Mr Trevor Torrington
Independent Community Living Ltd
Priory House
Randalls Way
Leatherhead
Surrey
KT22 7TP

Direct Line: 0300 062 8163
Fax: 0300 062 8387
E-mail: John powell@wales.gsi.gov.uk

17 November 2014

Dear Mr Torrington,

Re: Visit undertaken to Ty Gwyn Hall on the 7th, 8th and 9th October 2014

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to Ty Gwyn Hall independent hospital on the 7th, 8th and 9th October 2014.

Ty Gwyn Hall has three (3) wards and a total of 34 beds. The hospital is located in Abergavenny. Ty Gwyn has 18 beds and Skirrid View has 12 beds, both wards providing an open rehabilitation service. Pentwyn is a 4 bedded step down unit for those patients nearing discharge.

Our visit highlighted areas that are noteworthy and include:

- The positive way staff engaged with the inspection process
- The good rapport observed between staff and patients
- The on-going refurbishment programme was improving the environment of care
- The wide range of recreational, educational and social activities observed to be taking place
- A full and well functioning multi disciplinary team (MDT) was in place

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CF48 1UZ
Tel • Ffôn 0300 062 8163
Fax • Ffacs 0300 062 8387
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- The newly appointed responsible clinician (RC) was having a positive impact upon patient care

- The food quality, variety and choice was favourably commented upon by patients and staff

- The effective leadership of the registered manager was evident and staff and patients commented favourably upon his approach.

Our visit also highlighted a number of issues. We provided a verbal overview of our concerns to your registered manager at the end of our visit on 11 February 2014. A summary of these, which include regulatory breaches is set out below:

Issue of concern	**Regulation**
1. A review of three (3) sets of patient documentation was examined and the following observations noted: a. For patient A: i. There was no target weight recorded on the patients weight monitoring form. ii. Two key risks were identified in terms of self neglect/non adherence with treatment, but there was no risk management/care plan formulated in relation to these two key areas. b. For patient B: i. The electronic record created for the patient was dated 08/10/2014 but the patient was admitted on 07/10/2014. ii. The paper records for the patient dated 07/10/2014 had very basic information. In addition, there was no confirmation that their rights were read to them under section 132 of the Mental Health Act 1983 (MHA). iii. Two key risks had been identified, excessive alcohol consumption and harm to others, but there was no management plan formulated. iv. The patient was on 15 minute observational levels but no care plan had been formulated. c. For patient C: i. The care plan on diabetes was to general and not specific enough. An entry stated *"to be well controlled".* ii. There was no mention of any foot care for the patient or the fact that the patient injects herself on a daily basis. iii. The patient had a diagnosis of brain	Regulation 15 (1) (a) (b) & (c)

shrinkage but there was no care plan in place to deal with the psychological/physical processes. iv. There was no care plan in place for a letter the patient had received which had threatening language. v. The discharge plan/placement objective 1 was not specific and lacked goals, *"to remain in Ty Gwyn Hall to maintain her safety and quality of life until a suitable placement is identified*". vi. The care and treatment plan did not address the areas identified under The Mental Health (Wales) Measure 2010[1].	
2. A review is required of the appropriateness of patient D on an all male unit.	Regulation 15 (1) (a) (b) & (c) & Regulation 19 (1) (a) & (b)
3. A member of the bank staff did not have keys or a personal alarm whilst on duty. A review of the equipment issued to bank staff is required.	Regulation 19 (1) (b)
4. Ten (10) staff files were examined and the following observations were made: a. Two (2) files did not have any evidence of a medical questionnaire. b. There was a lack of employment information on the RCs file and there was also no training evidence available. All the identified areas must be addressed.	Regulation 20 (2) (a) & (b)
5. A review of the number of patients who have been at Ty Gwyn for a considerable period of time is required.	Regulation 15 (1) (a) (b) & (c)
6. There was a lack of training in place for staff to support patients with an acquired brain injury. Training in acquired brain injury for all staff is required.	Regulation 20 (1) (a) (2) (a) (b)

[1] Mental Health (Wales) Measure 2010 – The Measure is primary legislation passed by the National Assembly for Wales and has similar legal status in Wales as other UK Mental Health Acts. It sets out additional statutory requirements to improve the support available to people in Wales with mental health problems, whether they are in hospital or the community. These additional requirements are important for the assessment, care and treatment of all people with a mental health problem. www.hafal.org/hafal/pdf/April2014.pdf

Mental Health Act Monitoring – The Administration of the Act

We reviewed the statutory detention documents of 5 of the detained patients being cared for on 3 wards at Ty Gwyn Hall hospital at the time of our visit. The following noteworthy practice was observed:

- The files were generally in good order
- The files examined contained administrative and medical audits completed for each patient
- The form and process in relation to managers hearings was comprehensive

The following points were identified and needs to be included in your action plan:

7. A review of the administration of the MHA identified the following:
    - There was a lack of discharge planning
    - Extended period of action between application and completion of managers hearings
    - Section 17 leave form for patient E was outdated
    - Assessment of capacity needed to be completed

The areas identified must be addressed.

You are required to submit a detailed action plan to HIW by **8th December 2014** setting out the action you intend to take to address each of the above issues. The action plan should set out timescales and details of who will be 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 this letter the Registered Provider is required to comment on the factual accuracy of the issues detailed and 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 Mr Shaun Cooper, Manager at Ty Gwyn Hall Hospital.

Yours sincerely

Mr John Powell
Head of Regulation

cc – Mr Shaun Cooper, Registered Manager, Ty Gwyn Hall, Llantillio Pertholey, Abergavenny, Gwent NP7 6NY