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12 August 2013

Dear Mr Bartley,

Re: Visit undertaken to Llanbedr Court on the 24, 25 and 26 July 2013

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to Llanbedr Court independent hospital on the evening of 24 July and all day on 25 and 26 July 2013. This visit followed on from a previous visit on 12 July 2013.

Our visit highlighted a number of areas of noteworthy practice. These included:

- a good therapeutic relationship between staff and patients;
- a care plan for patient A on Brecon ward was comprehensive and addressed a number of conditions;
- a good range of activities observed taking place at the time of our visit, including music therapy, section 17 leave, fishing and crafts;
- the multi disciplinary team (MDT) decision making process had structured minutes and clear outcomes;
- a comprehensive range of training opportunities available for staff; and
- a willingness of the organisation to change.

However, our visit also highlighted a number of issues of concern where improvement is needed. We provided a verbal overview of our concerns to your

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nominated manager at the end of our visit on the 24 July 2013. The table below summarises the issues of concern and regulatory breaches identified during our visits on 12 July and 25, 26 July:

	Issue of concern	**Regulation**
1.	Governance and audit arrangements at both local and organisational level are inadequate. A robust governance framework incorporating clear audit arrangements needs to be developed and introduced.	Regulation 19(1) (a) (b) & 2(c)(ii)(d)(e)
2.	The culture of the hospital needs to be changed so that staff feel empowered to challenge and make decisions. The culture must be open, transparent and inclusive. We acknowledge this has already been identified and that action is underway to address this.	Regulation 18(2)
3.	The use of agency staff is excessive. Since 1 June 2013, agency staff have covered 277 shifts. The use of agency staff must be evaluated as a matter of urgency.	Regulation 20(1)(a) & 4
4.	An agency registered nurse was in charge of a ward during a night shift but had no access to the electronic records. All agency registered nurses must have suitable training and be granted access to electronic patient records.	Regulation 9(1)(e) & 4(e) Regulation 23(1)(a)(i)(ii) (3)(a) & Regulation 47(1)(b)
5.	A number of observational forms were not completed in a timely manner. A patient was on 15 minute observations and the sheet had no entries completed for over an hour. We were told they are completed retrospectively. All observational records must be completed at the agreed time.	Regulation 9(1)(e)(f) & Regulation 23(1)(a)(i)(3)(a)
6.	There were no observational care plans in place for a number of patients (B, C and D on Raglan ward and A and E on Brecon ward). All patients subject to observational levels must have an appropriate care plan.	Regulation 9(1)(b)(e)(f) & Regulation 23(1)(a)
7.	Patients C and B had no pain care plans and risk assessments for pain in place. Where patients are	Regulation 9(1)(e)(f) &

	prescribed pain relief, a care plan and pain relief assessment must be in place.	Regulation 23(1)(a)(i)(3)(a)
8.	Patient D (Raglan ward) did not have a care plan in place for their diabetes. There was a lack of blood monitoring recorded for this patient, the last entry was dated 9 June 2013. A specific care plan for diabetes is required and regular blood sugar monitoring must be undertaken.	Regulation 9(1)(b)(e)(f) & Regulation 23(1)(a)(3)(a)
9.	Patient D has no care plan in place for medication compliance. A specific care plan for medication compliance must be formulated together with a strategy in place to gain compliance.	Regulation 9(1)(e)(f) & Regulation 15(1)(b) & Regulation 23 (1)(a)(i) (3)(a)
10.	Patient E (Brecon ward) is identified as being high risk of pressure damage/sores, but there was no evidence of a Waterlow[1] risk assessment. A Waterlow risk assessment (or another appropriate model) must be routinely undertaken for patients at risk.	Regulation 9 (1)(b)(e)(f) Regulation 15 (1)(a)(b)(c) Regulation 23(1)
11.	The personal care plan for patient E contained information on catheter care, but this was not detailed enough. There was no mention of bladder washouts. A specific care plan on catheter care is required and must cover all fundamental areas.	Regulation 15 (1)(a)(b)(c) & 23(1)
12.	A specific care plan on bowel care needs to be put in place for patient E. The care plan in place was not sufficiently detailed and there was no mention of manual evacuation.	Regulation 15 (1)(a)(b)(c) & 23 (1)(a)(b)
13.	Upon our arrival at the hospital, there was confusion over who was in charge. The registered nurse presented to us as in charge when we arrived was knowledgeable about their own ward but was not aware of any information about the other wards. A nominated person must be in charge of the hospital, all staff must be made aware of who is in charge. The nominated person must have a knowledge base of all wards.	Regulation 20(1)(a)
14.	A number of issues were identified in the treatment room on Raglan ward. These included:	Regulation 15(5)(a)

[1] Waterlow risk assessment is a tool to assess the risk of a patient developing a pressure ulcer. For more information visit www.judy-waterlow.co.uk

	a. Clinic room checks were lasted completed on 23 June 2013. These checks must be done on a weekly basis. b. Once only prescription record for patient H was not signed by the prescriber. c. The large oxygen cylinder was not connected for use and was standing upright (without a stand). This is a hazard that needs addressing, to prevent it from falling over and causing injury. d. Medication for patient C was out of stock and has been since 16 July 2013.	Regulation 15(2) Regulation 15(2) Regulation 15(5)(a)(m)
15.	Patients said they would like a set time to meet with their responsible clinician (RC) on their ward rather than having the RC drop by at different times and days. A routine clinic should be introduced and held at ward level.	Regulation 17(1)(3) & Regulation 18(1)
16.	On Raglan ward there was no therapeutic opportunity for dining. We observed patients being served sandwiches from boxes and the tables were not laid appropriately. This was the result of the behaviour of one patient and an arbitrary decision applying to all patients. Action must be taken to create a more pleasant dining experience for patients.	Regulation 17(3) & Regulation 18(1)
17.	The care plans on Brecon ward did not address all patient issues. Patient G requires care plans covering the following issues: swallowing, speech, falls, medicine refusal. Patient F also requires a care plan for the permanent dislocated shoulder. A pain management plan/strategy must also be put in place. Care plans must reflect all identified needs and patients must have all the necessary care plans.	Regulation 15(1)(a)(b) & Regulation 23(1)(a)(i)(ii) & (3)(a)

You have already provided us with an action plan following on from our 12 July visit. You should now update that action plan to reflect all issues highlighted in the above table. Your updated action plan should be submitted to HIW by **27 August 2013**. It should set out the actions you have already taken, and any further action you intend to take to address all the issues raised. The action plan should also set out timescales and details of who is responsible for taking the action forward. When the plan has been agreed by HIW as being appropriate you will be required to provide monthly progress updates.

On receipt of your action plan, a copy of this management letter, accompanied by your action plan will be published on our website.

We may undertake a further visit to ensure that the above issues have been properly addressed and we will undertake more frequent visits if we have concerns that necessary action is not being taken forward in a timely manner.

Please do not hesitate to contact me should you wish to discuss the content of this letter.

A copy of this letter is being sent to Ms Sally Spillane acting Hospital Manager at Llanbedr Court hospital.

Yours sincerely

Mr John Powell
Head of Regulation

cc – Ms Sally Spillane, Llanbedr Court, Chepstow Road, Llandevaud, Newport NP18 2AA