Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

NHS Mental Health Service Inspection (Unannounced)

Ty Llidiard / Enfys Ward and Seren Ward / Cwm Taf University Health Board

Inspection date: 17 and 18 April 2018

Publication date: 19 July 2018

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Digital ISBN 978-1-78937-560-2

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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 mental health inspection of Ty Llidiard on 17 and 18 April 2018. The following wards were visited during this inspection:

- Enfys Ward
- Seren Ward

Our team, for the inspection comprised of the HIW Clinical Director, one HIW inspection manager, one HIW assistant inspection manager, two clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one lay reviewer. The inspection was led by the 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 met the Health and Care Standards (2015). Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

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

2. Summary of our inspection

Overall, we found that there were systems in place to promote safe and effective care to patients at Ty Llidiard in accordance with the Health and Care Standards.

This is what we found the service did well:

- Patients were treated with respect and kindness by the staff team
- Innovative use of technology to engage and encourage patients to provide feedback about their experiences
- Activity coordinators were employed and facilitated a range of meaningful activities for patients
- Overall, we found medicines were managed safely
- Comprehensive arrangements for the effective governance of the service were in place that took into account the Health and Care Standards.

This is what we recommend the service could improve:

- Further efforts need to be made to engage patients in meaningful activities when the activity coordinators are not working
- The arrangements for protecting patients' privacy when window curtains/coverings cannot be used
- Feedback received during the inspection indicated that improvement was needed around communication between staff and patients and their families/carers
- An ongoing programme of routine maintenance and redecoration that is completed at appropriate frequencies needs to be agreed
- Statutory documentation used in cases of compulsory admission must be in accordance with Schedule 1 of The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008
- Not all staff were up to date with mandatory training.

3. What we found

Background of the service

Ty Llidiard provides an inpatient NHS child and adolescent mental health service. The purpose built unit is located in the grounds of the Princess of Wales Hospital, Bridgend.

Ty Llidiard is a mixed gender unit with 19 beds[1]. At the time of inspection, there were nine patients, four of whom were on approved leave from the unit.

Although located within the grounds of the Princess of Wales Hospital, part of Abertawe Bro Morgannwg University Health Board, Ty Llidiard is operated by Cwm Taf University Health Board for patients from across South Wales.

[1] Whilst Ty Llidiard has 19 beds, the unit is only authorised to use 15 of these beds.

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 found that patients were treated with respect and courtesy by the staff team at Ty Llidiard.

Whilst opportunities were available for patients to engage in meaningful activities, we identified some improvement could be made in this regard.

The environment provided good facilities to promote patients' privacy and dignity. Attention needs to be given, however, to how patients' privacy can be further protected when it is necessary for window curtains/coverings to be removed for patient safety.

Whilst information was available, feedback received during the inspection indicated that improvement was needed around communication between staff and patients and their families/carers.

Arrangements were in place for patients and their families/carers to provide feedback about their experiences. These included the innovative use of technology to engage and encourage patients to provide comments.

Staying healthy

There was no health promotion material displayed within the wards to advise patients on how they could take responsibility for their own health and wellbeing.

Two activity coordinators worked at the unit. We were told that a planned activities programme was available seven days per week. Facilities and equipment for planned and ad hoc activities were available. We saw that there was a well equipped cinema room that included a large screen television, DVD player and games consoles. There was also a designated arts and crafts room, an activities room (including board games, a pool table and musical

instruments) and a lounge. An indoor sports hall and outdoor sports area were also available for patients to take part in physical activity, such as basket ball and badminton. Comments made by one patient indicated that staff did not encourage patients to use the outside areas.

Whilst an activities programme was displayed in the main reception area of the unit, this was out of date. In addition, we were told that patients did not usually spend time in the reception area and therefore would not likely see the information displayed.

Comments from patients and staff indicated there was a reliance on the activity coordinators to arrange and involve patients in activities, with few activities taking place when the coordinators were not working. During the course of our inspection, we also found that staff could have taken a more proactive approach to engaging patients in meaningful activities.

Patients of school age were encouraged to go to the school within the unit to continue their education whilst an inpatient.

Improvement needed

The health board is required to provide HIW with details of the action taken to:

- provide patients with relevant health promotion information and details of the activities available
- engage patients in appropriate and meaningful activities when the activity coordinators are not working
- encourage patients to make use of outside areas taking into account their wishes and care and safety needs.

Dignified care

Each patient had their own individual bedroom with en suite toilet and washing facilities. We saw that some patients had put their personal items in their rooms to create a more homely and personalised space where they could spend time privately. Patients told us that staff knocked their bedroom doors before entering, thus respecting their privacy. Each bedroom had a see through vision panel that could be used by staff to observe patients, without disturbing them. These would be used to check that patients were safe. Not all the bedrooms had panels that could be closed for privacy. Unit staff confirmed that, as far as possible, they would avoid using these rooms.

The unit had courtyard and garden areas that patients could use should they wish to spend time outdoors. We identified, however, that patients and visitors may be able to see into patients rooms from the courtyard areas. We discussed this with senior staff who confirmed that this had not been identified by patients and/or their families/carers as causing a problem. We saw that one bedroom did not have window curtains/coverings. This was deemed necessary to maintain the safety of the patient using the room. This arrangement, however, could have compromised patient privacy. In addition, this may not promote a restful sleeping environment due to daylight not being blocked out of the room.

All the patients we saw were appropriately dressed to maintain their dignity. We saw many examples of staff being kind to patients and treating them with respect. Patients we spoke to also told us that staff were kind to them.

We found that patients' care records were kept securely with the aim of preventing unauthorised access to confidential information. Information boards were used to record key information about patients that staff could see at a glance. These were located in an office that had restricted access. We saw that blinds were used to cover the boards when not in use to further protect confidential patient information.

Improvement needed

The health board is required to provide HIW with details of the action taken to:

- replace or repair the see through vision panels within doors
- promote patients' privacy and a restful sleeping environment when they do not have window curtains/coverings in their rooms.

Patient information

Information about advocacy services was displayed and available within the main reception area. There was no information displayed about the role of HIW and how patients could contact us. Comments from two patients indicated that they didn't know what advocacy was and were not aware of the advocacy services.

As previously described there was no health promotion material displayed within the wards and the activities programme was out of date.

Unit staff confirmed that new patients and their families/carers were provided with an information booklet. Whilst this provided useful information about the unit, we saw that information on the use of mobile phones was out of date.

Improvement needed

The health board is required to provide HIW with details of the action taken to provide:

- patients and their carers with the contact details for and information on the role of HIW
- up to date and relevant information about the unit, together with other services available (e.g. advocacy) to patients and their families/carers.

Communicating effectively

We saw that staff made efforts to communicate with patients in a way that they could understand. Comments received during the course of the inspection, however, indicated that communication between the staff team and patients and their families/carers could be improved. For example, communicating information about the next steps following a patient's admission to the unit and advice when allowed home.

There were no aids available to help patients with specific communication needs, for example a hearing loop system and use of Braille. Unit staff confirmed that arrangements would be made to support patients with specific communication needs.

Improvement needed

The health board is required to provide HIW with details of the action taken to further promote effective communication between the staff team and patients and their families/carers.

Individual care

People's rights

Not all patients were detained under the Mental Health Act (MHA). There was information displayed for informal patients[2] staying at the unit on their rights. Such patients were advised to speak with nursing staff if they wished to leave.

Unit staff confirmed that some items were restricted on the unit in the interest of patient safety. Information on restrictions, such as items and activities, was included within the information booklet.

At the time of our inspection, there was a restriction on the amount of time patients could use their mobile phones. Senior unit staff confirmed that this arrangement was in the process of being reviewed to allow patients more access.

We saw that rooms were available that patients could use to see their family and friends in private. There was also a self contained flat at the unit that could be used by patients and their families so that they could spend time together away from the ward areas. This is a very useful resource that seemed to be appreciated by patients and their families.

Listening and learning from feedback

We saw that written information on how patients could provide feedback or raise a concern about their care was displayed within the unit and available in the information booklet. We were told that an advocate was available and visited the unit weekly. Information on independent advocacy was displayed within the unit. Whilst information was displayed, this was mainly within the reception area. As previously described, we were told that patients did not usually spend time in this area.

The health board had a procedure for handling concerns (complaints) raised by patients and/or their carers. This was in accordance with Putting Things Right,

[2] An informal patient is someone who is being treated for a mental disorder in hospital and who is not detained under the Act (also sometimes known as a voluntary patient).

the arrangements for handling concerns about NHS care and treatment in Wales.

Senior staff described they were trying an innovative way to engage and encourage patients to provide feedback using an online survey tool. We saw that responses were checked regularly by senior staff with a view to identifying areas for improvement. Patients could also provide their feedback via paper questionnaires.

Delivery of safe and effective care

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

Overall, we found that there were systems in place to promote safe and effective care to patients.

The unit appeared generally well maintained. The health board needs to agree suitable arrangements to ensure that there is an ongoing programme of routine maintenance and redecoration so that work is completed at appropriate frequencies.

We found that medicines were managed safely but action needs to be taken to demonstrate that medicines requiring refrigeration are being stored at an appropriate temperature.

Statutory detention documentation showed that an appropriate process had been followed to promote and protect a patient's rights as required by the Mental Health Act. Staff responsible for completing, scrutinising and receiving statutory documentation on behalf of the health board at the time of admission under the Act must ensure that the correct prescribed forms are used in accordance with the Regulations.[3]

We found patients had Care and Treatment Plans as required by the Mental Health (Wales) Measure 2010. These were generally well organised and reflected the domains of the Measure. We identified some improvement was needed around the completeness of such plans.

[3] Schedule 1 of the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008.

Safe care

Managing risk and promoting health and safety

The unit was organised over two floors, with both wards located on the ground floor. There was level access to the main entrance and wards. A passenger lift provided access to the first floor. These arrangements allowed patients and visitors, including those with mobility difficulties, safe and easy access to the unit.

Visitors were required to enter the unit via a reception area and intercom system. This helps to deter unauthorised persons from entering the building. Access within the unit was generally restricted for safety reasons. Ward areas were spacious and there were enclosed courtyards and a garden.

Whilst the unit was operated by Cwm Taf University Health Board, responsibility for the cleaning and upkeep of the building was the responsibility of Abertawe Bro Morgannwg University Health Board. Overall, the unit appeared well maintained and systems were in place to report environmental hazards that required urgent and non urgent attention and repair. Some areas required attention, for example, there was damaged plasterwork, finger guards on doors were missing and some redecoration was required. In addition the courtyards needed weeding, the glass canopy at the entrance was dirty and parts of the guttering needed to be cleared.

Unit staff explained that there was a rolling programme of redecoration and maintenance work. In their view, however, the frequency of undertaking this work needed to be reviewed to ensure a continued safe and pleasant environment for patients and staff. In addition, we were told that patients now being referred for assessment at the unit often had more complex care needs compared to those patients that were referred when it first opened. This meant that environmental changes had been necessary, for example, the fitting of additional doors. We were told it had taken a long time for the work to be completed.

Storage rooms were locked to prevent unauthorised and accidental access by patients and visitors to the unit.

We reviewed the Care and Treatment Plans of two patients. We saw that risk assessments had been completed to help identify patients' needs in relation to promoting their safety and wellbeing. No specific written plans had been developed, however, setting out how these risks would be mitigated and managed.

The written therapeutic engagement and observation procedure in use was overdue its review. Senior staff confirmed that the policy had been revised in 2017 but had not yet been formally agreed via the health board's governance procedures. Therapeutic engagement and observation aims to promote patient safety and wellbeing.

Unit staff confirmed they had access to personal alarms to promote their personal safety whilst in work. We were told that these were not worn routinely by staff and the decision to wear them was based upon a risk assessment. Call bells were available in all bedrooms for patients and staff to use.

Senior staff provided a summary of staff training. We considered compliance with fire safety, health and safety, moving and handling, resuscitation and violence and aggression training. There was variable compliance but most nursing and therapies staff were up to date with their training. We saw that all therapies staff were up to date with moving and handling and violence and aggression training. Medical staff required update training on health and safety.

Improvement needed

The health board is required to provide HIW with details of the action taken to:

- address the maintenance and redecoration issues identified at the HIW inspection
- implement an ongoing programme of maintenance and redecoration so that work is completed at appropriate frequencies taking into account the needs of the patients accommodated at the unit
- ensure any environmental changes deemed necessary are completed in a timely way
- formally agree the revised therapeutic engagement and observation policy.

Infection prevention and control

This standard was not inspected in depth at this inspection. We saw that the unit was clean and generally tidy.

Each patient had their own room and en suite toilet and washing facilities, which helps to promote effective infection prevention and control.

Nutrition and hydration

Staff confirmed that patients had a choice of meals that could be selected from a menu. Meal and snack times were at set times during the day. Whilst food and drinks were available throughout the day, patients were encouraged to eat at the designated times.

There was a fridge in the dining room that patients could use to store food and drinks brought in from their homes. Whilst a fridge was available, families were discouraged from bringing perishable food items into the unit to reduce the risk of food-borne infections. Records were available to show when the fridge had been cleaned and the contents checked. This had not been completed regularly and we saw items being stored that had passed their 'best before' or 'use by' dates.

We saw that assessments of patients' eating and drinking needs had been completed. We also saw that care plans had been developed together with individual meal plans as appropriate to meet patients' care and treatment needs.

There were occasions when patients may need to have nasogastric (NG) tubes[4] inserted as part of their care. Training information provided by senior staff showed that most staff had received training on how to insert and on the appropriate management of NG tubes. We were told that unit staff could access advice and support from staff working on the children's ward in the nearby Princess of Wales hospital.

Improvement needed

The health board is required to provide HIW with details of the action taken to promote safe and effective food hygiene in relation to the fridge provided for patients' use.

[4] A nasogastric tube is a narrow tube passed into the stomach via the nose. It can be used for short- or medium-term nutritional support.

Medicines management

Both wards on the unit had designated treatment rooms for storing medicines. At the time of our inspection only the room on Enfys was being used. Unit staff explained that both wards shared the same treatment room for storing stock medicines and other items. When patients were accommodated on Seren, patients' own medication was stored in a lockable trolley within a lockable treatment room.

We saw that medicines were stored securely within the treatment room on Enfys. Whilst medicines requiring refrigeration were being stored in a lockable medicines fridge, temperature checks were not being done routinely with records kept. This meant that we could not be assured that these medicines were being stored at a temperature recommended by their manufacturer. The temperature of the treatment room, however, was being checked and records were available.

Staff had access to a policy that aimed to promote the safe management of medicines on the unit. Arrangements were described for the effective ordering and receipt of medicines, including medicines required in an emergency. Pharmacy staff were available to provide help and advice to unit staff on the medicines used at the unit.

An up to date rapid tranquillisation policy was in place. This aimed to promote the safe use of tranquillisation medicine.

We reviewed a sample of patients' drug charts and saw that these had been completed fully to show the medicines administered by nursing staff. Patients' identification details had been recorded together with their MHA legal status. This information helps ensure patients' receive the correct medication and that their rights are protected.

Staff explained that patients' drug charts were checked throughout the day. This was with the aim of ensuring that all the medication administered had been signed for or, in the event of non administration, the reason why. This system was used mainly to identify areas for improvement around the completion of drug charts but it also provided an opportunity for any queries around the administration of medication to be highlighted and discussed. The unit staff may wish to consider conducting these checks at staff handovers so that any queries or omissions can be dealt with immediately.

We found that patients had individualised medicine management plans and that their medicines were regularly reviewed to determine that they remained appropriate according to patients' care needs.

Improvement needed

The health board is required to provide HIW with details of the action taken to demonstrate that medicines requiring refrigeration are stored at an appropriate temperature.

Consideration must be given to Patient Safety Notice: PSN 015 / July 2015 The storage of medicines: Refrigerators

Safeguarding children and adults at risk

The unit provided care to children and adolescents only. Senior staff confirmed that written procedures were in place to promote and protect the welfare and safety of children. We saw that these were available to staff via the health board's intranet. Staff we spoke to confirmed that the intranet had recently being updated and staff experienced some difficulty in locating policies and procedures.

Training information provided by senior staff showed that all therapies and medical staff and most nursing staff were up to date with safeguarding children training. Most therapies and nursing staff were up to date with safeguarding adults training but medical staff required update training.

Medical devices, equipment and diagnostic systems

Staff confirmed that emergency equipment for responding to a patient emergency (collapse) was stored within grab bags located in the treatment rooms on both Enfys and Seren. We were told that in the event of a patient collapse, unit staff would contact 999 and administer immediate life support until the emergency ambulance arrived.

We considered the arrangements on Enfys and saw that a grab bag was readily available within the locked treatment room. Records showed that daily checks had been made of the grab bag to check that the security seal was intact. Checks of individual items were not made. We were told that provided the seal was intact, staff could assume that a full set of equipment was available and suitable for use.

Training information provided by senior staff showed that most nursing and therapies staff were up to date with resuscitation training. All medical staff were up to date.

Ligature cutters were readily available. These were stored separately to the grab bags. Given that both the ligature cutters and the grab bags may be

needed at the same time, the health board may wish to consider storing these together, subject to a suitable risk assessment being completed. We discussed this with senior staff during the inspection. They were receptive to our comments and they agreed to explore this option further.

Effective care

Safe and clinically effective care

A range of written policies and procedures were available to instruct and guide staff on providing safe care and effective care. These were available as electronic versions on the health board's intranet and as paper copies on the wards. Staff we spoke to were unsure of whether the paper copies were up to date. There was no auditable system to show that staff had read and understood updates to policies.

Our findings in relation to the other arrangements in place and their effectiveness are described throughout this section - Delivery of safe and effective care.

Improvement needed

The health board is required to provide HIW with details of the action taken to satisfy itself that staff are referring to current policies,

Record keeping

We found that records held at the unit were kept securely when not being used. Staff knew where to find relevant records and were able to provide these in a timely way when requested.

Overall, we saw good record keeping practice within the sample of Care and Treatment Plans and observation records we reviewed. Staff had not always printed their names in addition to signing for entries made within the Care and Treatment Plans. Printing a name would make it easier to identify the person making the entry and is an expected aspect of professional record keeping practice.

Improvement needed

The health board is required to provide HIW with details of the action taken to further promote standards associated with professional record keeping.

Mental Health Act Monitoring

We reviewed the statutory detention documents of one of the patients on Enfys ward.

The documentation was easily accessible for review and stored securely. Whilst information could be accessed electronically by the health board's Mental Health Act team, this facility was not available within the unit.

The documentation showed that an appropriate process had been followed to promote and protect the patient's rights as required by the Act. We identified, however, that an incorrect form had been completed[5] as part of the application to detain the patient. This meant that the patient's detention was invalid. We informed the Mental Health Act Administrator of our findings and the matter was rectified quickly and efficiently.

Whilst the documentation indicated that an assessment had been conducted by the Approved Mental Health Professional (AMHP), a copy was not available on the patient's file. This is an important document that contains key information relating to the application to detain a patient. Again we informed the Mental Health Act administrator of our findings so that arrangements could be made to address this.

The unit did not have a clerk to support staff to effectively maintain legal and other documentation used on the unit. The appointment of a suitably trained

[5] A statutory section 2 medical recommendation form for admission for assessment had been completed by the registered medical practitioner when, under the circumstances the application was for emergency admission under section 4 due to the urgent necessity for the patient to be admitted and detained under section 2 of the Act and compliance with the provisions relating to applications under that section would involve undesirable delay.

ward clerk would help ensure that documentation, particularly pertaining to the Mental Health Act, is complete and retained in appropriate order.

Unit staff confirmed that verbal and written information about a patient's detention is provided to the patient. We were also able to confirm that detained patients have access to an independent advocacy service in accordance with their legal rights.

Copies of the Mental Health Act 1983 Code of Practice for Wales (both Welsh and English language versions) were readily available for staff, patients, relatives and other interested parties, which is commendable.

Training information provided by senior staff showed that most staff required update training on the Mental Health Act. Senior staff described difficulty in being able to access such training.

Improvement needed

The health board is required to provide HIW with details of the action taken to:

- ensure that the correct statutory detention documents are completed by relevant staff
- support staff to effectively maintain legal and other documentation used on the unit.

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

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

Both patients had Care and Treatment Plans (CTPs) as required by the Mental Health (Wales) Measure 2010. These were generally well organised with the different sections of the plans easily identifiable. The CTPs reflected the domains of the Measure.

We saw that relevant assessments had been completed to help inform and develop individualised CTPs that were outcome based and patient recovery focussed. As described previously risk assessments had been completed, however, specific written plans had not been developed setting out how these risks would be mitigated and managed. In addition, the patients' unmet needs were not identified. 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 needs.

We found that staff made efforts to involve patients and their families (where appropriate) in the development of patients' CTPs.

Whilst dates for reviewing the CTPs had been clearly identified, entries within the CTPs showed they had not always been reviewed by the due date. At the time of our inspection, a review of the CTP for one of the patients was overdue.

Each patient had a care coordinator identified as required by the Measure.

Senior staff described difficulties in obtaining care and treatment plan information from community based mental health teams. This meant that sometimes a new CTP needed to be developed when patients were admitted to the unit, without all the relevant information being readily available. This was described as an ongoing issue and senior staff were taking continued action to rectify this.

Improvement needed

The health board is required to provide HIW with details of the action taken to:

- ensure appropriate plans are developed in response to findings from risk assessments
- ensure patients' unmet needs are identified and recorded with CTPs
- CTPs are reviewed in accordance with their identified review dates.

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 Health and Care Standards.

A management structure was in place and clear lines of reporting and accountability were demonstrated.

Comprehensive arrangements for the effective governance of the service were described that took into account the Health and Care Standards.

We found that staff were expected to complete training on a range of topics relevant to their roles. Not all staff were up to date, however, with mandatory training.

Governance, leadership and accountability

A local management structure was in place and clear lines of reporting and accountability were demonstrated.

Ty Llidiard provides inpatient care and is part of the South Wales CAMHS network. The network is made up of four localities providing different levels of mental health services for children and young people. Senior staff described a system of meetings that formed part of the governance arrangements for each locality. Information from these is then brought together and shared at quarterly meetings as part of the overall governance arrangements for the network. There were also subgroups for audit, safeguarding, training, risk management and health and safety. We were told that these subgroups provide updates to the quarterly governance meeting.

A number of local audits were described as being performed to identify areas for improvement. This included activity in relation to medicines management, record keeping and the environment. We saw records demonstrating this process.

Ty Llidiard participates in the Quality Network for Inpatient CAMHS (QNIC) scheme[6]. This aims to demonstrate and improve the quality of inpatient child and adolescent psychiatric in-patient care through a system of review against the QNIC service standards. This process follows a clinical audit cycle with self-review and peer-review.

During the course of our inspection, senior staff were visible and provided support to the staff team. They were also receptive to our comments and demonstrated a commitment to learn from the inspection and to make improvements as appropriate.

We spoke to a small number of staff. Comments we received indicated there was sometimes a lack of clarity around the delegation of duties. This meant they were unclear who had responsibility for ensuring work related tasks were followed up or completed. In addition, comments also indicated that whilst staff knew the names of managers, they were not always sure who they were.

Suitable arrangements were described for reporting, recording and investigating incidents together with sharing learning from such incidents and concerns. This helps to promote patient safety and continuous improvement of the service provided.

Improvement needed

The health board is required to provide HIW with details of the action taken to:

- ensure staff are aware of each others' specific roles and responsibilities on a day to day basis
- promote staff awareness of the managers and their roles and responsibilities.

[6] Quality Network for Inpatient CAMHS

https://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualitynetworks/childandadolescent/inpatientcamhsqnic.aspx

Staff and resources

Workforce

The staffing levels and skill mix appeared appropriate to meet the assessed needs of the patients accommodated on the unit at the time of our inspection.

Senior staff confirmed that there were a number of nursing staff vacancies and explained that considerable efforts had been made to recruit to these posts. At the time of our inspection the majority of posts had been filled but staff had yet to take up their posts. Staff recruitment was managed centrally via the health board.

Senior staff also confirmed that, when needed, agency and bank staff were used to cover any shortfalls in staffing. We were told that efforts were made to use the same staff to promote continuity of care to patients. We saw records demonstrating that new staff (including agency and bank staff) had received an induction when they first worked on the unit. This helped ensure that new staff were familiar with local procedures.

We observed part of a ward round. This included members of the multi-disciplinary team attached to the unit. Effective multi-disciplinary team working was demonstrated.

Training information provided by senior staff showed that staff were expected to complete mandatory training on a range of topics relevant to their roles. Training compliance was regularly monitored by managers. At the time of our inspection the information supplied showed that compliance ranged from nil percent to 100 percent. This included medical, nursing and therapies staff. Our specific findings in this regard can be found throughout section - Delivery of safe and effective care.

We also saw that there was a system for staff appraisal. Appraisals help to identify training needs and provide an opportunity for staff to receive feedback on their work performance. Staff appraisal compliance was regularly monitored by managers. At the time of our inspection, most nursing and therapies staff were reported to have had an appraisal within the last year.

Improvement needed

The health board is required to provide HIW with details of the action taken to support staff to complete training relevant to their role.

Consideration must be given to improving compliance with resuscitation,

safeguarding, health and safety and Mental Health Act training.

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 immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: 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

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 NHS mental health services

Our inspections of NHS 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 NHS mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Meet the Health and Care Standards 2015

We also consider other professional standards and guidance as applicable. These inspections capture a snapshot of the standards of care within NHS mental health services.

Further detail about how HIW inspects mental health and the NHS 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 during the inspection.	-	-	-

Appendix B – Immediate improvement plan

Service: Ty Llidiard

Ward/unit(s): Enfys Ward and Seren Ward

Date of inspection: 17 and 18 April 2018

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No immediate improvement plan was required.	-	-	-	-

Appendix C – Improvement plan

Service: Ty Llidiard

Ward/unit(s): Enfys Ward and Seren Ward

Date of inspection: 17 and 18 April 2018

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	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board is required to provide HIW with details of the action taken to: • provide patients with relevant health promotion information and details of the activities available • engage patients in appropriate and meaningful activities when the activity coordinators are not working • encourage patients to make use of outside areas taking into account their	1.1 Health promotion, protection and improvement	• Format of ward management plans to be reviewed to ensure that health promotion and well-being is clearly incorporated and included as part of assessment for admission • Other units to be contacted for information regarding available nutritional screens so that the most appropriate can be identified and implemented	Ward Manager Lead Dietician	Complete 31.08.18

Improvement needed	Standard	Service action	Responsible officer	Timescale
wishes and care and safety needs.		• Weekly health promotion group attended by Dietician, Psychologist, Nurse and patients established • Ensure that therapies/ school timetable is available on patient noticeboard • Ward Manager and Activities Coordinator to review activities timetable to ensure that there are meaningful activities when young people are unable to attend therapies/ school or when therapies/ school are not running. This work to include- -discussion in patient community meeting to ensure involvement of young people in developing the programme -wider staff team to be engaged in delivery of the programme -use of outside areas -method of monitoring attendance	Lead Psychologist Lead Psychologist Ward Manager	Complete Complete 31.08.18

Improvement needed	Standard	Service action	Responsible officer	Timescale
		of young people		
The health board is required to provide HIW with details of the action take to: • replace or repair see through vision panels within doors • promote patients' privacy and a restful sleeping environment when they do not have window curtains/coverings in their rooms.	4.1 Dignified Care	• Vision panels to be fitted in patient bedrooms • Request through QNIC advice from other units as to any innovative solutions that have been identified for the replacement of curtains when it is not safe to have these in patient rooms. Should any have potential for Ty Llidiard, to urgently progress associated bids • Review costs to fit windows with in-built blinds	Locality Manager Senior Nurse Locality Manager	Complete 30.06.18 31.07.18
The health board is required to provide HIW with details of the action taken to provide: • patients and their carers with the contact details for and information on the role of HIW • up to date and relevant information about the unit, together with other	4.2 Patient Information	• Booklets / information to be requested from HIW • Ty Llidiard patient information booklet to be reviewed to incorporate up to date and relevant information about the unit, together with other services available (e.g. advocacy) and	Locality Manager Ward Manager	Complete 31.08.18

Improvement needed	Standard	Service action	Responsible officer	Timescale
services available (e.g. advocacy) to patients and their families/carers.		paragraph regarding the role of HIW and contact details • Explore the potential to develop a video providing information about the unit that can be linked to via the website.	Senior Nurse	31.12.18
The health board is required to provide HIW with details of the action taken to further promote effective communication between the staff team and patients and their families/carers.	3.2 Communicating effectively	• All families to be offered a meeting within 72 hours of admission and a review meeting with patient and family within 2 weeks. To be audited on a quarterly basis. • Non Violence Resistance (NVR) groups to continue to be offered to families, with next group planned for June 2018 • Nurse in Charge or delegated clinician to meet with families prior to home leave to discuss plan of care. As part of this discussion, feedback forms to be given to families to complete and return following period of home	Ward Manager Ward Manager/ Family Therapist Ward Manager	Complete/ ongoing Ongoing 30.06.18

Improvement needed	Standard	Service action	Responsible officer	Timescale
		leave		
Delivery of safe and effective care				
The health board is required to provide HIW with details of the action taken to: • address the maintenance and redecoration issues identified at the HIW inspection • implement an ongoing programme of maintenance and redecoration so that work is completed at appropriate frequencies taking into account the needs of the patients accommodated at the unit • ensure any environmental changes deemed necessary are completed in a timely way • formally agree the revised therapeutic engagement and observation policy.	2.1 Managing risk and promoting health and safety	• Develop a regular report of jobs requested, timeframe for completion and outstanding jobs. Escalate to Directorate Manager where delays encountered. • Organise meeting with ABM UHB to discuss SLA and requirement to add additional detail to this e.g. programme of maintenance and redecoration, agreed timeframe for jobs to be completed • Updated observation policy has now been ratified through CAMHS Governance meeting and discussed in Ty Llidiard Nurses meeting. Confirmation from all nurses via individual signature being sought to confirm awareness of updated policy	Locality Manager/ Directorate Manager Directorate Manager Ward Manager	30.06.18 31.07.18 30.06.18

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken to promote safe and effective food hygiene in relation to the fridge provided for patients' use.	2.5 Nutrition and Hydration	• Patient fridge to be checked as part of environmental checks and compliance with this to be audited monthly	Ward Manager	Complete/ ongoing
The health board is required to provide HIW with details of the action taken to demonstrate that medicines requiring refrigeration are stored at an appropriate temperature. Consideration must be given to Patient Safety Notice: PSN 015 / July 2015 The storage of medicines: Refrigerators	2.6 Medicines Management	• Fridge temperature to be recorded daily and compliance with this to be audited monthly	Ward Manager	Complete/ ongoing
The health board is required to provide HIW with details of the action taken to satisfy itself that staff are referring to current policies,	3.1 Safe and Clinically Effective care	• Staff sign to confirm knowledge of policies at induction. New/ updated policies to be discussed in staff meetings and made available in staff areas and on the shared drive where all policies are saved. • All new/ updated policies to require signature from all staff to confirm knowledge of this.	Senior Nurse Senior Nurse, Lead Clinician, Lead Therapist	Complete/ ongoing Complete/ ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken to further promote standards associated with professional record keeping.	3.5 Record keeping	• Written message to be circulated to all staff to confirm requirement for names to be clearly written in Medical Records • Training sessions to be organised for all staff regarding record keeping • Notes to be audited every 6 months • Work with Informatics re: implementation of digital records	Clinical Director Lead Psychologist Ward Manager Senior Nurse	30.06.18 31.08.18 31.08.18/ ongoing 31.03.19
The health board is required to provide HIW with details of the action taken to: • ensure that the correct statutory detention documents are completed by relevant staff • support staff to effectively maintain legal and other documentation used on the unit.	Application of the Mental Health Act	• Nurse in charge on shift to check MHA paperwork for new admissions *(see actions below re: MHA training for staff)* • Progress bid for ward clerk to support paperwork and processes	Nurse in charge Directorate Manager	Complete/ ongoing 31.07.18

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken to: • ensure appropriate plans are developed in response to findings from risk assessments • ensure patients' unmet needs are identified and recorded with CTPs • CTPs are reviewed in accordance with their identified review dates.	Monitoring the Mental Health Measure	• WARRN risk assessment to be provided on admission or in emergency cases within 2 days, referrers to be reminded of this requirement • Individual WARRN risk assessment to be completed by Key Worker on admission, to include clear plans to manage and reduce risks, for review and discussion in weekly MDTs • CTPs to be completed by referring community teams on admission or within 2 weeks for patients no known to these services. Community teams to be reminded of this responsibility. • CTPs to be reviewed as part of patient assessment review, within 2 weeks of admission. Community teams to be reminded of this responsibility. • CTPs to be regularly reviewed,	Senior Nurse Ward Manager Directorate Manager Directorate Manager Directorate	Complete Complete/ ongoing 30.06.18 30.06.18 30.06.18

Improvement needed	Standard	Service action	Responsible officer	Timescale
		generally every 4 weeks, Community teams to be reminded of this responsibility. • Audit sheet to be completed for each patient and reviewed in each MDT meeting to ensure compliance.	Manager Psychology Lead	 31.07.18
Quality of management and leadership				
The health board is required to provide HIW with details of the action taken to: • ensure staff are aware of each others' specific roles and responsibilities on a day to day basis • promote staff awareness of the managers and their roles and responsibilities.	Governance, Leadership and Accountability	• Shift coordinator to ensure that all staff are clear of roles and responsibilities at handover meetings for each shift, with a form completed at each meeting confirming this and written on the staff information board in nurses office • Organisational chart to be displayed in staff room with pictures of senior staff	Ward Manager Locality Manager	Complete 31.07.18
The health board is required to provide HIW with details of the action taken to support staff to	7.1 Workforce	• Current position with electronically captured training		

Improvement needed	Standard	Service action	Responsible officer	Timescale
complete training relevant to their role. Consideration must be given to improving compliance with resuscitation, safeguarding, health and safety and Mental Health Act training.		(as at 01.06.18)- - Resuscitation – 86% - Health and Safety – 84% - Safeguarding children – 96% • Compliance with mandatory training will be monitored, discussed and escalated through all staff PDRs to ensure compliance • Log of staff training to be updated • Liaison with training departments for dates and staff booked into available sessions • Liaise with MHA office around provision of training dates • An escalation process to Head of Nursing when staff are unable to be released for booked training due to service pressures to be devised and implemented and audited on an ongoing basis.	Ward Manager, Lead Psychologist Locality Manager Locality Manager Directorate Manager Head of Nursing	Ongoing Ongoing Complete 30.06.18 30.06.18

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): **Chris Coslett**

Job role: **Directorate Manager**

Date: **12.06.18**