governance oversight to ensure Daily Satellite Kitchen Safety Checklists are routinely completed throughout the hospital • Ensure patient foods are regularly checked and appropriately labelled so that the opening and expiry date can be viewed, to ensure patient safety.	Infection prevention and control (IPC) and decontamination	Catering Staff to attend each unit daily to ensure checklist has been completed and signed off. Catering staff to complete daily food checks.	Catering Staff Catering Staff	01.03.2024 01.03.2024
The registered provider must review the out-dated rapid tranquilisation policy to ensure the provision of clear and up to date guidance for staff.	Medicines management	Prevention and Management of Behaviour that Communicates Distress in Adults policy in place – Issue Date: 09.06.2023. Review Date: 09.06.2026. This is displayed in both clinics.	Michelle Mason	19.02.2024 - Complete

The service should consider the routine provision of patient medication information in easy read format to support patient understanding of their medications.	Medicines management	There is a folder in each clinic which has easy-read patient medication information available. Easy read poster to be displayed next to each clinic hatch to inform patients of the above and prompt them to request medication information.	Christie Reames Christie Reames	01.03.2024 21.02.2024 - Complete
The service must continue to improve staff mandatory Safeguarding training compliance.	Safeguarding children and safeguarding vulnerable adults	Current Safeguarding training compliance is 78%. Remainder of staff are now booked into training courses to achieve 100% compliance.	Michelle Mason	17.04.2024
The service must continue to improve staff compliance with mandatory BLS Training.	Safe and clinically effective care	BLS Stats are now 84.5%. Remainder of staff are booked onto a BLS course to achieve 100% compliance.	Michelle Mason	14.03.2024
The service must: • Implement additional RRI training to support staff in their roles and ensure the safety of staff and patients as a matter of priority • Conduct further discussions with staff to	Safe and clinically effective care	Additional workshops carried out on 17.01.2024 and 18.01.2024. Additional Training carried out on 07.02.2024 and 08.02.2024. Monthly RRI training has been scheduled with Priory Lead RRI tutors. Monthly training scheduled in.	Michelle Mason Michelle Mason Michelle Mason Michelle Mason	10.02.2024 – Complete. 10.02.2024 – Complete. Ongoing 28.02.2024 – Complete

improve the support systems in place for staff following patient safety incidents • Strengthen the leadership and management systems within the hospital to ensure effective governance oversight of patient safety incidents.		De-brief day held at site. Monthly patient safety meetings scheduled for 2024, these will then be discussed in our monthly site clinical governance.	Michelle Mason	29.03.2024
Section 17 forms should be amended to include a section for recording patient agreement and signature.	Mental Health Act Monitoring	Email sent to IT Implementation & Training Specialist (SK) to request a review of Section 17 leave forms on carenotes to include a section for patient signature. Print out S17 leave, ask patient to sign and add to correspondence (Easy Read).	Michelle Mason Christie Reames	22.02.2024 - Complete 29.03.2024
The service must implement processes to ensure discussions between the statutory consultees and SOAD are routinely and fully recorded within patient records.	Mental Health Act Monitoring	Clearer guidance has been sent out to all staff around the statutory consultee role and documentation expectations. MHA Admin to monitor going forward.	Christie Reames/ Michelle Mason	22.02.2024 - Complete

The service must: • Ensure the hospital is visited in accordance with Regulation 28 of The Independent Health Care (Wales) Regulations 2011 • Prepare a written report on the conduct of the establishment and provide HIW with a copy of the report when complete.	Governance and accountability framework	Quality Improvement and Assurance Site Visit completed by Amir Ali to be uploaded to Objective Connect.	Michelle Mason	01.03.2024
The service must review any policies which are past review dates to support staff in their roles.	Workforce planning, training and organisational development	Health & Safety Policy, Organisation and Arrangements issued: 13/02/2024. Date of Review: 12/02/2025 Safer Recruitment and Selection Policy – review date 07.12.2023 – Email sent to Central HR to request policy review. Chair of HR policy working party has responded to advise that a comprehensive review of this policy is underway. Revised version to be ratified, signed off and published by the end of March 2024.	Michelle Mason Michelle Mason	13.02.2024 – Complete 01.04.2024

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): Michelle Mason

Job role: Hospital Director

Date: 28 February 2024