Independent Mental Health Service Inspection (Unannounced)

Cefn Carnau - Sylfaen Unit, Bryntirion Unit and Derwen Unit

Elysium Health Care (No. 3) Ltd

Inspection date: 10 - 12 May 2017

Publication date: 14 August 2017

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In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@wales.gsi.gov.uk**

Fax: **0300 062 8387**
Website: **www.hiw.org.uk**

Digital ISBN 978-1-4734-9744-3

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

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection of Cefn Carnau on the evening of 10 May and days of 11 and 12 May 2017. The following wards were visited during this inspection:

- Sylfaen Unit
- Bryntirion Unit
- Derwen Unit

Our team, for the inspection comprised of one HIW inspector, two clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one lay reviewer. The inspection was led by a HIW inspection manager.

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

HIW explored how the service complied with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and met the National Minimum Standards (NMS) for Independent Health Care Services in Wales. Where appropriate, HIW also consider how services comply with the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards.

Further details about how we conduct independent mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we found evidence that the service provided safe and effective care. However, we found evidence that the requirement to use levels of agency staff at the hospital was impacting upon the delivery of safe and dignified care, in particular, on Sylfaen Unit.

This is what we found the service did well:

- Ward staff and senior management interacted and engaged with patients respectfully.
- Provided a good range of activities for patients at the hospital and in the community.
- Good physical health assessments and monitoring recorded in patient notes.
- Completed Care and Treatment Plans to reflected the domains of the Welsh Measure and these were regularly reviewed

This is what we recommend the service could improve:

- Recruit staff to vacancies which will reduce the reliance on agency staff.
- The environment of care as part of the current refurbishment programme.
- Access to personal alarms for all staff members.
- The documentation of medication on Sylfaen Unit.

We identified regulatory breaches during this inspection regarding managing risk and health and safety, medicine management and Infection prevention and control. Further details can be found in Appendix B. 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. What we found

Background of the service

Cefn Carnau is registered to provide an independent learning disability service at Cefn Carnau, Cefn Carnau Lane, Thornhill, Caerphilly, CF83 1LX.

The service was first registered on 11 December 2003. It is a mixed gender hospital with 22 beds, it consists of:

- Sylfaen Unit

  A low secure service only for a maximum 8 (eight) female adults over the age of 18 (eighteen) years diagnosed with a primary diagnosis of a learning disability and who may be liable to be detained under the Mental Health Act 1983.

- Bryntirion Unit

  A low secure service only for a maximum 8 (eight) male adults over the age of 18 (eighteen) years diagnosed with a primary diagnosis of learning disability who may be liable to be detained under the Mental Health Act 1983.

- Derwen Unit

  A low secure service only for a maximum 6 (six) male adults over the age of 18 (eighteen) years diagnosed with a primary diagnosis of learning disability who may be liable to be detained under the Mental Health Act 1983.

At the time of inspection there were 18 patients at the hospital.

The service employees a staff team which includes the hospital manager. The multi-disciplinary team includes, a consultant psychiatrist, clinical services manager, a social worker, two psychologists and psychology assistant, occupational therapist and occupational therapist assistants, art therapists, a team of registered nurses and health care assistants and a physical health nurse.

The team could also access other disciplines such as a dietician, speech and language therapy and physiotherapy.

Quality of patient experience

We spoke with patients,, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We saw staff treating patients with respect whilst providing patients with individualised rehabilitation care. We saw that staff upheld patients' rights and supported patients to be as independent as possible.

There were concerns raised by patients and staff over the high usage of agency staff which was felt impacted upon the consistency of dignified care.

Health promotion, protection and improvement were evident at the hospital, with input from various disciplines to support patients and detailed physical health monitoring.

Patients were provided with a range of up-to-date information to enable them to make choices regarding their care, treatment and wellbeing. However the hospital could improve accessibility of information by ensuring it is available in each patient's preferred language and format.

Health promotion, protection and improvement

It was evident that health promotion, protection and improvement were part of the care provided at Cefn Carnau. There was a Physical Health and Wellbeing Strategy being implemented that supported patient's physical health, this will include a patients' Wellbeing Group.

There was a physical health nurse available at the hospital one day a week. It was positive to hear that the hospital had created a new role of a full time practice nurse, which at the time of the inspection the registered provider confirmed that they were in the process of recruiting to this position.

Patients at the Cefn Carnau had hospital passports; these assist people with learning disabilities to provide staff in general hospitals with important information about the person and their physical health when they are admitted.

However, we noted that these were incomplete for five of the current patients at the hospital.

There was a dietician who attended the hospital every month or when required. The dietician inputted in to the menu choices at the hospital to assist in providing patients at the hospital with a range of balanced menu options, along with providing specialist advice for individual patient's diet.

A wide range of physical activities were available for patients within the hospital or within the community for those patients that were authorised to leave the hospital.

The hospital also provided patients with the option to participate in smoking cessation if they wished.

Dignity and respect

We observed ward staff and senior management at the hospital interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke to were enthusiastic about how they supported and cared for the patients.

We heard staff speaking with patients in calm tones throughout our inspection. There was evidence that staff addressed patients by their preferred name. We observed staff being respectful toward patients including prompt and appropriate interaction in an attempt to prevent patient behaviours escalating.

However, there were concerns raised by patients and staff regarding the quantity and quality of agency staff that impacted upon the engagement with patients and the level of care that should be provided. Senior management at the hospital clarified that if there were concerns regarding individual agency staff then they would notify the agency that the member of staff would not be used again explaining the reason(s) why.

Patients' consent was requested when we asked to view an individual patient's bedroom or sit in on patient meetings. Each patient had their own bedrooms and the hospital provided care, treatment and support to patients in gender specific units.

We observed a number of patient bedrooms and it was evident that 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.

The registered provider's Statement of Purpose also described how hospital staff would support patients in ways which would maintain their privacy and dignity.

Patient information and consent

Within the hospital there were areas where up-to-date patient information was clearly displayed. The reception area included statutory information, such as details of advocacy and HIW, along with information on operation of the hospital.

However, some of the information on display throughout the hospital could be improved to be learning disability specific and in suitable format such as easy read / pictorial. There was also limited information displayed in Welsh, we recommend that information is also displayed in Welsh for those patients whose preferred language is Welsh.

Improvement needed

The registered provider must ensure that information is available to patients in their preferred language and format.

Communicating effectively

Through our observations of staff-patient interactions it was evident that staff ensured that they communicated with patients effectively. Staff took time to undertake discussions using words and language suitable to the individual patient. Where patients remained unclear or misunderstood, staff would patiently clarify what they had said.

There were a number of meetings that involved patients and staff, this included formal individual care planning meetings and group community meetings.

For individual meetings patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. Patient families and carers were also included in some individual meetings.

There were regular documented patient meetings with senior members of staff present. Patients were able to express their views on the operation of the hospital and provide suggestions or raise concerns.

Care planning and provision

There was a clear focus on patient rehabilitation, with measured steps for discharge to a less restrictive environment.

Each patient had their own individual activity planner, this included individual and group sessions, based within the hospital and the community (when required authorisation was in place).

We saw that activities were available for patients within the hospital or in the community for those patients that were authorised to leave the hospital. Staff and patients spoke very favourably regarding the activities and the occupational therapy team.

Throughout the inspection we observed patients participating in individual and group activities within the hospital and accessing the community.

Equality, diversity and human rights

Legal documentation to detain patients under the Mental Health Act was compliant with the legislation.

Citizen engagement and feedback

The hospital provided patients with comments and complaints book on each unit to provide feedback on the care that they receive. There was also a kitchen feedback book for each of the units to provide information to the kitchen staff.

Each unit has a ward community meeting to express their views on the operation of the hospital and provide suggestions or raise concerns.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

The recent commencement of a hospital refurbishment programme evidenced that the registered provider was committed to improve the hospital environment to provide a setting that was modern and suitable for the patient group.

There were established processes and audits in place at the hospital to manage risk and safety, infection control and medicine management. This enabled staff to continue to provide safe and clinically effective care.

However, the lack of personal alarms, medication omissions on Sylfaen Unit, the high use of agency staff to maintain required levels of enhanced patient observations, impacted negatively on safety at the hospital, particularly Sylfaen Unit.

Legal documentation to detain patients under the Mental Health Act were compliant with the legislation.

Patients' Care and Treatment Plans reflected the domains of the Welsh Measure and were regularly reviewed.

Managing risk and health and safety

The registered provider had commenced a refurbishment programme for the hospital; work had commenced in the activity block with further scheduled work to refurbish each of the patient units. Although this is positive and we saw that the hospital environment was clean with environmental risk assessments to maintain safety; there were also areas throughout the hospital such as; furniture, fixtures and fittings which were worn and required repair or replacing.

As part of the refurbishment programme the registered provider stated that the furniture, fixtures and fittings would be replaced with those of the standard to meet low secure mental health and learning disability settings.

During the inspection two areas of safety risk on Bryntirion Unit were brought to our attention. We were informed that a patient had accessed the loft space entry on Bryntirion Unit and a manhole cover within the secure garden. The registered provider must confirm that all non-patient areas access points and all utility access points are secured from entry.

Access to the hospital grounds was via a secured gate controlled via intercom to reception or staff electronic key fob. All hospital buildings were also secured via key fob access.

The hospital provided staff with personal alarms at the start of each shift. At the time of the inspection there was a shortage of personal alarms meaning there was insufficient numbers for all staff at the hospital. The registered provider confirmed that additional alarms were on order and they were awaiting delivery. Arrangements were in place to ensure that no staff worked alone without an alarm.

There was an up-to-date ligature point risk assessment in place, this identified potential ligature points and what action had been taken to remove or manage these.

In the preceding weeks and at the time of our inspection the level of patient acuity on Sylfaen Unit had resulted on the requirement of high number of enhanced patient observations to manage associated patient risky behaviours. Some patients stated that they felt unsettled by other patients' behaviours and this impacted negatively on how safe they felt at the hospital.

Through observing multi-disciplinary team meetings and conversations with staff it was evident that the registered provider was managing patient behaviours appropriately whilst an alternative hospital placement was confirmed. However, the necessity to use agency staff to help fulfil the enhanced patient observation levels requirements, impacted upon the staff team's ability to provide care for all patients on the Sylfaen Unit.

Enhanced patient observation charts were not always fully complete and lacked the detail required by the registered provider's policy. Therefore they did not always record the required detail to evidence that staff were ensuring that the patient was safe and well.

Improvement needed

The registered provider must confirm that all non-patient areas are secure from unauthorised access.

The registered provider must ensure there is sufficient number of personal alarms for all staff to carry one.

The registered provider must ensure that enhanced patient observation charts are completed accurately.

Infection prevention and control (IPC) and decontamination

Throughout the inspection we observed the hospital to be visibly clean and free from clutter. Cleaning equipment was stored and organised appropriately. There were records of cleaning schedules being maintained which evidenced regular cleaning.

There were hand hygiene products available in relevant areas around the hospital; these were accompanied by signage and pictograms. Staff also had access to infection prevention and control and decontamination PPE when required. One hand gel dispenser was missing on Sylfaen Unit, this must be replaced.

There were 2.5 Full Time Equivalent (FTE) housekeepers for the hospital site. We were informed that during periods of leave cover was not provided and therefore the remaining staff had difficulty in fulfilling the required duties. This had a potential impact upon the hospital's infection prevention and control procedures. .

We noted during the first evening of our inspection one of the toilets within Bryntirion Unit had an unpleasant odour, one of the housekeepers was absent from work during this time. We also received comments from one patient that on occasions the toilet facilities are not always as clean as they could be, however they were unable to provide us with any specific dates or times.

Improvement needed

The registered provider must ensure that hand gel dispensers are in the required areas.

The registered provider must ensure that there are sufficient domestic staff resources and cover arrangements at the hospital to maintain a clean environment for patients.

Nutrition

Patients were provided with meals at the hospital which included breakfast, lunch, evening meal and super. Patients choose their meals from the hospital menu that was on a four week cycle and changed seasonally. Patients also had access to snacks along with hot and cold drinks.

There was a dietician who attended the hospital every month or when required. The dietician inputted in to the menu choices at the hospital to assist in providing patients at the hospital with a range of balanced menu options, along with providing specialist advice for individual patient's diet.

The menus were pictorial to aid patients who may have difficulty with reading. However, some of the pictures were difficult to identify due to their size or quality of the picture.

Patients and staff confirmed that kitchen staff were flexible by providing additional options or variation on menu options to meet patient needs and preferences.

There were patient kitchens on each of the wards and an occupational therapy kitchen within the activities block which enabled patients to make their own meals and develop their skills.

Patients with leave could access the community to purchase food items and ingredients. We also noted that ward staff and kitchen staff would purchase specific food items and ingredients on patient's behalf if they did not have leave.

Improvement needed

The registered provider must ensure that pictorial options on the menus are easily identifiable to assist patients.

Medicines management

Overall medicines management at the hospital was safe and effective. Medication was stored securely with cupboards and medication fridges locked. Medication trolleys were locked and secured to the wall when not in use. There was evidence that there were regular temperature checks of the medication fridge and clinic room temperature to ensure that medication was stored at the manufacture's advised temperature.

We reviewed Medication Admission Record (MAR) charts on Bryntirion Unit and Sylfaen Unit. All the MAR Charts reviewed on Bryntirion Unit contained the patients name and their mental health act legal status. Charts were consistently signed and dated when prescribed and administered, and a reason recorded when medication was not administered.

However, there were incomplete MAR charts on Sylfaen Unit with omissions on recording administration or when medication had been refused by the patient. There was also liquid medication on Sylfaen Unit that had not had its opened on date recorded; therefore staff could not confirm how long it had been opened.

It was positive to note that two patients were being supported to self medicate as part of their care plans. There were appropriate processes in place at the hospital to support this.

There were no controlled drugs stored or in use at the time of the inspection. There were Drugs Liable to Misuse and these were accurately accounted for and checked daily.

There was a regular external pharmacy audit undertaken that assisted the management, prescribing and administration of medication at the hospital. However, it was evident that errors we repeatedly being identified by the audit and not always improving the practice of staff.

Staff had access to all relevant medicine management policies at the hospital along with the current British National Formulary (BNF)[1].

[1] British National Formulary is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about individual medicines.

Improvement needed

The registered provider must ensure that all Medication Admission Record (MAR) charts are accurately completed.

The registered provider must ensure that staff record the opened on date for all liquid medication.

The registered provider must ensure that areas for improvement identified by the pharmacy audit are acted upon to improve staff practice.

Safeguarding children and safeguarding vulnerable adults

There were established processes in place to ensure that the hospital safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Medical devices, equipment and diagnostic systems

There was a clinic room on each of the units at the hospital with weekly audits of resuscitation equipment. We reviewed the audits and the resuscitation equipment on Bryntirion Unit and Sylfaen Unit and found that the audits were undertaken when required and that all resuscitation equipment was in date.

The emergency drugs for the hospital were stored in the clinic room on Sylfaen Unit. Speaking to staff, some staff were unclear whether there were emergency drugs on each unit or only Sylfaen Unit.

At the time of the inspection these had recently been moved from the nursing office on Sylfaen Unit. Some signage around the hospital was out of date and did not state the correct location of the emergency drugs; these must be updated to prevent any delay in retrieving the emergency drugs. The registered provider must ensure that all staff know where the emergency drugs are located at the hospital.

Each ward had ligature cutters that were stored in a designate place. However, the ligature cutters on Bryntirion Unit were not stored with the resuscitation equipment in the clinic room; this could cause a delay in retrieving the ligature cutters and resuscitation equipment from two separate locations. During the inspection feedback it was confirmed that additional ligature cutters would be stored with the resuscitation equipment.

Improvement needed

The registered provider must ensure that all staff know where the emergency drugs are located at the hospital.

The registered provider must ensure that all signage state the correct location for the hospital's emergency drugs.

The registered provider must confirm that there are ligature cutters are stored with the resuscitation equipment on each ward.

Safe and clinically effective care

Overall we found governance arrangements in place that helped ensure that staff at Cefn Carnau provided safe and clinically effective care. The high usage of agency staff has impacted negatively on the some patients' feelings of security and their dignity. Permanent staff also raised their concerns about the high agency staff usage and some agency staff's capabilities.

However, senior management at Cefn Carnau provide assurance that they were endeavouring to fulfil vacancies to reduce the requirement to use agency staff. They also confirmed that appropriate processes were in place to check the skillset of agency staff prior to commencing work at the hospital and arrangements to cease using individual agency staff if they performed duties poorly.

Records management

Patient records were either electronic, which were password-protected or paper files that were stored and maintained within the locked nursing office. We observed staff storing the records appropriately during our inspection.

Each patient at Cefn Carnau had several different records of care information. However following the care and treatment of an individual patient could be complex and time consuming across the individual records. The registered provider confirmed that they were reviewing the record keeping documentation to reduce the number of systems in place.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients across the three wards at Cefn Carnau.

It was evident that detentions had been applied and renewed within the requirements of the Act. Copies of legal documentation were organised appropriately within patient files.

Consent to treatment certificates were kept with the corresponding Medication Administration Record (MAR Chart). This meant staff administering medication could refer to the certificate to ensure that medication was prescribed under the consent to treatment provisions of section 58 of the Act. Where PRN medication[2] had been recorded on the MAR Charts, the reason why PRN medication was required was documented in patient notes.

There was well documented evidence of patients being provided with their statutory rights under the Act. There was evidence that some patients were supported by the advocacy service. However, the provision of information in easy read format, particularly regarding advocacy service(s), should be improved to assist some patients' understanding. This improvement was highlighted earlier in the report.

Patient risk assessments were very detailed. Section 17 leave authorisations were completed and maintained on file in date order. Where Ministry of Justice authorisation was required copies of these were maintained alongside the corresponding responsible clinician's leave authorisation.

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

We reviewed the care plans of a total of three patients.

There was evidence that care co-ordinators had been identified for the patients and where appropriate family members were involved in care planning arrangements. Care and Treatment Plans were regularly reviewed.

The Care and Treatment Plans reflected the domains of the Welsh Measure. However, it was common occurrence that staff were not documenting any unmet needs a patient may have whilst being cared for at the hospital. It is important that unmet needs are documented so that these can be regularly reviewed by the multi-disciplinary team to look at options for meeting those

[2] PRN medication is prescribed to be administered as needed and not at regular times.

needs. Documenting unmet needs will also assist the registered provider in understanding its service needs.

There were very detailed physical health assessments and monitoring recorded in patient notes, however not all patients had up-to-date Health Passports.

Improvement needed

The registered provider must ensure that patients' unmet needs are documented in their Care and Treatment Plans.

The registered provider must ensure that all patients have up-to-date Health Passports.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Independent Health Care Regulations and National Minimum Standards.

We saw good management and leadership from the multi-disciplinary team at Cefn Carnau. There was a committed staff team who appeared to have a very good understanding of the needs of the patients at the hospital.

Due to changes in ownership of Cefn Carnau the hospital was going through transition of electronic systems, therefore there was difficulty in verifying staff training and analysing incident information. However, we were assured that there had been ongoing monitoring of these areas and that this will continue when new systems are implemented.

There was high usage of agency staff at the hospital, this impacted upon the provision of care and the morale of permanent staff. The registered provider gave assurance that recruitment to vacancies was continuing to reduce the level of agency use and provide a more stable staff team.

Governance and accountability framework

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.

Identified senior managers had specific responsibilities for ensuring that the programme for governance remained at the forefront of service delivery. We found that staff were committed to providing patient care to high standards.

Since our previous inspection there had been a number of significant changes to the ownership, management and multi-disciplinary team. There had been a change in the registered provider from Priory Healthcare to Elysium Health Care (No. 3) Ltd. A new Hospital Manager had been appointed along with permanent appointments of a consultant psychiatrist and two psychologists.

There was strong multi-disciplinary team-working with staff commenting favourably on each other and stating that they felt that their views were listened to and respected by other members of staff.

It was positive that throughout the inspection that the staff at Cefn Carnau were receptive to our views, findings and recommendations.

Dealing with concerns and managing incidents

There was an incident reporting process at Cefn Carnau, at the time of the inspection the registered provider was in the process of transferring to a new incident recording system.

Senior management provided an overview of the previous system and how incidents were recorded and monitored. We could see that incidents were reviewed and identified areas for lessons learnt. It was encouraging to hear that the new incident reporting system would be able to provide detailed reports on incidents that will assist staff in identifying trends and learning from incidents. .

Workforce planning, training and organisational development

Due to the change of ownership of Cefn Carnau the system for recording and monitoring training was in the process of transition from one system to another. We reviewed the staff training records held for individual staff members and it was noted that on the whole there was high compliance with staff completing their mandatory training.

However, due to the information not being the most up-to-date we were unable to verify the mandatory training completion for staff at the hospital, with records stating that some staff members had not completed areas of mandatory training. The registered provider confirmed at the inspection feedback that they would ensure that the staff will complete the required training.

Clinical supervision and group supervision was available to staff; staff spoke favourably of these.

At the time of the inspection the hospital had five registered nurse vacancies, with two appointments being processed, additionally five health care assistant were also due to be appointed. The registered provider demonstrated that they

were actively attempting to recruit to vacancies. To cover shortfall there was a requirement to use staff overtime, bank staff and agency staff.

The use of staff overtime, bank staff and agency staff was compounded by the high level of enhanced observations in place to manage some patients' challenging behaviours. The hospital manager confirmed that the on-going recruitment programme would continue to reduce the use of agency staff as far as possible.

As stated earlier in the report, there were concerns raised by patients and staff regarding the quantity and quality of agency staff that impacted upon the engagement with patients and the level of care that could be provided. Senior management at the hospital clarified that if there were concerns regarding individual agency staff then they would notify the agency that the member of staff would not be used again explaining the reason(s) why.

Given the concerns we heard from staff and patients the registered provider should remind staff and patients that if they have concerns regarding agency staff (or permanent staff) they must bring these to the attention of the registered provider in confidence.

Some staff also stated that staff morale was low, indicating the uncertainty during the change of ownership, the level of patient acuity on Sylfaen Unit and the high level of agency usage to fulfil staffing requirements. At the inspection feedback it was positive to hear that senior management were understanding of the difficulties faced by ward staff and were open to suggestions from staff as to how to raise staff morale to the hospital.

Improvement needed

The registered provider must ensure that staff are supported to complete mandatory training.

The registered provider must ensure that vacancies are appointed to.

Workforce recruitment and employment practices

Staff explained the recruitment processes that were in place at Cefn Carnau. It was evident that there were systems in place to ensure that recruitment followed an open and fair process. Prior to employment staff references received, Disclosure and Baring Service checks were undertaken and professional qualifications checked.

The registered provider maintained agency staff files which included details of relevant training and employment checks.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

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

5. How we inspect independent mental health services

Our inspections of independent mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of independent mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005 and implementation of Deprivation of Liberty Safeguards
- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent mental health services.

Further detail about how HIW inspects mental health and independent services can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.	Not Applicable	Not Applicable	Not Applicable

Appendix B – Improvement plan

Service: Cefn Carnau

Wards: Bryntirion Unit, Dderwen Unit and Sylfaen Unit

Date of inspection: 8 - 10 May 2017

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The registered provider must ensure that information is available to patients in their preferred language and format.	9. Patient information and consent	All Patients are asked in the Pre-admission assessment what is their preferred language and this would be care planned on admission. We would allocate Welsh Speaking staff to be in the patients nursing team if that was the patients wish. Our advocate is bilingual. Information leaflets can be made available in different languages as required.	Hospital Director	Complete

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The registered provider must confirm that all non-patient areas are secure from unauthorised access.	22. Managing risk and health and safety	The loft space cover has been secured as well as the manhole cover. This has been added to the monthly Health and Safety Check list.	Director of Clinical Services	Complete
The registered provider must ensure there is sufficient number of personal alarms for all staff to carry one.	22. Managing risk and health and safety	An additional 25 Personal Alarms had been ordered and are now available for use.	Hospital Director	Complete
The registered provider must ensure that enhanced patient observation charts are accurately completed.	22. Managing risk and health and safety	The new Elysium Safe and Supportive Observation Policy has been implemented across site since the inspection and is monitored through management supervision. The observation sheets are scrutinised during Ward manager meetings on a weekly basis.	Director of Clinical Services	30 June 2017

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that hand gel dispensers are in the required areas.	13. Infection prevention and control (IPC) and decontamination	Hand Gel dispenser has been replaced on Sylfean Ward Hand Gel dispensers has been added to Environmental walk around monthly check.	Housekeeping Manager Director of Clinical Services	Complete 30 June 2017
The registered provider must ensure that there are sufficient domestic staff resources and cover arrangements at the hospital to maintain a clean environment for patients.	13. Infection prevention and control (IPC) and decontamination	If a member of housekeeping staff is on leave or is sick the remaining staff will not service the staff areas and maintain the patient areas. Staff will empty their own bins and clean their own offices.	Support Services Manager	30 June 2017
The registered provider must ensure that pictorial options on the menus are easily identifiable to assist patients.	14. Nutrition	The pictorial menus will be reviewed and revised with new pictures in a larger format.	Support Services Manager	30 June 2017
The registered provider must ensure that all Medication Administration Record (MAR) charts are accurately completed.	15. Medicines management	Elysium Clinic Room Audit will be implemented week commencing 05.06.2017; this will be completed by nursing staff and monitored by ward managers.	Director of Clinical Services	30 June 2017

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Ward managers to access Ashtons Hospital Pharmacy Services Live View on a weekly basis and action any concerns that have been identified during the Ashtons Hospital Pharmacy Services audit. Any medication errors will be managed through management supervision	Director of Clinical Services Director of Clinical Services	30 June 2017 Complete
The registered provider must ensure that staff record the opened on date for all liquid medication.	15. Medicines management	Nursing staff have been emailed reminding them, of their responsibility to label bottles when opened. Labels have been provided to staff This will be monitored through Ashtons Hospital Pharmacy Services auditing.	Director of Clinical Services	Complete
The registered provider must ensure that areas for improvement identified by the pharmacy audit are acted upon to improve staff practice.	15. Medicines management	Ward managers have access to Ashtons Hospital Pharmacy Services live view and will receive an email informing them that reports are available for viewing following an audit.	Director of Clinical Services	30 June 2017

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Monthly medication management meetings will be facilitated by Director of Clinical Services to promote learning from errors and promote improvements going forward.	Director of Clinical Services	Complete
The registered provider must ensure that all staff know where the emergency drugs are located at the hospital.	16. Medical devices, equipment and diagnostic systems	Signage has been updated and will be displayed throughout the hospital. Medical Emergency drills will be facilitated on a monthly basis.	Director of Clinical Services Director of Clinical Services	10 June 2017 Complete
The registered provider must ensure that all signage state the correct location for the hospital's emergency drugs.	16. Medical devices, equipment and diagnostic systems	Signage has been updated and will be displayed throughout the hospital.	Director of Clinical Services	10 June 2017
The registered provider must confirm that there are ligature cutters stored with the resuscitation equipment on each ward.	16. Medical devices, equipment and diagnostic systems	Location of ligature cutters is documented on resuscitation signage. There are ligature cutters stored with the resuscitation equipment on each ward and there is a list of contents on the outside of the bag.	Director of Clinical Services Director of Clinical Services	10 June 2017 10 June 2017

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that patients' unmet needs are documented in their Care and Treatment Plans.	Monitoring the Mental Health (Wales) Measure 2010	Unmet needs will be discussed in each patient's Ward Round (ICR) and documented on carenotes.	Multi-Disciplinary Team	30 June 2017
The registered provider must ensure that all patients have up-to-date Health Passports.	Monitoring the Mental Health (Wales) Measure 2010	All patient Health Passports will be reviewed and uploaded to care notes. Completion will be monitored by Ward Managers and Director of Clinical Services	Director of Clinical Services	30 June 2017
Quality of management and leadership				
The registered provider must ensure that staff are supported to complete mandatory training	Workforce planning, training and organisational development	New e-learn system has replaced old system for training via internet and recording classroom and face to face staff training. Monitored by Heads of Department and Hospital Director.	Hospital Director	30 June 2017

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that vacancies are appointed to.	Workforce planning, training and organisational development	All vacancies are advertised on the Elysium web site, other internet sites as well as attending job fairs and Universities to create interest in working at Cefn Carnau Hospital. Due to this process we currently have a full MDT in post and have offers to 4 registered nurses who complete their training in September. We have also employed 13 healthcare Assistants via this process of which 7 have commenced their role and 5 are in the recruitment process We continue recruiting to fill any deficits and bolster our bank staff	Hospital Director	30 Sep 2017 30 July 2017 On going

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Andrew Goldsworthy

Job role: Hospital Director

Date: 02/06/2017