Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Independent Mental Health Service Inspection (Unannounced)

Ty Cwm Rhondda, Priory Healthcare and Partnerships in Care (Rhondda) Limited

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1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW completed an unannounced inspection of Ty Cwm Rhondda mental health service on the 13 and 14 December 2016. The following wards were visited during this inspection:

- Cilliad
- Clydwch

HIW explored how Ty Cwm Rhondda complied with the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards. For independent mental health services, HIW also considers how the service meets the requirements of the Independent Health Care (Wales) Regulations 2011 and National Minimum Standards (NMS) for Independent Health Care Services in Wales[1].

[1] The National Minimum Standards (NMS) for Independent Health Care Services in Wales were published in April 2011. The intention of the NMS is to ensure patients and people who choose private healthcare are assured of safe, quality services.
http://www.hiw.org.uk/regulate-healthcare-1

Our inspection team was made up of two HIW inspection managers (one of whom led the inspection), two clinical peer reviewers, (one of whom was the nominated Mental Health Act reviewer) and a lay reviewer.

During our inspections, we consider and review the following areas:

- **Quality of the patient experience:** We speak to patients (adults and children), their relatives, representatives and/or advocates to ensure that the patients' perspective is at the centre of our approach to how we inspect
- **Delivery of safe and effective care:** We consider the extent to which services provide high quality, safe and reliable care centred on the person
- **Quality of management and leadership**: We consider how services are managed and led and whether the culture is conducive to providing safe and effective care. We also consider how services review and monitor their own performance against relevant standards and guidance.

More details about our methodology can be found in section 6 of this report.

2. Context

Ty Cwm Rhondda is a purpose built Low Secure Environment/independent hospital which provides mental health services in the Ystrad Rhondda valley of South Wales.

Ty Cwm Rhondda was first registered with HIW during October 2007. The service is currently registered to provide low secure[2] nursing care and treatment services to a maximum of 20 patients with a mental illness and/or personality disorder[3]. Such individuals are liable to be detained under the provisions of the Mental Health Act 1983.

Each of the two wards at the hospital provides accommodation to a maximum of ten male patients. One ward is situated on the ground floor, the other being located on the first floor. There were 17 patients in receipt of services at the hospital at the time of our inspection.

The service employs a team which includes a registered manager (who is also a registered nurse and employed as the Hospital Director), a practice (primary care) nurse who ensures that patients' physical health needs are met together with their mental health needs and a team of registered nurses, support workers and hotel services/maintenance staff.

The multi-disciplinary team

Ty Cwm Rhondda also employs a multi-disciplinary team (MDT) which comprises:

- A responsible clinician (1.00 whole time equivalent (WTE))

[2] Low secure units offer care, treatment and support to patients who have severe and enduring **mental health** problems that cannot be safely treated in an open inpatient recovery **care facility.**

[3] **Personality disorders** are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others. Changes in how a person feels and distorted beliefs about other people can lead to odd behaviour, which can be distressing and may upset others. www.nhs.uk/Conditions/**personality disorder**/Pages/Definition.aspx

- Clinical psychologists (1.50 WTE)
- Psychology trainee assistant (1.00 (WTE)
- A senior Social Work Practitioner (1.00 WTE)
- A senior Occupational Therapist (this 1.00 WTE role was being covered by a member of staff from another group hospital at the time of inspection)

Occupational health technicians (x2 were to be employed in the near future-as stated within the hospital's Statement of Purpose).

We were able to confirm that the MDT met regularly to discuss patient progress. This was in order to reflect on care practices and to strengthen continuity of care. We also found that patients were able to access a range of other therapies from dieticians, physiotherapy and podiatry, via referral, in accordance with identified need. This meant that patients were enabled to obtain support and advice from a wide range of professionals to improve, or maintain their health and wellbeing.

3. Summary

At the time of this inspection, the hospital was being run by Priory Healthcare and Partnerships in Care (Rhondda) Limited (the name of the provider as of 1 December 2016). As a result, some administrative aspects of the service were yet to be agreed and the associated changes to the hospital's registration with HIW, was underway. This was in terms of the appointed Responsible Individual and company information, as required by the Regulations.

Despite the organisational change as outlined above, we received very positive comments from the staff team about how they were being supported by the registered manager and senior staff. Similarly, the registered manager described how the hospital staff had embraced the change which had resulted in the ongoing provision of good quality care and treatment.

Overall, we found evidence that Ty Cwm Rhondda was well led and managed; services being provided by an experienced multidisciplinary team through the use of a comprehensive range of corporate/local policies and procedures. Quality assurance and governance arrangements were regularly monitored and changes made to improve the service as far as possible, with the support and input from patients and staff.

This is what we found the service did well:

- Patients who spoke with us were very satisfied with their care and treatment and told us how well they had been supported by staff
- Ward staff worked very well together and were observed to be very calm and respectful toward patients throughout the visit
- We found that there was a considerable emphasis on involving patients in decisions about their care and treatment as well as aspects of the day to day running of the hospital

These are the areas of non-compliance identified at this inspection:

- The registered provider is required to inform HIW of the action taken/to be taken to ensure that all staff receive training regarding the revised mental health code of practice and refresher training regarding the Mental Health (Wales) Measure 2010.
- The registered provider must ensure that patients' pre-assessment information is present in all electronically held records.

- The registered provider is required to describe the action taken to ensure safe transportation of medicines to, and from, the clinical rooms

Details of each of the areas of non-compliance can be seen within Appendix A of this report. Whilst our findings have not resulted in the issue of non compliance notices, there is an expectation that the registered provider takes meaningful action to address these matters, as a failure to do so could result in non-compliance with the Regulations.

4. Findings

Quality of the patient experience

Dignity and Respect (Standard 10)

General issues

We found that the privacy and dignity of patients was upheld and they had their own rooms with en-suite facilities as well as access to communal and visitor areas at times of their own choosing. The hospital provided care, treatment and support to male patients only.

The registered provider's Statement of Purpose also described how hospital staff would support patients in ways which would maintain their privacy and dignity. Patients who spoke with us and those who provided us with comments (within completed HIW questionnaires), stated that they had no general issues of concern regarding their privacy or dignity. One patient did tell us that they were not allowed to use their mobile telephone unless they were on section 17 leave; however, this was in-keeping with individual risk assessments as stated by staff.

We heard staff speaking with patients in calm tones throughout our inspection and patients' consent was requested when we asked to view some individual rooms. We also observed staff being respectful toward patients at all times. Additionally, patients told us that they felt comfortable in approaching any member of staff for advice or guidance and had received a great deal of help with their care and treatment.

Discussions with the registered manager and staff and exploration of the patient engagement/partnership arrangements in place, revealed the considerable emphasis on involving patients and their families/representatives in day to day care and running of the service. This was, in part, achieved through the use of appropriate verbal and written information, encouragement to participate in a variety of 'in-house community' meetings. It was also achieved by the completion of regular patient surveys which resulted in improvements being made to menus and care planning arrangements.

The patient handbook was found to be well laid out and easy to read, to assist people to gain a good understanding of their rights and what they could expect from the service.

Environment (Standard 12)

General issues

We were provided with details of capital improvements that had been requested by the registered manager, some of which had been approved by the registered provider (such as replacement flooring at the nurses station- which had become a trip hazard and reconfiguration of the hospitals' plant room, for safety reasons).

Patients had their own rooms which could be locked if they chose. Staff were however, able to over-ride the locks in the event of an emergency/incident. Each room had sufficient storage space for individuals' personal items and we were told that patients had been involved in agreeing colour schemes.

We saw that patients were able to spend time in their own rooms, or the designated communal areas. Call bells were present in patients' rooms together with a visual alert by means of a flashing green light directly outside of patients' rooms. Other call bells were located in suitable areas of the wards. This enabled patients and staff to call for assistance, as and when required. The doors to all patients' rooms were fitted with an observation panel so that staff could ensure that patients remained safe.

Information boards contained information relevant to patients (such as advocacy services, menus and healthy eating advice).

We found that patients had access to two separate gardens and were told that they were encouraged to spend time outdoors when weather permitted. We did however see that both areas were bland in their presentation. In addition, garden furniture required updating. The registered manager told us that there were plans in place to re-develop the garden.

Both wards had a designated visitors' room to enable patients to speak with their family/friends in a private environment; appropriate observation points being present. We advised the registered manager and ward staff that both required some updating and re-decoration. Patients also had access to a private room where they could use the telephone provided. In addition, there was a secure, but separate room-away from the award areas, where patients could receive visits from children (following appropriate risk assessments).

We looked at the dining room facilities and saw that they contained lockable cupboards which were used to store individual patients' non-perishable food. Patients confirmed that they were able to access this area during the day.

We asked about the arrangements in place to support patients who smoked and were told that the registered provider had established a procedure whereby such patients were allowed the use of 'vaping'[4] until February 2017. Patients who were able to take leave from the hospital (via Section 17[5] of the Mental Health Act) were able to smoke outside of the hospital. Those patients who were not eligible for section 17 leave were provided with aids for smoking cessation. These arrangements had been put in place to promote the health and well-being of patients and in accordance with Smoke Free Premises legislation.

There were no seclusion facilities within the hospital; the ward teams trained to support patients through the use of recognised techniques at times when they presented with behaviours that challenged.

All staff and visitors were provided with safety alarms to enable them to call for assistance if required.

With the exception of the point in the immediate paragraph below, the ward environments were found to be safe.

Cilliad Ward

Whilst undertaking a tour of the ward environment, we identified a potential safety issue within a patient's room. This was highlighted to the member of staff present at the time and then reported to the registered manager in order that the matter be considered, and addressed.

We were told that patients' rooms had been re-decorated in the past twelve months and saw that they were suitably furnished. However, other areas within the ward were in need of re-decoration; wood work showing visible signs of wear and tear.

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[4] **Vaping** is an alternative to smoking. The process involves applying heat to a liquid which generates vapour. The user, (smoker in traditional cigarette circles) gets their nicotine hit through inhaling the almost odourless vapour

[5] Section 17 leave is a **Section** of the Mental Health Act (1983) which allows the Responsible Clinician (RC) to grant a detained patient **leave** of absence from hospital. It is the only legal means by which a detained patient may **leave** the hospital site.

We saw one room which (we were told), had been unoccupied since August 2016. The room was seen to be in need of cleaning. We were informed that a deep clean would take place prior to patient use.

The washing machine in the ward had been out of order for five days prior to our inspection. Conversation with a member of the ward team indicated that a new machine was to be delivered the following day.

Clydwch Ward

Conversations with the registered manager revealed that patients' rooms were to be re-decorated during 2017 as per the planned rolling programme of maintenance.

Nutrition (Standard 14)

General issues

When we looked at a sample of patients' records, we were able to see that their dietary needs had been assessed and their body weight was being monitored.

Discussions with patients and staff also revealed the emphasis being placed on 'healthy eating' and use of the gym at the premises as a result of the 'Mission Fit' initiative. This, we were told, was a physical health and wellbeing programme aimed at helping patients to improve their overall physical fitness through education on healthy lifestyles and individually tailored fitness sessions (over a 12 week period). Patients were keen to tell us how they had benefitted from this approach.

There were suitable facilities available to patients in both wards for hot and cold drinks and patients confirmed that they were able to access kitchen facilities throughout the day.

We spoke with kitchen staff and looked at patient menus and found that a four week menu plan had been devised by a dietician. In addition, we were told that alternative menus were available in response to individuals' cultural requirements and medical needs.

We further found that patients were encouraged to attend any meetings regarding menus/food provision in order that they may raise any concerns or make recommendations. The chef also told us that they occasionally visited the ward areas to speak with patients directly as a means of obtaining their views and suggestions.

We saw that food looked appetising at the point when it was being served to patients. We were also made aware that patients could buy snacks between 10.30 and 11.30 am each morning. Those patients who were able to leave the hospital on section 17 leave, were also able to purchase food items during those periods, in accordance with their wishes and preferences.

The hospital had recently been inspected by the Food Standards Agency and given a three star rating. When we spoke with the registered manager about this, we were told that this essentially related to some improvement required to parts of their Hazard Analysis Critical Control Point (HACCP)[6] administrative process; the improvements being underway.

[6] HACCP is a process control system that identifies where hazards might occur in the food production process and puts into place stringent actions to take to prevent the hazards from occurring.

Delivery of safe and effective care

Application of the Mental Health Act

General issues

We reviewed the statutory detention documents in relation to eight patients receiving care within the two wards and found that the staff team had completed those, in accordance with the Mental Health Act code of practice.

More specifically, there were clear records showing that patients were being kept informed of their rights and that all medication (under section 58 of the Mental Health Act 1983 (the Act)), had been authorised appropriately. We were able to confirm that patients had been supported in applying for a manager's hearing about their mental health status and in respect of Mental Health Review Tribunals. Likewise, hospital manager's reports were very detailed; clearly outlining their reasons for supporting ongoing patient's detention at the hospital.

We found that all patients had access to an independent mental health advocate as a means of promoting their rights and choices.

Patients' Section 17 leave arrangements were found to be well managed. We did though see some old forms within records and suggested that they be archived. This was in order that ward based staff were able to identify the most recent period of leave (supported by valid authorisation).

However, statutory consultee[7] forms that had been completed and scanned electronically were not kept together with second opinion doctor's information. This may lead to confusion/error.

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[7] Where sections of the Mental Health Act (MHA) requiring consent and a second opinion (57,58 and 58A) are being applied, before issuing certificates approving treatment, the Second Opinion Appointed Doctor's (SOAD) are required to consult two people (Statutory Consultees), one of whom must be a nurse, the other must not be a nurse or a medical doctor. Both must have been professionally concerned with the patients' medical treatment and neither may be the clinician in charge of the proposed treatment or the Responsible Clinician (RC) responsible for the patients care. Statutory Consultees should ensure they make a record of their consultation with the SOAD and this is placed in the patients notes. It

Non compliance

The registered provider is required to describe the action taken, to ensure that statutory consultee forms are readily available to staff as a means of ensuring continuity of appropriate patient care and treatment.

We also found that staff had not yet received recent training regarding the revised mental health Code of Practice 2016, or refresher training on the topic of the Mental Health (Wales) Measure 2010[8].

Non compliance

The registered provider is required to inform HIW of the action taken/to be taken to ensure that all staff receive training regarding the revised mental health code of practice and refresher training regarding the Mental Health (Wales) Measure 2010.

Conversations with the registered manager also revealed that the service would benefit from strengthening its existing audit activity associated with monitoring of the application of the Act. This would then assist in identifying improvements needed at an early stage.

Non compliance

The registered provider is required inform HIW of the action taken to strengthen existing audit activity and audit content associated with the application of the MHA.

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is considered good practice to have a specific form for recording this information and that this is kept together with the SOAD certificates, as well as with the patients MHA documentation.

Section 57 *(applies to treatment, usually neurosurgery),* ***Section 58*** *(applies to treatment with medication for mental disorder),* ***Section 58 A*** *applies to treatment with Electro Convulsive Therapy (ECT).*

[8] Mental Health (Wales) Measure 2010 sets out provision for primary mental health support services; the coordination of and planning for secondary mental health services; assessments of the needs of former users of secondary mental health services; independent advocacy for persons detained under the Mental Health Act 1983 and other persons who are receiving in-patient hospital treatment for mental health; and for connected purposes.

Care Planning and Provision (Standard 8)-Monitoring the Mental Health (Wales) Measure 2010

General issues

We looked at a sample of patients' records in both wards where they were stored and updated electronically. The software system used was clear and easy to navigate and each record provided information about patients' care and treatment plans (in the case of Welsh patients as the Mental Health measure only applied to them) or the Care Programme Approach (CPA) required for English patients.

There were detailed and individualised 12 week risk assessments and care plans in place for each patient, evidence of ongoing multidisciplinary contribution to their care and an emphasis on monitoring and improving their physical and mental health needs. In addition, relevant care plans provided information about the outcomes of care (otherwise known as the dimensions of life[9]) as set out in the Mental Health Measure.

We saw recorded evidence of the identification of patients' care coordinators and timely reviews of care and treatment plans/the care programme approach.

However, on viewing patients' care records in greater depth, we found that daily report writing was minimal and did not provide us with evidence of outcomes from planned leisure activities. Neither were we able to find sufficient information about what patients' had achieved on a daily basis or the challenges that they faced. In addition, we were unable to find a recorded pre-admission assessment in all records viewed which meant that some information about patients' care pathway from the point of admission was unclear

[9] Dimensions of life. This area of the Mental Health Measure (Wales) refers to eight key areas of a patient's life and should be incorporated in to the Care and Treatment Plan (CTP) ; Finance and Money, Accommodation, Personal Care/ Physical Well Being, Education and Training, Work and Occupation, Parenting or Caring Relationships, Social, Cultural and Spiritual needs, Medical and other forms of treatment including Psychological Interventions

Non compliance

The registered provider must inform HIW of the action taken to ensure that patients' pre-assessment information is present in all electronically held records.

Non compliance

The registered provider is required to inform HIW of the action taken to ensure that staff record daily outcomes and activities for all patients.

Discussions with health and social care professionals highlighted the presence of a 'recovery college' which had been established at the hospital. The recovery college idea related to an environment where people can discover their potential and learn the skills to develop their strengths and achieve their goals within a hospital setting. At Ty Cwm Rhondda, this was being emphasised through the development of workshops between patients and staff on topics such as:

- Keeping calm
- Retail skills
- Catering
- How do I do?

Whilst patient involvement was crucial to the above (although their involvement was voluntary), we were told that this approach was working well.

Safe and Clinically Effective Care (Standard 7)

We found that care and treatment was provided in accordance with well established guidelines and relevant national/professional guidelines, reference to which was made within relevant policy documents that supported staff in their work.

There were also well established systems for revising policies, procedures and guidelines on a regular basis, or at the point when a change was required. This meant that staff had access to up to date guidance to help them care for their patients.

Safeguarding Children and Safeguarding Vulnerable Adults (Standard 11)

We found that staff had access to, and sufficient knowledge of, the detailed current, hospital policy on the protection of vulnerable adults. We were also able to confirm that there were suitable arrangements in place at such times when children visited patients at the hospital.

Infection Prevention and Control (IPC) (Standard 13)

All areas of the hospital were visibly clean and hygienic and there was access to hand washing and drying facilities in all ward/kitchen and bathing areas.

We saw that staff were provided with relevant training on this topic; corporate compliance for this being exceeded at 98 per cent. Only one member of staff had not completed level 2 IPC training at the point of this inspection and we were told that this matter would be addressed in the very near future.

Medicines Management (Standard 15)

General issues

We obtained a copy of the service's medicines management policy/manual and considered the arrangements in place, in both wards.

Overall, we found that there were well understood and established procedures in place in terms of the ordering of medicines, medication administration, storage and the reporting of medicines incidents. Drug charts were seen to be completed as required and the recording of the use and stock of, controlled drugs was satisfactory.

We did identify the need for improvement at such times when patients expressed their wish to receive injections in their own room. Specifically, we found that the registered nurse would prepare the injection and then transport items in an open tray from the clinical room to the patient's room. This had the potential for accidents/incidents to occur. We therefore advised senior managers of the need to obtain a lockable container for transportation and safety purposes; amendments to be made to the medicines management manual accordingly.

Non compliance

The registered provider is required to describe the action taken to ensure safe transportation of medicines to, and from, the clinical rooms.

The medicines management manual (point 20) refers to a procedure to protect the safety of patients and others, if self administration was approved by the responsible clinician. However, there was no reference to a separate policy, or staff guide for this to take place. Conversations with a staff member indicated that a small number of patients would be able to administer their own medication. We therefore advised staff present at the HIW feedback session, to consider how the service would develop its approach to staged self administration in accordance with the current policy/manual as a means of increasing patients' level of independence.

Both clinical rooms were clean and well organised; relevant information being available to staff with regard to medicines management.

Clydwch Ward

We saw that opened medicine bottles were not marked with the date of opening. This had the potential for on-going administration beyond its 'use by' date. We therefore brought this to the attention of senior staff and advised them to consider this aspect of medicine's storage/administration; adding relevant information to guide staff within the medicines policy/manual.

The door of the medicines fridge was broken and would not close properly. This had the potential to compromise security of the medicines concerned and adversely affect the drugs which needed to be stored within a certain temperature range. The matter was brought to the attention of the registered manager, so that action could be taken.

Non compliance

The registered provider is required to inform HIW of the action taken to ensure that drugs which require refrigeration within Clydwch Ward are stored safely and appropriately.

Managing Risk and Health and safety (Standard 22)

Following an audit of fire safety at the hospital on the 28 April 2016, by the Fire and Rescue Authority, the registered provider was required to take some action in relation to emergency routes and exits.

HIW therefore requested an update on those matters and found that the service had taken appropriate action which included updating their fire risk assessment (November 2016) and the development of a detailed action plan.

Entry and exit arrangements at the hospital were considered to be suitable and appropriate to the patients in receipt of care and treatment.

We were provided with a copy of the current Business Continuity Plan for this service (reviewed June 2016). The document provided useful information for staff about what needed to be done in the event of total power failure, water leakage and temporary loss of heating (to name but a few instances). We also saw copies of the service's risk management policy which set out how the service would provide a systematic and coordinated approach to risk management, together with the assessment and management of clinical risk and the Health and Safety Strategy (2016-17). The service was commended for their approach to policy development, content and review.

There was a well established and understood serious incident standard operating procedure in place. This served as a guide to staff in terms of what they were expected to do if such incidents occurred, and as a means of learning from such incidents. This was with a view to minimising the risk of repeated events.

Dealing with Concerns and Managing Incidents (Standard 23)

We discussed, and looked at electronic records in place for responding to, and managing, concerns and incidents and found the system to be clear and detailed. For example, each concern or incident provided specific information about the event and included details of the staff and patient(s) involved, the time and location. That information was also automatically linked to patients' records. We were told that all such data relating to Ty Cwm Rhondda was analysed regularly to look for any trends/repeated incidents; comparisons being made between this hospital and others in the healthcare group. This assisted with making improvements to the services provided to patients.

We further found that there was an established process in place for recording and responding to, informal concerns/complaints. Whilst we did not explore this in detail, staff told us that they had no concerns about this process.

One of the many patients, who spoke with a member of our team, described a concern they had about care received at a previous healthcare facility. On gaining their consent, this matter was shared with the registered manager and ward manager who told us that they would liaise with the patient concerned and investigate the issues fully.

Quality of management and leadership

We were aware that a significant organisational change had taken place at the service from the 1 December 2016. This related to the purchase of the hospital and its assets by Priory Healthcare. As a result, some administrative aspects of the service were yet to be agreed and the associated HIW registration process was underway in terms of the newly appointed Responsible Individual and company information, as required by the Regulations.

We were told that the experienced, long standing registered manager (Hospital Director) employed at Ty Cwm Rhondda, would continue in her role.

Despite the organisational change as outlined above, we received very positive comments from the staff team about how they were being supported by the registered manager. The registered manager also indicated that staff had adopted a positive attitude to the change. Similarly, patients did not suggest to us that they had noticed any reduction in the level of care or support during this difficult period. The registered manager and other senior representatives were commended for that, during our inspection feedback session.

Governance, leadership and accountability (Standard 1)

We found that there were well defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This was, in part, achieved through an agreed rolling programme of audit and its established governance structure which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

Those arrangements were captured and recorded within a comprehensive electronic system; staff having delegated responsibilities to input data on all elements of day to day operations, and patient care and treatment.

Named senior managers had specific responsibilities for ensuring that the programme for governance remained at the forefront of service delivery and we found that staff were committed to providing patient care to high standards. Conversation with the registered manager further revealed her crucial role in monitoring governance processes and reporting at corporate level.

Our observations and discussions held with staff over a two day period clearly demonstrated that they worked effectively as a team. This was despite the challenges they faced in order to meet patients' complex, changing needs.

We were provided with a written report of the most recent Regulation 28 visit from the registered provider as at 9 November 2016 (when the service was being run by Partnerships in Care). The report and assurance/action plan clearly showed what the service was doing well and highlighted what needed to be improved (and who would be responsible for doing what). This was in-keeping with the Regulations.

We reminded the registered manager of the need to provide us with a revised Statement of Purpose, to reflect the change to registered provider and other operational changes-in accordance with the Regulations.

Non compliance

The service is required to provide HIW with an up to date Statement of Purpose to reflect the changes to its organisational structure.

Workforce Recruitment and Employment Practices (Standard 24)

The Ty Cwm Rhondda 'Site Briefing' report dated December 2016, set out its staff recruitment and retention strategy which supported its ability to recruit and retain staff. The strategy included the following:

- Flexible working where possible
- Staff recognition awards-'Going the Extra Mile'
- Monthly prize draw recognising exceptional performance
- Benefits package

We looked at a sample of eight staff recruitment records and identified the need for improvement as a result of the following:

- The registered provider must ensure that people applying to work at the hospital provide details of their full employment history-expressed in months/years. This will enable the recruitment team to explore the reasons for any gaps in employment
- One record did not contain evidence of an application form or curriculum vitae (CV) making it difficult to determine their level of experience

- One file did not contain two work references, as required by the regulations

Non compliance

The registered provider is required to inform HIW of the action taken to ensure that all individuals employed at the hospital have been subject to a robust recruitment process. This is as a means of protecting patients from harm and in accordance with the regulations.

Workforce planning training and organisational development (Standard 25

During the twelve month period prior to this inspection, there were three occasions when the hospital had reported insufficient numbers of registered nurses on duty in accordance with the needs of patients at that time. This matter was due to a series of unforeseen circumstances (for example, unexpected staff sickness) and was addressed by the registered provider; HIW having been involved in discussions and exchange of information with the service, to ensure that the matter had been resolved in a timely and appropriate way.

Since that time, the service had formalised and published its 'Safe Staffing Model' through the use of evidence based staffing tools and guidance from national bodies. This was to ensure that nurses and other clinical staff were deployed in sufficient numbers to meet the health, safety and welfare needs of patients and hospital staff. Conversations with the registered manager indicated that there had been no further instances whereby the service has operated with insufficient registered nurses.

Discussions about the management of staff sickness/absence highlighted that there were suitable arrangements in place to use bank nurses as and when required. Such nurses were deemed to be part of the team and completed all training provided by the registered provider, to ensure continuity of expected care standards. In addition, the use of agency staff was kept to a minimum-as stated, in accordance with the expectations and requirements of health care commissioners across Wales and England.

During our two day inspection, staff were easily located in all areas occupied by patients and there appeared to be sufficient numbers present to meet individuals' needs.

We found that ward managers were responsible for ensuring that all staff were able to attend their monthly supervision and reflective practice sessions. In

addition, we were able to confirm that staff had been issued with a 'supervision passport' to record those meetings for ease of reference and to monitor compliance with corporate requirements.

We were provided with records to confirm that staff received an annual appraisal of their work; high percentages being achieved each quarter across the hospital team.

During 2016, a trainee forensic psychologist had completed a staff training analysis at Ty Cwm Rhondda, as a result of which a specific training programme had been developed and was underway. However, the programme seen did not include reference to training in relation to the revised mental health Code of Practice, or refresher training with regard to the Mental Health (Wales) Measure 2010 (this issue has been highlighted as an improvement on page 13 of this report).

We were provided with details of the induction programme available to new members of staff and found the content to be appropriate.

We offered staff the opportunity to complete a HIW questionnaire as a means of seeking their views about what worked well at the hospital, whether they received sufficient support in their work and whether improvements to patients' services were needed. Four completed questionnaires were returned. One respondent indicated the need for greater support on occasions when a patient incident occurred and another commented on the need for social/leisure opportunities at weekends together with improved outdoor space for patients. Positive comments were provided in relation to how the hospital team worked together and the efforts made to involve patients in their care and treatment as much as possible.

5. Next steps

This inspection has resulted in the need for the service to complete an improvement plan (Appendix A) to address the key findings from the inspection.

The improvement plan should clearly state when and how the findings identified at Ty Cwm Rhondda will be addressed, including timescales.

The action(s) taken by the service in response to the issues identified within the improvement plan need to be specific, measureable, achievable, realistic and timed. Overall, the plan should be detailed enough to provide HIW with sufficient assurance concerning the matters therein.

Where actions within the service improvement plan remain outstanding and/or in progress, the service should provide HIW with updates to confirm when these have been addressed.

The improvement plan, once agreed, will be evaluated and published on HIW's website.

6. Methodology

HIW inspections of mental health services seek to ensure services comply with the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards. The focus of HIW's mental health inspections is to ensure that individuals accessing such services are:

- Safe
- Cared for in a therapeutic, homely environment
- In receipt of appropriate care and treatment from staff who are appropriately trained
- Encouraged to input into their care and treatment plan
- Supported to be as independent as possible
- Allowed and encouraged to make choice
- Given access to a range of activities that encourage them to reach their full potential
- Able to access independent advocates and are supported to raise concerns and complaints
- Supported to maintain relationships with family and friends where they wish to do so.

We reviewed documentation and information from a number of sources including:

- Information held by HIW
- Conversations with patients and interviews with staff
- General observation of the environment of care and care practice
- Discussions with senior management within the directorate
- Examination of a sample of patient medical records
- Scrutiny of particular policies and procedures which underpin patient care
- Consideration of quality improvement processes, activities and programmes.

HIW inspections capture a snapshot of the standards of care patients receive. They may also point to wider issues associated with the quality, safety and effectiveness of healthcare provided and the way which service delivery upholds essential care and dignity.

HIW uses a range of expert and lay reviewers for the inspection process, including a reviewer with extensive experience of monitoring compliance with the Mental Health Act 1983.

We provide an overview of our main findings to representatives of the service at the feedback meeting held at the end of each of our inspections.

Any urgent concerns emerging from these inspections are brought to the attention of the service via an immediate action letter. For independent services, the registered provider of the service will be notified of urgent concerns and serious regulatory breaches via a non-compliance notice[10]. These findings (where they apply) are detailed within Appendix A of the inspection report.

[10] As part of HIW's non-compliance and enforcement process for independent healthcare, a non compliance notice will be issued where regulatory non-compliance is more serious and relates to poor outcomes and systemic failing. This is where there are poor outcomes for people (adults or children) using the service, and where failures lead to people's rights being compromised. A copy of HIW's compliance process is available upon request.

Mental Health Service: Non compliance-Improvement Plan

Service: Ty Cwm Rhondda

Date of Inspection: 13 and 14 December 2016

Page Number	Non compliance	Standard/ Regulation	Service Action	Responsible Officer	Timescale
Quality of the patient experience					
	No non-compliance issues identified.				
Delivery of safe and effective care					
14	The registered provider is required to describe the action taken, to ensure that statutory consultee forms are readily available to staff as a means of ensuring continuity of appropriate patient care and treatment.	Mental Health Act 1983; Mental Health (Wales) Measure 2010	*Statutory Consultee Forms are always completed following a SOAD visit and are filed in patients Mental Health Detaining paperwork file held by the Mental Health Act Manager.* *Consent to Treatment Documentation;* • *CO2's & CO3's (Welsh Patients)* • *T2's & T3's (English Patients)* *are uploaded to the `Legal` Section of Care Notes (electronic patient record).* Statutory Consultee Forms will now be uploaded with the Consent to treatment documentation to the `Legal` Section of Care Notes (electronic patient record)	JH	09/02/2017
14	The registered provider is required inform HIW of the action taken to strengthen existing audit activity and audit content associated with the application of the MHA.	Mental Health Act 1983	*Audit of MHA Documentation currently takes place every 6 weeks and is completed by the MHA Manager. A random selection of files are audited (up to 5) each time.*	JH	Ongoing

Page Number	Non compliance	Standard/ Regulation	Service Action	Responsible Officer	Timescale
			Audit findings to be presented at Clinical Governance with action plans (as necessary).	JH	08/02/2017
			Monitor the Mental Health `dashboard` (Section 22) to ensure the following areas remain compliant: • Current Section of MHA • Start Date / Expiry Date • Alerts (2 months prior to expiry) • Consent to Treatment • MHRT's • Managers Hearings • Section 132 (Patient Rights)	JH & DR	17/02/2017
14	The registered provider is required to inform HIW of the action taken/to be taken to ensure that all staff receive training regarding the revised mental health code of practice and refresher training regarding the Mental Health (Wales) Measure 2010.	Mental Health Act 1983; Mental Health (Wales) Measure 2010	Initial discussions with Responsible Clinician and Mental health Act Manager	TG	25/01/2017 **Completed:** 25/01/2017
			Review of existing training materials available via the Welsh assembly Government (WAG) and adapt for TCR	JH & TG	30/01/2017

Page Number	Non compliance	Standard/ Regulation	Service Action	Responsible Officer	Timescale
			service. http://www.wales.nhs.uk/sites3/page.cfm?orgid=816&pid=33958 An electronic version of the revised Code of Practice has been issued to the Clinical Team and Wards in the interim of a printed copy. WAG have been contacted by email re: delivery date of new copy		**Completed**: 26/01/2017
			Agree Training dates against `In House` Training Schedule	JH	30/01/2017 **Completed**: 26/01/2017
			Deliver Training as specified. Training Dates agreed as follows; • 24/03/2017 • 07/04/2017 • 21/04/2017 • 05/05/2017	JH & NB	05/05/2017
16	The registered provider must inform HIW of the action taken to ensure that patients' pre-assessment information is present in all electronically held	Standard 8; Regulations 9 and 47.	*The Initial Assessment Reports for patients are collated from face to face interviews and pre-assessment information available to the team.* *The Initial Assessment Report is available to all staff (read only) on the shared drive and within the `Mental Health Patient` folder.* *Paper copies of the pre-assessment information are*		

Page Number	Non compliance	Standard/ Regulation	Service Action	Responsible Officer	Timescale
	records.		*archived accordingly for reference and in line with Records Management Policies.* The Initial Assessment Reports will be uploaded to Care Notes under the `Operational Report` section for ease of access to external visitors.	DR & JM	03/02/2017 **Completed:** 26/01/2017
16	The registered provider is required to inform HIW of the action taken to ensure that staff record daily outcomes and activities for all patients.	Standard 8; Regulation 9	*Discussion with Ward Managers re: feedback from the report and audit process completed by TG.* Ward Managers to complete an audit of clinical entries to establish a `baseline` re; quality of records. Audits will be performed weekly thereafter.	AK & BM	03/02/2017
			Discuss Quality Assurance via Group and Individual Supervision – implement Performance Management Plans where necessary. Proposed discussions at Group Supervision over next 4 weeks to cascade information and plans to all ward based staff. Next proposed Group Supervision: 27/01/2017	AK & BM AK & BM	17/02/2017 **Completed:** 27/01/2017 03/02/2017

Page Number	Non compliance	Standard/ Regulation	Service Action	Responsible Officer	Timescale
			Raise the issue at Clinical Governance Next proposed Clinical Governance: 08/02/2017	TG	08/02/2017
			Devise a guideline for staff re: qualitative clinical note writing.	AK & BM	10/02/2017
18	The registered provider is required to describe the action taken to ensure safe transportation of medicines to, and from, the clinical rooms.	Standard15; Regulation 15	*Training compliance is monitored at least weekly by the Learning & Development Lead.* *Staff were 100% compliant at time of inspection re; Control of Infection Level 1* *Only one staff member was out of date for the Level 2 Infection Control Training. Resulting in 98% compliance.* Member of Staff concerned has been advised to complete the Level 2 Control of Infection Training.	MF	31/01/2017 **Completed**; 30/01/2017
18	The registered provider is required to inform HIW of the action taken to ensure that drugs which require refrigeration within Clydwch Ward are stored safely and appropriately.	Standard 15; Regulation 15	Secure Storage boxes purchased of which are lockable and hold sharps box, compartments etc	TG	20/01/2017 **Completed;** 20/01/2017

Page Number	Non compliance	Standard/ Regulation	Service Action	Responsible Officer	Timescale
			Protocol devised for staff re; safe use of storage box		23/01/2017 **Completed;** 31/01/2017
			Protocol and boxes implemented on wards		27/01/2017 **Completed;** 03/21/2017
			Review of clinic room fridge with maintenance. *Ward staff record daily temperatures to ensure adequate temperatures are maintained in the interim of repairing/replacing fridge.*		20/01/2017 **Completed;** 20/01/2017
			Contact suppliers of fridge due to recent purchase and cover under warranty *Fridge remains under warranty. Suppliers have agreed to repair/replace the fridge. They will supply an alternative fridge in the interim period.* *Replacement fridge delivered on 31/01/2017*		30/01/2017 **Completed;** 23/01/2017
Quality of management and leadership					

Page Number	Non compliance	Standard/ Regulation	Service Action	Responsible Officer	Timescale
21	The service is required to provide HIW with an up to date Statement of Purpose to reflect the changes to its organisational structure.	Standard 1; Regulation 6	Statement of Purpose to be reviewed and updated accordingly. *Draft of revised Statement of Purpose is currently with Priory Compliance team*	TG	03/02/2017 **Completed;** 06/02/2017
22	The registered provider is required to inform HIW of the action taken to ensure that all individuals employed at the hospital have been subject to a robust recruitment process. This is as a means of protecting patients from harm and in accordance with the regulations.	Standard 24;Regulation 21 and Schedule 2	***Existing Staff****: where there are gaps in Employment History, A written explanation and/or up to date Curriculum Vitae (CV) is requested.* Audit of all HR Personnel Files to establish missing information.	HS & SW	14/02/2017 **Completed:** 03/02/2017
			One record did not contain evidence of an application form or curriculum vitae (CV) making it difficult to determine their level of experience Audit HR Personnel Files re: missing information.	HS & SW	14/02/2017 **Completed:** 03/02/2017
			Contact staff (following audit) to provide relevant information. **Historical Applications**: Request up to date Curriculum Vitae	HS & SW	28/02/2017

Page Number	Non compliance	Standard/ Regulation	Service Action	Responsible Officer	Timescale
			(CV) retrospectively. *PiC Applications are completed online. These will be printed off if no Curriculum Vitae (CV) are provided by candidates.* *New Applicants without a Curriculum Vitae (CV) / Application Form are rejected.*		
			One file did not contain two work references, as required by the regulations *Since acquisition by PiC in April 2015; 2 references are evident on file for all `new` employees from this date.* Where there is only one reference, HR to provide a written statement for (Historical Applications /Files prior to April 2015).	HS & SW	28/02/2017

Service representative:

Name (print): Therisa Galazka

Title: Registered Manager

Date: 30/01/2017

Updated: 07/02/2017