Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health Service Inspection (Unannounced)

Ty Gwyn Hall, Elysium Healthcare

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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 Gwyn Hall, Llantilio Pertholey, Abergavenny, NP7 6NY (mental health hospital) within Elysium Healthcare on the 11 – 12 January 2017. All hospital wards were visited during this inspection which comprised of:

- Ty Gwyn House
- Skirrid View
- Pentwyn House

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 one lay reviewer.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act.

This report details our findings following the inspection of an independent mental health service. HIW is responsible for the registration and inspection of independent healthcare services in Wales. This includes independent hospitals, independent clinics and independent medical agencies.

Further details about our approach to inspection of independent mental health services can be found in Section 6.

2. Context

Ty Gwyn Hall currently provides mental health services in the Abergavenny area of Monmouthshire. At the time of our inspection Ty Gwyn Hall was being transferred to a new company (registered provider), Elysium Healthcare. Ty Gwyn Hall falls under rehabilitation services within Elysium Healthcare.

Ty Gwyn Hall provides the following, as outlined in their conditions of registration:

- Ty Gwyn (18 bed mixed gender rehabilitation unit)
- Skirrid View (12 bed mixed gender assessment unit)
- Pentwyn House (four bed mixed gender step down unit)

There were 28 patients there at the time of the inspection.

The service employs a staff team which includes one registered manager, one clinical services manager, one ward manager, a consultant who is also the responsible clinician, a specialty doctor, one forensic psychologist and one integrative psychotherapist, two occupational therapists and four occupational therapy assistants, one music therapist and one hospital social worker. The ward teams include registered nurses and health care assistants. There is also a team of support services, housekeeping and administrative staff.

Ty Gwyn Hall is also engaged with local community services for the physical health and wellbeing of the patients which includes General Practice (GP) surgeries, dentists and opticians.

Summary

Overall, we found evidence that Ty Gwyn Hall provides safe and effective care.

This is what we found the service did well:

- Patients we spoke with were happy with the standard of treatment and care provided. We observed respectful and patient centred interactions in the delivery of care
- Staff we spoke with were happy in their roles, understood their responsibilities and felt well supported by management
- There were thorough health and safety policies, procedures and risk assessments to promote a safe environment
- Although the hospital was going through a period of transition, due to changes in ownership, staff were clear about their values base and this had not affected the delivery of patient care and treatment.

This is what we recommend the service could improve:

- Considerable improvements are required to a number of aspects of patient documentation and note keeping including care and treatment plans, incident forms, nursing assessments and risk assessments
- IT and records management systems need to be transferred to the new registered provider's systems to ensure systems effectively support the delivery of patient care
- Although an ongoing programme of refurbishment was in place and the environment was pleasant and well maintained, there were aspects which required review. For example the multi-use space in Ty Gwyn House of clinic room/medicines management/reception needs to be addressed to ensure patients are afforded appropriate privacy and dignity. ....

We identified the following regulatory areas for improvement during this inspection regarding:

- Amendments to the Statement of Purpose and Patients Guide
- Completion of annual returns and six monthly registered provider visits

- Policies and procedures require updating due to the change of registered provider
- Ensure that HIW certificates displayed are the most up to date versions
- Appointment of Responsible Individual under the new registered provider.

Whilst this has not resulted in the issue of a non compliance notice, 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 regulations.

3. Findings

Quality of patient experience

Overall patient satisfaction with Ty Gwyn Hall was high. We saw staff treating patients with respect whilst providing patients with individualised assessment and rehabilitation care.

We saw that staff upheld patients' rights and were person centred in their approach. Patients' current needs were being met by the staff team who were providing care, treatment and suitable activities within the hospital and the community.

Patient records systems required improvement to ensure that the care being provided in practice was adequately demonstrated in records.

Aspects of the Patients Guide required updating to ensure it met the regulatory requirements.

During our inspection we spoke with a number of patients informally about the care provided and also asked patients to complete HIW questionnaires to gain formal feedback. Nine questionnaires were completed in total. Overall patient satisfaction was high. Patients were positive about their relationships with staff, the activities on offer and told us they were involved in decisions around their care and treatment. Where patients made negative comments or had individual concerns about their care we addressed these with the registered manager who resolved these over the course of the inspection. Further detail from questionnaires is included throughout the body of the report.

Some comments included:

> *"Staff exceptional and will do anything for you. Service is excellent. Always give time to explain things. Good transparency between health care assistants, nurse, clinical"*
>
> *"Would like more varied choice of food and better quality"*
>
> *"Love it here"*
>
> *"Cleaners are nice and very respectful"*
>
> *"Always there when you need a chat. Love the room. Good access to OT activities"*

"Best hospital going. Homely".

Health promotion, protection and improvement

We found that patients' health was promoted and protected by the service.

Patients told us about health promotion activities they were involved in such as weight loss and exercise programmes. Hospital staff ran and supported these programmes, with particular input from occupational therapy staff. We also saw health promotional information on display across the hospital.

Patients were able to access GPs and dentist services where required and reported no significant delays in waiting for these appointments. Medical staff had recently commenced twice weekly physical health clinics as an additional way to assess and monitor all physical aspects of patients' health which was particularly noteworthy practice.

Dignity and respect

We found that patients were treated with dignity and respect by staff.

All patients told us they felt that their privacy and dignity was respected and maintained. Patients told us that they felt staff listened to them and responded to their wishes. Over the course of the inspection we saw staff treating patients with respect and responding to their individual needs in kind and caring ways. We saw that staff asked for patients' consent before entering rooms or before allowing the inspection team to sit in on meetings.

There was a privacy and dignity policy in place and the registered provider's Statement of Purpose also described how hospital staff would support patients in ways which would maintain their privacy and dignity. Discussions with the registered manager and the multi-disciplinary team revealed the considerable emphasis on involving patients and their families/representatives in day-to-day care and running of the service.

Patients had their own bedrooms with ensuite facilities (Ty Gwyn and Skirrid View) or single sex bathroom wings (Pentwyn House). There were communal and visitor areas that patients could access when required or chosen. Patients were able to personalise their rooms and had sufficient storage for their possessions. Patients had their own keys for their bedrooms so that they could lock them and access them freely; staff were able to over-ride the locks if required.

Patient information and consent

Throughout the hospital there were areas where up to date information for patients was clearly displayed. This included statutory information such as easy read information about patient's rights under the Mental Health Act and how to access legal advice to further their appeals against their detention. Displays also included information on the operation of the hospital and activities/events that were being undertaken in the hospital and community.

The Patient Guide provided most of the essential information for patients staying there and gave clear information about patients' rights and what patients could expect from the service. There were some amendments needed to ensure the patient guide fully complied with regulations.

Improvement needed

The Patients' Guide must include all information as listed under Regulation 7. The service's current patient guide must be updated to include:

- ***The terms and conditions in respect of services to be provided for patients, including as to the amount and method of payment of charges by patients for all aspects of their treatment (Regulation 7b).***
- ***Summary of the complaints procedure (Regulation 7d).***
- ***Summary of the views of patients and others obtained (Regulation 7e)***
- ***The most recent inspection report prepared by the registration authority or information as to how a copy of that report may be obtained (Regulation 7g).***

All patients told us they felt listened to during discussions with their doctor about their treatment and were given enough information to make an informed decision. All patients we spoke with told us they had been involved in their care and signed their care plans.

Patients were provided information in written format and we were assured that staff discussed this information with patients because patients confirmed this. However, it was difficult to find evidence of this in patient records due to incomplete information in the care records we reviewed. In one patient record for example, staff had noted that the patient did not understand their care plan

but staff had not recorded whether other methods had been used to support the patient to understand.

Improvement needed

Staff must consistently and accurately record how they provide information to patients and how they endeavour to assist patients in understanding information.

It was difficult to find information regarding capacity, consent and Deprivation of Liberty Safeguards (DoLS) in patient records. This was contained within Multidisciplinary Team Meeting (MDT) records rather than being indicated in a clearly accessible place. Improvements in record organisation are addressed below. We looked at three patients' DoLS documents and found that assessments and authorisations were up to date and reviewed within specified timescales. Patients had been advised of their rights of review.

Communicating effectively

We saw that staff took time and care to communicate with patients effectively. We observed staff taking time to undertake discussions using words and language suitable to the individual patient.

We saw that there was easy read material available and staff told us that other languages and formats could be produced on request. Staff were able to access interpreting and translation services when required.

For individual meetings patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. Patients' families and/or carers were also involved in some individual meetings. All patients we spoke with knew how to access advocacy services and told us they found these services very useful.

Care planning and provision

Through our observation of a MDT meeting and through speaking with patients and staff we saw that patients' needs were thoroughly assessed and reviewed. We saw that the multidisciplinary team worked effectively to ensure patients accessed the care, treatment and support they required and future goals were identified and actions supported to reach those goals. The MDT meeting we observed was solution and outcome focussed with a clear action plan identified. A lack of organisation in patient records meant that this thorough care planning approach was not always demonstrated by patient notes. This is addressed below.

There was a model for progression through the service with Pentwyn House offering an environment of support for patients who would be progressing to live in the community. There had been several community homes available to support this step under the previous registered provider. Whilst this option no longer existed, the registered manager told us that Elysium Healthcare, the new registered provider, had committed to building their own community home service to continue this as an optional pathway for patients in the future.

Patients were particularly positive about occupational therapy input and the range of activities offered including life skills, weight loss programmes, swimming groups and art club. There were hospital vehicles available to support access into the local community. Patients were also encouraged to use public transport as part of their rehabilitation programme.

Citizen engagement and feedback

We found a variety of methods in place for patients to be able to provide the service with their views and feedback. We also saw evidence that, as a result of patient feedback, staff had made service improvements, for example, installing outside smoking shelters. Our discussions with staff and our observations confirmed that patients' views were valued and encouraged.

We saw that patient surveys were undertaken and there were patient forums and meetings to enable patient representatives to raise and escalate any issues. Patient experience systems were currently being reviewed by the new registered provider, with a view to confirming the new arrangements that would be put in place.

Delivery of safe and effective care

Overall we found that safe and effective care was provided to patients.

The statutory documentation in relation to the Mental Health Act was compliant with associated legislation except in one isolated case which was being addressed by staff.

The standard of recording and organisation of care planning records required considerable improvements to ensure they were compliant with the Mental Health (Wales) Measure. Although we were assured that safe and effective care was taking place in practice, patient documentation did not reflect this.

Ty Gwyn Hall was suitable for providing assessment and rehabilitation services with good facilities within the hospital. The environment provided constraints and some aspects required improvements, particularly to ensure privacy and dignity could be maintained in one clinic area and around the management of medicines. However, overall the environment was maintained to a high standard and there were plans for ongoing improvements and refurbishment.

There was safe management of medication at Ty Gwyn Hall; however we identified one issue with fridge temperatures that required review.

We found appropriate systems in place to manage safeguarding concerns.

IT systems required review to ensure they could function at optimal levels to support the delivery of patient care.

Application of the Mental Health Act

We reviewed the statutory detention documents of six patients (two patients from each unit) at Ty Gwyn Hall. Five of the patients had been detained for a number of years. The other patient had been previously detained but had a period of informal care (not detained under the Act) more recently.

Overall Mental Health Act documentation was well organised. The documentation evidenced that the detentions were compliant with the Mental Health Act (the Act).

It was evident that the application and renewal of detentions had been completed as and when required by the Act. Patient detentions were reviewed

at hospital manager's hearings and patients had the opportunity to appeal against their detention to Mental Health Review Tribunals and the hospital managers as per the statutory timescales indicated in the Act and the Code of Practice for Wales. The mental health act coordinator confirmed that a structured system of timescales had been implemented following the last HIW inspection.

All leave had been authorised by the responsible clinician on Section 17 Leave authorisation forms and the conditions of leave were detailed. There was evidence of regular review. All patients had signed their leave forms and had been offered copies.

In one case we saw that nurse holding powers and subsequently, doctors holding powers, had been lawfully applied. However, in this case we found that no records existed that the patient had been informed that they were now detained under the relevant section or that they had previously been detained under the holding powers. Ward staff acknowledged that they had not attempted to give the information to the patient and neither had they recorded why they had not attempted to present the information, as guided by the 2016 Mental Health Code of Practice for Wales. Staff addressed this when we brought this to their attention. Although it was acknowledged that this was a rare occurrence for the service, the mental health act coordinator advised they would provide training for staff.

Improvement needed

The service must ensure that staff are aware of their duties in regards to section 132 of the Act regarding patients' rights, in all possible situations.

We saw that in all other cases, patients rights were recorded as given and presented at appropriate intervals.

Medication was provided to patients in line with Section 58 of the Act, Consent to Treatment. Where a Second Opinion Appointed Doctor (SOAD) had been required all documentation reviewed complied with the Act.

Staff at Ty Gwyn Hall had not received training on the Mental Health (Wales) Measure 2010. HIW recommend that staff are provided with training on the Measure to ensure that they practice in line with the statutory guidance.

Improvement needed

Staff should receive training on the Mental Health (Wales) Measure 2010.

The majority of patients we spoke with were aware of why they were detained and understood that they could appeal against their detention. Patients told us that if they were refused leave, the reasons for this were explained to them and they were aware of when the decision would be reviewed.

Care planning and provision - Monitoring the Mental Health (Wales) Measure 2010

We reviewed five sets of Care and Treatment Plan documentation. Not all documentation that we reviewed was completed to an adequate standard. The following observations were identified which require urgent review and attention, given that our findings are similar to findings from previous inspections:

- There was a lack of organisation regarding patient documentation overall. Some key patient information was stored separately to the electronic system. Some disciplines continued to use paper records and did not input entries into the electronic system. An issue with scanning meant that not all relevant and important up to date information was available in one central place e.g. Speech and Language Therapy (SALT) and psychology assessments were stored elsewhere. There was a lack of notes evident by the responsible clinician. Overall this meant that it was difficult to get a clear, up to date and fully comprehensive idea of each patient's needs in an easily accessible way.

- Overall we found incomplete recording of basic information, due to some information being kept elsewhere. For example, referral information was kept on an external drive. It was difficult to find patients' personal histories and mental state examinations. In the records we reviewed these were of poor quality.

- Lack of detail on risk assessments. Although, on investigation, we were assured that risks were being reviewed and appropriately managed, there was a lack of documentation to support this.

- Evidence of appropriate nursing assessments was not easily accessible. Where we found assessments these were sometimes incomplete, e.g. one Malnutrition Universal Screening Tool (MUST) assessment did not have the corresponding tool.

- We found some care plans that were not up to date. On investigation we found that although patients' care plans were being reviewed, their original care plans were not being updated to reflect their current needs. Some notes were being added without the out of date information being removed or review notes were

being saved elsewhere. Some care plan reviews stated to 'refer to MDT notes', however, this meant that a current up-to-date indication of a patient's reviewed needs was not easily accessible.

- The care plans used did not easily match the specified domains of the Measure. We observed an MDT meeting which was very effectively organised around the domains of the Measure, however, this was not reflected in patient notes.

- Health care assistants were unable to log onto the system to enter their own notes at the time of our inspection. We were told this was being resolved.

Management staff advised that they were experiencing issues with IT systems due to the changeover of company. However, we could not be assured that staff had taken appropriate action following some of these concerns being raised during previous inspection visits. Although we did not have concerns about the standards of care being provided in practice, the systems and quality of recording patient care required considerable improvements. Management staff agreed to start working on the concerns identified immediately.

Improvement needed

Staff must take action to address the concerns identified with patient documentation as outlined in the report. These areas are as follows:

- ***Improved organisation of records and ensuring that all current, important, up to date, key information relating to all disciplines and by all involved professionals is easily accessible and stored in one central place. This must include all care plans, assessments and any other relevant notes and records.***

- ***Recording of all basic information (including personal histories and mental state examinations) must be sufficiently detailed and completed to professional standards.***

- ***Risk assessments must be sufficiently detailed and completed to professional standards.***

- ***Nursing assessments must be sufficiently detailed and completed to professional standards.***

- ***Care plans must be sufficiently detailed and completed to professional standards. Care plans, once reviewed, must be***

updated so that they provide clear information about the patient's up to date needs.

- ***Staff must ensure that care plans can demonstrate how each domain of the Measure is assessed and reviewed.***

- ***Staff must address all ongoing IT issues including lack of effective scanning facilities and health care assistants' difficulties in logging onto the electronic system.***

Although care plan audit systems were in place, they had not addressed the issues identified above. HIW therefore recommends that the system for auditing patient documentation is reviewed and an effective system implemented going forward.

Environment

Ty Gwyn Hall is located on the outskirts of Abergavenny. There is a bus stop at the end of the drive which is on a bus route which provides access into Abergavenny. The hospital is set within ample grounds and gardens. There is a separate Occupational Therapy department which houses a therapy room, kitchen and gym.

Ty Gwyn Hall is divided into three separate wards; Ty Gwyn House (which also houses the main reception, staff offices and meeting rooms), Skirrid View and Pentwyn House. Across all wards there were separate visitor rooms and dining areas. Where doors were locked, informal patients were aware of procedures in order to be able to let themselves in and out. Patients had contributed to the environments through their artwork and/or collections. Overall the environment across the hospital was clean, pleasant, and friendly and had been designed or adapted with a patient focus.

We found that on the whole, all wards were well maintained and fit for purpose and any maintenance requests were responded to promptly. However, we found the following aspects of the environment that required review:

- Although we saw that parts had been refurbished and new upholstery items supplied, certain areas of Ty Gwyn House appeared tired. We saw that on the top floor there was evidence of water penetration around the skylight. One toilet was out of order at the time of the inspection. The registered manager advised that capital funding had been secured in order to refurbish Ty Gwyn House.

- The clinic area and treatment room in Ty Gwyn House was not suitable in affording patients adequate privacy and dignity due to

part of the area having a dual use as reception. This is addressed under the medicines management section below.

- Some patients told us they felt there were not enough private areas available to them on Skirrid View and staff confirmed difficulties in managing this aspect of the environment on the ward. We saw that plans were in place to extend space on the ward with the addition of a conservatory.

- The kitchen space in Pentwyn House was particularly small and we identified risks associated with the layout of the kitchen, particularly if more than one patient was accessing this space. We advised the hospital to carry out a risk assessment for this area to ensure any environmental risks are identified and managed.

Improvement needed

Staff should review and address the aspects of the environment identified in the report, specifically:

- ***Tired aspects of Ty Gwyn House***
- ***Lack of private areas available within Skirrid View***
- ***Risk assessment of kitchen space in Pentwyn House***

Managing risk and health and safety

There were appropriate health and safety policies, procedures and working practices in place in order to promote staff, patient and visitor safety within the hospital.

We saw that environmental and fire risk assessments had been carried out and where any issues were identified, these had been actioned and addressed in a timely way. We saw evidence of fire equipment being regularly checked and serviced. We saw that portable appliance testing (PAT) was carried out on electrical items. We advised staff to make sure PAT testing records were dated.

A tour of the hospital revealed that appropriate storage, staff awareness of risks and an effective maintenance team ensured that any risks within the environment were monitored, assessed and reduced, for example, slips/trips/falls. The support services manager was passionate about their role, completed regular walkarounds to identify risks and worked effectively with staff teams.

We saw that there was a clear anti-ligature policy in place and a very thorough and detailed anti-ligature risk assessment across the whole hospital environment had been carried out with appropriate actions taken where required.

We saw that regular health and safety meetings took place and we reviewed the minutes for these. There were several points which we identified as having been ongoing for seven months and we suggested that management staff review these points to ensure that appropriate action could be taken to address and complete actions.

Infection prevention and control (IPC) and decontamination

Dedicated cleaning staff provided a high standard of cleaning services compliant with healthcare environment and patient safety core standards. There was a team of dedicated housekeeping staff in place. All areas of the hospital appeared visibly clean and hygienic throughout the inspection. There was access to hand washing and drying facilities in all ward areas.

We saw that infection control audits took place to identify and manage any infection control risks within the environment. Infection prevention and control meetings were held in order to review and progress actions.

Nutrition

The majority of patients we spoke with gave positive comments about their meals and told us they were given choices. We saw that healthy eating was promoted across the hospital.

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

As part of patient rehabilitation care, patients were encouraged and supported to cook their own meals. Where patients had Section 17 Leave authorisation they could also undertake food shopping as part of their community focused rehabilitation activities.

There were suitable facilities available to patients for hot and cold drinks and we observed patients accessing the patient kitchen facilities throughout the inspection.

Medicines management

Overall we found safe management of medicines at the hospital. There was a comprehensive medicines management policy in place and we observed staff safely administering medicines to patients.

We found medicines to be safely stored in locked cupboards and fridges across the three wards. However, we saw that there was a shortage of storage for medicines, particularly at Ty Gwyn House. We found that medication areas were multi-use due to restrictions within the current environment and therefore did not provide the most appropriate space for all aspects of medicines management. The clinic room at Ty Gwyn House was used for storing medicines, as a treatment room and also shared space with reception. There was a lack of privacy and dignity for patients accessing the clinic room and in the administration of medicines to patients in this main reception area.

Improvement needed

The registered provider must review the multi-use area at Ty Gwyn House and take action to separate clinic room/medicines management/reception functions to ensure patients are afforded appropriate privacy and dignity.

It was evident that staff monitored the temperature of the clinic fridge to ensure that medication was stored at the correct temperature as indicated by the manufacturer. However, at Ty Gwyn House we saw that two sensors were in place on one fridge, with one sensor indicating a temperature that was out of the safe range. The registered manager agreed to check and rectify this immediately.

Improvement needed

The registered provider must ensure that the temperature of the clinic fridge at Ty Gwyn House is kept within the safe range and must ensure there is a clear system in place to monitor fridge temperatures, taking action where required.

Medication Administration Records (MAR) charts we reviewed had been completed as required. There were appropriate systems in place to document the use of controlled drugs and we saw that stock levels were monitored with the manager providing an additional layer of checks.

There was an audit trail in place which demonstrated that all required emergency equipment was present and regularly checked.

Safeguarding children and safeguarding vulnerable adults

We found that staff had access to, and sufficient knowledge of, the current hospital policy on the protection of vulnerable adults. Staff had received training in the protection of vulnerable adults and children; updates were required for some staff.

There was a lead for safeguarding at the hospital and on inspection of records we found that prompt and appropriate referrals had been made to external safeguarding authorities to investigate concerns/incidents, where this was appropriate. There were also identified rooms within the service that were used when children visited.

Safe and clinically effective care

We found that care and treatment was provided in accordance with well established guidelines and relevant national and professional guidelines; reference to which was made within relevant policy documents that supported staff in their work. There was an appropriate system in place for managing and disseminating patient safety alerts to all relevant staff.

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. These arrangements still needed to be finalised under the new registered provider. However, at the time of the inspection staff had access to up to date guidance to help them care for their patients.

Information management and communications technology

Due to the changeover in company, staff were currently experiencing some difficulties with information technology systems. The hospital was currently still using systems from the old company before transferring to new systems. This meant that some aspects of systems were not functioning to an optimum level.

Improvement needed

The new registered provider must ensure that their IT systems are implemented as soon as possible so that staff can transfer from the old systems which no longer function to an optimal level.

Records management

Records used at the hospital were stored securely to prevent unauthorised access. At the time of our inspection some paper records were being archived to free up additional storage space on the wards. Arrangements were in place for electronic records to be backed up in the event of loss of data.

Quality of management and leadership

Although the hospital was in a period of transition to a new registered provider, we found clear reporting and accountability structures within the hospital and a high standard of management and leadership. There was a committed and person centred staff team who told us they felt well supported by hospital and senior management. Management were clearly responsive to staff's ideas and needs.

We found staffing levels to be appropriate to provide safe and effective care, however we advised staff to update the Statement of Purpose to more accurately reflect the staffing levels they were working to.

We found incidents and concerns to be appropriately and sensitively managed. However, record keeping required improvements in regard to incidents. Improvements were also required to ensure regulatory requirements were met in terms of the Statement of Purpose, annual returns and registered provider visits.

Workforce recruitment included suitable checks and assurances for new employees.

Governance and accountability framework

At the time of our inspection the hospital was being transferred to a new company and registered provider, Elysium Healthcare. Both staff and patients told us that this hadn't affected patient care. However, this meant that the hospital was in a period of transition and some of the policies and procedures that staff were working to still needed to be reviewed and updated to encompass arrangements under the new company.

Improvement needed

All hospital policies and procedures require review and updating to ensure they encompass new arrangements under Elysium Healthcare. New policies and procedures must be communicated to staff.

Despite the transition we found that there were clear lines of management and accountability and staff told us that senior management from Elysium Healthcare were engaging with the staff team during this transition. Clear management structures were in place which clarified the new reporting arrangements. Hospital staff told us that Elysium Healthcare had also given assurances in terms of continuing the strong value based care and support of

the hospital. For example, staff told us about intended investments with funding having been agreed for a full refurbishment programme and modernisation of the hospital's computer server. We also saw that a meeting with patients was planned imminently to discuss how to proceed in a meaningful way with patient feedback systems.

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 a 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 recorded so that they could be reviewed. At the time of the inspection hospital staff were continuing with current arrangements which we found to be robust.

Conversation with the registered manager further revealed their role in monitoring governance processes and reporting at corporate level. We found the staff team were committed to providing high standards of patient care and were open and receptive to our findings.

We found that two specific requirements in regards to quality assurance under the regulations were not being implemented; Responsible Individual six monthly visits and the completion of annual returns. We alerted staff to the need to implement these.

Improvement needed

The registered provider must carry out and document six monthly registered provider visits in accordance with regulation 28.

The registered provider must produce an annual assessment including information as specified under Regulation 19 (3).

At the time of our inspection Elysium Healthcare still needed to appoint a new Responsible Individual to hold and carry out specific duties under the regulations.

Improvement needed

Elysium Healthcare must appoint a Responsible Individual to carry out specific duties as outlined under the regulations and inform HIW of the details of the new appointment.

There was a Statement of Purpose in place but this required updating and amendments to ensure it met the requirements of Regulation 6.

Improvement needed

The Statement of Purpose must include all information as listed under Regulation 6. The service's Statement of Purpose must be updated to include:

- ***Reference to the Independent Healthcare (Wales) Regulations 2011 which have now replaced the quoted PVH regulations***
- ***Details of the responsible individual's roles and responsibilities within the organisation (Schedule 1, point 4)***
- ***The arrangements for dealing with complaints as set out in regulation 24 (Schedule 1, point 10)***
- ***New organisational structure (Schedule 1, point 6).***

We saw that HIW registration certificates were prominently displayed across all wards. However, we saw that the certificates on display at Pentwyn House were out of date.

Improvement needed

The registered provider must ensure that all HIW registration certificates displayed are the most up-to-date versions.

Dealing with concerns and managing incidents

We reviewed a small sample of incidents and concerns and although we were assured that actions were taken promptly in response, this was not always reflected in the records maintained.

Staff reported incidents through an electronic system which automatically prompted senior staff to review the incident. All incidents were then reviewed at the weekly senior management team meetings. We followed through three incidents and were assured that appropriate actions had been taken in a timely way. However, we found in two cases that incident forms either had brief or incomplete details or that staff had not indicated on the system that actions had now been completed appropriately. The registered manager agreed to implement staff training around these issues.

Improvement needed

Incident forms must be completed in sufficient detail and appropriate systems must be in place and effectively used by staff to demonstrate actions taken.

We found there was a system in place to notify HIW of any incidents which fell under Regulation 30 and 31 notifiable events. Following the inspection hospital staff liaised with HIW to ensure that incidents could be submitted electronically.

The sample of concerns and complaints we reviewed had been managed in a timely way and in an appropriate and sensitive manner. All patients we spoke with knew how to make a complaint. There was a comprehensive complaints policy in place and we saw that complaints had been managed within the timescales specified by the policy. Although the policy still referred to contacts within the old company in terms of escalation, senior management were clear in regards to their reporting lines under the new registered provider.

Workforce planning, training and organisational development

The hospital's statement of purpose included a staffing ladder which was used to ascertain staffing levels and skill mix according to the number and acuity of patients. On inspection of staff rotas we saw that there were occasions when the hospital was not meeting staffing levels as specified under the staffing ladder. We discussed this with management staff who explained that in certain circumstances, they, as a management team, provided cover as registered nurses. We saw this in practice on the first day of our inspection when there was a last minute staff absence which was filled by the clinical services manager during the morning shift.

During our inspection, staff were easily located in all areas occupied by patients and there appeared to be sufficient numbers present to meet individuals' needs. We advised the hospital management team to review the staffing ladder to more accurately capture and reflect the staffing levels they were working to and the arrangements for providing cover.

Improvement needed

Staff must ensure there is a staffing ladder in place which is accurate, up to date and which captures the current arrangements for providing cover across the hospital site during periods of staff absence. The hospital must review and amend this in their Statement of Purpose and re-submit this to HIW.

Discussions about the management of staff sickness/absence highlighted that there were suitable arrangements in place to use bank staff as and when required. The hospital had recently increased its pool of bank staff and staff told us that bank staff were offered permanent positions when they became available. We saw that agency staff had also been used in recent months. The registered manager gave assurances that this was due to a period of high levels of sickness and only agency staff who knew the setting were used.

We saw that staff appraisals took place yearly and records we reviewed were up to date. It was positive to note that the registered manager had already been set clear objectives for the year by the new registered provider. We also saw that themes from staff appraisals for the preceding year had been collated into a poster that was displayed in staff areas of the hospital. We saw that themes had been reviewed and where there had been common requests, e.g. for specific training topics, the management team had taken action to address this and provide training in those areas. This was a particularly noteworthy area. Staff were positive about the support offered to them and it was clear that management staff valued their input. There was a clear whistleblowing policy in place and staff told us they felt able to raise concerns and had confidence that concerns would be addressed.

We identified in five from the seven staff records we reviewed that there were some gaps in providing staff with regular supervision. However it was clear that informal supervision and support was offered on an ongoing basis.

Improvement needed

Management staff must ensure that staff have access to regular formal supervision and that this is recorded to demonstrate compliance.

Staff spoke positively about the training provided by Ty Gwyn Hall and the staff mandatory training records showed high completion compliance. Some staff required update training in some areas. Staff did not currently receive training in the Mental Health (Wales) Measure and this has been addressed above.

Workforce recruitment and employment practices

We looked at a sample of eight staff recruitment records which reflected that staff recruitment was open and fair. In each case there was a record of application, interview, and references being received. The registered provider validated individuals' professional qualification on appointment and continued registration with professional bodies.

Ty Gwyn Hall also undertook Disclosure and Baring Service (DBS) checks on appointment and then every three years. This assisted in providing assurance about the integrity of character of those employed by the registered provider.

At the time of our inspection there was a vacancy for a registered nurse, music therapist and for the hospital social worker. Recruitment processes were underway for these roles. It was positive to note that the new registered provider had also agreed to an additional ward manager post, with interviews taking place on the day of our inspection.

4. 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 Gwyn Hall 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.

5. Methodology

HIW inspections of mental health services seek to ensure services meet the requirements of the Independent Health Care (Wales) Regulations 2011 and National Minimum Standards (NMS) for Independent Health Care Services in Wales[1]. Where appropriate, HIW also consider how services comply with the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards.

Mental health service inspections are unannounced and we inspect and report against three themes:

- **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.

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

[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

- 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.

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[2]. These findings (where they apply) are detailed within Appendix A of the inspection report.

[2] 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.

Appendix A

Mental Health Service: Improvement Plan

Service: Ty Gwyn Hall

Date of Inspection: 11 – 12 January 2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
Quality of the patient experience					
8	The Patients' Guide must include all information as listed under Regulation 7. The service's current patient guide must be updated to include: • The terms and conditions in respect of services to be provided for patients, including as to the amount and method of payment of charges by patients for all aspects of their treatment (Regulation 7b). • Summary of the complaints procedure (Regulation 7 d). • Summary of the views of	Regulation 7	The Hospitals Patient Guide will be reviewed by the Senior Management Team. The following guide will be updated to accurately reflect: The terms and conditions in respect of services provided to patients. A summary of the complaints policy which will include an easy read version. A summary of the most recent feedback from service users.	Shaun Cooper	30/04/2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	patients and others obtained (Regulation 7e) • The most recent inspection report prepared by the registration authority or information as to how a copy of that report may be obtained (Regulation 7g).		Detailed information as to how a copy of the most recent HIW inspection report can be obtained.		
9	Staff must consistently and accurately record how they provide information to patients and how they endeavour to assist patients in understanding information.	NMS (Standard 9); Regulation 40	With the implantation of updated Carenotes and Path-Nav system staff will be able to evidence that they have provided information and how they have done so, incorporating patient's comments onto care plans and nursing assessments. There is a link on all patient related documents which staff must complete to evidence that they have offered patients copies of the information and what the outcome was.	Shaun Cooper	31/07/2017
Delivery of safe and effective care					
12	The service must ensure that staff are aware of their duties in regards to section 132 of the Act regarding	Mental Health Act (Section	Staff will complete s132 rights on Carenotes this will evidence what information the patient has been	Shaun Cooper	31/03/2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	patients' rights, in all possible situations.	132)	offered and their comments and understanding. Ward managers will audit the completion and documentation of this through live dashboards which will highlight when section 132 rights have been completed and when they are next due.		
12	Staff should receive training on the Mental Health (Wales) Measure 2010.	Mental Health (Wales) Measure 2010	Ty Gwyn Hall's Mental Health Act Administrator will produce a Mental Health (Wales) Measure training pack. The Mental Health Act Administrator will schedule training dates for relevant clinical staff within the hospital to be provided with this training. Where relevant the staff induction form will be updated to ensure that all new starters are provided with training and information in relation to the Mental Health (Wales) Measure 2010. The Mental Health Act Administrator will liaise with Elysium Healthcare to	Shaun Cooper Shaun Cooper Shaun Cooper	30/04/2017 30/04/2017 30/04/2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
			develop an e-learning module which can be added to our mandatory training. Training in the Mental Health (Wales) Measure 2010 will be refreshed annually.	Shaun Cooper	31/07/2017 Ongoing
14	Staff must take action to address the concerns identified with patient documentation as outlined in the report. These areas are as follows: □ Improved organisation of records and ensuring that all current, important, up to date, key information relating to all disciplines and by all involved professionals is easily accessible and stored in one central place. This must include all care plans, assessments and any other relevant notes and records. □ Recording of all basic information (including personal histories and mental state	Mental Health (Wales) Measure 2010 ; NMS Standard 8 ; Regulation 9 and 15	Elysium Healthcare are currently transferring Ty Gwyn Hall to an updated Electronic Health Records system. With the implementation of the updated Carenotes and Path-Nav system all patient documentation including any assessments will be stored electronically. All members of the MDT will have responsibilities to record on the systems and have documented input in Individual Care Reviews and CTP/CPA meetings.	Shaun Cooper	31/07/2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	examinations) must be sufficiently detailed and completed to professional standards. □ Risk assessments must be sufficiently detailed and completed to professional standards. □ Nursing assessments must be sufficiently detailed and completed to professional standards. □ Care plans must be sufficiently detailed and completed to professional standards. Care plans, once reviewed, must be updated so that they provide clear information about the patient's up to date needs. □ Staff must ensure that care plans can demonstrate how each domain of the Measure is assessed and reviewed. □ Staff must address all ongoing IT issues including lack of effective scanning facilities and health care assistants' difficulties in logging onto the electronic system.		Pre-admission assessment will be stored on Carenotes. On admission all relevant documentation will be completed in a detailed and professional manner and this will be audited by Ward Managers. Updated Carenotes will offer formulated risk assessments such as START, HCR20 and Escort Baseline Risk Assessment as well as PBS plans. The completion of these documents will be audited through a live dashboard. The Path-Nav element of Carenotes will offer patients input into their care plans. Care plans will be reviewed at a minimum of 4 weekly at the patients Individual Care review. All care plans on Path-Nav system are related to the domain measures. Updated IT systems are being put in place to ensure IT hardware is available and all clinical staff will have access to Carenotes and Path-	Shaun Cooper	31/07/2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	Although care plan audit systems were in place, they had not addressed the issues identified above. HIW therefore recommends that the system for auditing patient documentation is reviewed and an effective system implemented going forward.		Nav. The Carenotes compliance dashboard will be reviewed at the monthly Clinical Governance meeting where any themes or additional actions will be discussed and actioned.		
16	Staff should review and address the aspects of the environment identified in the report, specifically: □ Tired aspects of Ty Gwyn House □ Lack of private areas available within Skirrid View □ Risk assessment of kitchen space in Pentwyn House	NMS Standard 12 ; Regulation 26,40	The Support Services Manager will liaise with Elysium Estates to address the environmental issues identified within the report. This will include the following areas and provisional timescales for completion: 1. Water damage around the skylight on the 2nd Floor of Ty Gwyn House. 2. Separation of Ty Gwyn House Clinic and reception to provide for a separate medication room. 3. Provision of a conservatory to provide additional recreational space within	Shaun Cooper	31/05/2017 31/05/2017 30/09/2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
			Skirrid View. 4. Risk assessment of Pentwyn House kitchen 5. Refurbishment of Pentwyn House kitchen to improve layout and further reduce risk.		31/03/2017 30/04/2017
18	The registered provider must review the multi-use area at Ty Gwyn House and take action to separate clinic room/medicines management/reception functions to ensure patients are afforded appropriate privacy and dignity.	NMS Standard 15 ; Regulation 9, 15	The Support Services Manager will liaise with Elysium estates to develop a plan to provide a separate medication room in the Ty Gwyn House clinic.	Shaun Cooper	31/05/2017
18	The registered provider must ensure that the temperature of the clinic fridge at Ty Gwyn House is kept within the safe range and must ensure there is a clear system in place to monitor fridge temperatures, taking action where required.	NMS Standard 15 ; Regulation 9, 15	The Ward Managers will review each of the unit medication fridges. Where appropriate redundant temperature sensors will be removed. The Ward Managers will complete a weekly audit of each clinical area to ensure that fridge temperatures are accurately recorded and that any discrepancies are quickly resolved.	Shaun Cooper	31/03/2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
19	The new registered provider must ensure that their IT systems are implemented as soon as possible so that staff can transfer from the old systems which no longer function to an optimal level.	NMS Standard 19 ; Regulation 9	Elysium Healthcare are transferring all of the healthcare Information Technology systems over from our previous organisation The Hospital Director will ensure that the transfer of the CAREnotes Electronic Healthcare system is completed within the specified timescale. The Hospital Director will ensure that all staff receive appropriate training on the use of this system.	Shaun Cooper	31/07/2017
Quality of management and leadership					
21	All hospital policies and procedures require review and updating to ensure they encompass new arrangements under Elysium Healthcare. New policies and procedures must be communicated to staff.	NMS Standard 1 ; Regulation 9	Elysium Healthcare will continue to develop and issue new policies and procedures. The Hospital Director will identify a named coordinator within Ty Gwyn Halls administration team to collate all new Elysium policies and procedures as they are released. Hard copies will be placed in files on each of the units and staff will receive training and support to	Shaun Cooper	31/07/2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
			ensure they are aware of these. Ward Managers will support staff on a day to day basis with using these policies and procedures as part of their day to day practice.		
22	The registered provider must carry out and document six monthly registered provider visits in accordance with regulation 28. The registered provider must produce an annual assessment including information as specified under Regulation 19 (3).	NMS Standard 1 ; Regulation 28, 19	A regulation 28 visit was completed by Elysium Healthcare's Quality Team on the 30th and 31st January 2017. This was arranged immediately following the HIW inspection. The Hospital Manager will ensure that at a maximum of six monthly intervals that Elysium Healthcare provide and document a Regulation 28 visit. The Hospital Director will liaise with Elysium Healthcare and ensure that an Annual Assessment is provided by the organisation.	Shaun Cooper	31/03/2017
22	Elysium Healthcare must appoint a Responsible Individual to carry out specific duties as outlined under the regulations and inform HIW of the	NMS Standard 1 ; Regulation 13	Elysium Healthcare appointed Mr Steven Woolgar, Director of Policy and Regulation as the Responsible Individual for Ty Gwyn Hall.	Shaun Cooper	01/01/2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	details of the new appointment				
23	The Statement of Purpose must include all information as listed under Regulation 6. The service's Statement of Purpose must be updated to include: • Reference to the Independent Healthcare (Wales) Regulations 2011 which have now replaced the quoted PVH regulations • Details of the responsible individual's roles and responsibilities within the organisation (Schedule 1, point 4) • The arrangements for dealing with complaints as set out in regulation 24 (Schedule 1, point 10) • New organisational structure (Schedule 1, point 6).	NMS Standard 1 ; Regulation 6, Schedule 1	The Hospital Director will review and update the Hospitals Statement of Purpose to include the following: Review the contents of the Statement of Purpose and update any references around the PVH regulations to reflect that they have been replaced by the Independent Healthcare (Wales) Regulations 2011. Update information in relation to the Responsible Individual and their roles and responsibilities. Provide comprehensive information in relation to the arrangements within Ty Gwyn Hall for dealing with complaints. Include within the Statement of Purpose an updated organisational structure.	Shaun Cooper	30/4/2017
23	The registered provider must ensure that all HIW registration certificates on display are the most up to date	NMS Standard 1	All HIW registration certificates that are located within the service will be reviewed by the Support Services	Shaun Cooper	31/03/2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	versions.		Manager to ensure that they are the most up to date versions.		
24	Incident forms must be completed in sufficient detail and appropriate systems must be in place and effectively used by staff to demonstrate actions taken	NMS Standard 23 ; Regulation 19, 24	The updated reporting system IRIS will be accessible to all staff and will automatically link to Carenotes formulating a clinical entry with a log number. The system will talk staff through the process and ensure that all details are completed before the form can be confirmed. The incident will then automatically be sent to the Manager and the Health and Safety officer for their sign off and for any lessons learnt actions. A review of all incidents will be completed weekly by the Senior Management Team where any themes or additional actions will be identified. All incidents will be reviewed within the Monthly Clinical Governance meeting.	Shaun Cooper	31/07/2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
24	Staff must ensure there is a staffing ladder in place which is accurate, up to date and which captures the current arrangements for providing cover across the hospital site during periods of staff absence. The hospital must review and amend this in their Statement of Purpose and re-submit this to HIW.	NMS Standard 24 ; Regulation 20	The Hospital Director will review the current Staffing Ladder and the processes that are in place to manage periods of staff absence. Once this review has taken place the hospitals Statement of Purpose will be updated to amend any changes. A copy will then be submitted to the Health Inspectorate for Wales for their review.	Shaun Cooper	30/04/2017
25	Management staff must ensure that staff have access to regular formal supervision and that this is recorded to demonstrate compliance	NMS Standard 24 ; Regulation 20	The staff supervision timetable has been reviewed and updated. Managerial supervision will be provided by the Ward Managers for Nursing staff and Nursing staff will offer supervision to allocated Health Care Workers on a minimum monthly basis. Weekly group clinical supervision will be offered to all clinical staff by the Ward Managers. Supervision will be documented and placed in personnel files and evidenced on a database. This will be audited to ensure that	Shaun Cooper	31/05/2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
			supervision is happening regularly.		

Service representative:

Name (print): **Shaun Cooper**

Title: **Hospital Director**

Date: **14th March 2017**