Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Cefn Carnau - Bryntirion Unit, Derwen Unit and Sylfaen Unit

Elysium Health Care (No. 3) Ltd

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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 13 August and days of 14 and 15 August 2018. The following sites and wards were visited during this inspection:

- Sylfaen Unit
- Bryntirion Unit
- Derwen Unit

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

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 Health (Wales) Measure (2010), Mental Capacity Act (2005) 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

We found a service that had improved since our previous inspection when it was in transition of ownership and which had impacted negatively upon staff morale.

On the whole the registered provider had progressed on the areas of improvement. However, leading up to this inspection there continued to be a reliance on agency staff to fulfil rotas, although continued recruitment was addressing this.

The registered provider is required to review its policies and processes for providing care to those patients that are not detained under the Mental Health Act. .

This is what we found the service did well:

- Maintained an environment of care that was appropriate for the patient group
- Activities within the hospital and community supported patients to maintain and develop skills
- Established governance arrangements that provided safe and clinically effective care
- On the whole staff interacted and engaged with patients respectfully
- Patient records were written to a high professional standard.

This is what we recommend the service could improve:

- Mandatory training in some essential skills
- Documenting the use of holding powers under Mental Health Act
- Policies and procedures for patients who are not detained under the Mental Health Act
- The effectiveness of medicine management audits.

We identified regulatory breaches during this inspection regarding medicine management, workforce (mandatory) training and recordkeeping (with regards to the Mental Health Act). 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 21 patients at the hospital.

The hospital director is the registered manager for the service. The multi-disciplinary team includes a consultant psychiatrist, clinical services manager, a social worker, psychology and therapy teams, a physical health team, along with a team of registered nurses and health care assistants.

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 observed, and patients we spoke with confirmed, that on the whole staff interacted and engaged with patients appropriately and treated patients with dignity and respect. However there were some concerns raised regarding unprofessional behaviours of some staff.

There were a range of suitable activities and therapies available at Cefn Carnau and within the community.

Health promotion, protection and improvement were evident at the hospital, with input from various disciplines to support patients and detailed physical health monitoring. However additional information should be displayed on the wards.

Health promotion, protection and improvement

Health promotion, protection and improvement were part of the care provided at Cefn Carnau. The Physical Health and Wellbeing Strategy supported patient's physical health; this included physical health and wellbeing initiatives.

Since our previous inspection the provider had recruited a full time practice nurse which was a positive addition to the physical health team which included regular attendance from a GP throughout the week.

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.

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. They also provided specialist advice to respond to patients' specific dietary requirements.

Cefn Carnau had a range of facilities to support the provision of therapies and activities along with regular access to the community for those patients that were authorised to leave the hospital.

Patients were engaged and supported in undertaking Activities of Daily Living[1] that promoted recovery and rehabilitation, such as preparing meals and other domestic activities.

The hospital had an occupational therapy kitchen which patients could access to prepare meals and a laundry room with a washing machine and tumble drier so that patients could learn and maintain their skills.

The hospital had a gym which patients could use. Patients with leave from the hospital also accessed gym and other leisure facilities within the local community.

There were three designated hospital vehicles; these assisted staff to facilitate patient activities, voluntary work placements and medical appointments in the community.

It was positive to note that patients had access and were encouraged to participate in educational programmes. This included classes facilitated within the hospital and also accessing courses in the community. The hospital had developed a hospital library since our previous inspection.

There was information displayed at the hospital for patients which included details on how to raise a complaint and contact external organisations such as Healthcare Inspectorate Wales and details on the advocacy arrangements available. However, the service could improve the range of information displayed for patients to include further information on health promotion. There was also limited information displayed or readily available to patients either in Easy Read or Welsh.

Due to an incident where a patient removed information on Sylfaen Unit there was limited information on display throughout the inspection on this ward.

[1] These activities can include everyday tasks such as dressing, self-feeding, bathing, laundry, and meal preparation.

Improvement needed

The registered provider must increase the range of information displayed for patients to include more on health promotion.

The registered provider must ensure that information is displayed and available in a suitable format for patients, such as Easy Read and Welsh.

The registered provider must ensure that patient information displays are appropriately secured.

Dignity and respect

We observed that all employees: ward staff, senior management and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients.

We heard staff speaking with patients in calm tones throughout our inspection. We observed staff being respectful toward patients; when patients approached staff members, they were met with polite and responsive caring attitudes. On the whole patients we spoke with agreed that they were treated with dignity and respect at hospital.

However, some patients on Sylfaen Unit raised concerns about overhearing staff conversations within patient areas of the ward that were inappropriate and unprofessional. These included discussions regarding staff's personal circumstances or confidential information about other patients. The ward manager evidenced that the concerns were being reviewed and assured us that appropriate action would be taken.

Each patient had their own bedroom which they could access throughout the day; the bedrooms provided patients with a good standard of privacy. Patients were able to lock their own bedrooms which staff could over-ride if required. 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.

The hospital had suitable rooms for patients to meet ward staff and other healthcare professionals in private. There were visiting arrangements in place for patients to meet visitors at the hospital. However, some rooms were unkempt with unwanted items and the toys for children visitors were inappropriately stored.

Improvement needed

The registered provider must ensure that unwanted items are not discarded in communal rooms.

The registered provider must ensure that toys for children visitors are appropriately stored.

Patient information and consent

As detailed above there was information displayed for patients at the hospital. However, an increase in the range of information formats is required to best meet the needs of the patient group.

Communicating effectively

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

Each ward had daily morning meetings to arrange the activities, within the hospital and the community, alongside other activities and meetings, such as care planning meetings, medical appointments and tribunals. Patients also had the opportunity to provide feedback on the care they receive at the hospital and discuss any developments or concerns.

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. With patients' agreement, their families and/or carers could also be present.

Patients that we spoke with confirmed that staff communicated clearly and that they understood their care. Patients also felt listened to and that with the electronic records for care reviews patients could see that their views were being included and considered.

We attended a number of clinical meetings and it was evident that discussions focused on what was best for the individual patient. Where the patient was present at the meeting all staff engaged respectfully and listened to the patient's views and provided the patient with clear reasons for the decisions taken.

Care planning and provision

There was a clear focus on providing safe and effective care for patients, with measured steps for discharge to a less restrictive environment. Care was individualised, focused on recovery and was supported by least restrictive practices, both in care planning and ward or hospital practices. However, details of discharge arrangements for one patient whose discharge was imminent were not recorded in the Care and Treatment Plan and the electronic records did not include information about the community care coordinator and the patient's discharge support team.

Each patient had their own programme of care based on their individual needs such as medication, therapy sessions and activities. These included individual and group sessions, based within the hospital and the community (when required authorisation was in place).

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

Equality, diversity and human rights

Staff practices aligned to established hospital policies and systems ensured that the patients' equality, diversity and rights were maintained. Statistics evidenced that 94% of staff were up-to-date with applicable training.

However, we identified areas for improvement in the application of the Mental Health Act (the Act); this is detailed further later in the report

Citizen engagement and feedback

There were the opportunities for patients, relatives and carers to provide feedback on the care provided at the hospital; this included individual and communal meetings.

Each ward had a complaints book to log informal complaints and the outcome of the complaint. Formal complaints were logged electronically documenting the progress and outcome of the complaint. The registered provider's governance arrangements allowed for analysis of complaints and to monitor the handling of complaints in line with the registered provider's policy.

Patients we spoke with said that they felt comfortable in discussing any concerns with staff members and that they knew how to raise a complaint if required. However, information on how to raise a complaint was not displayed on all wards.

As stated earlier each ward had a daily meeting where patients could raise any concerns that they had. There were also minuted monthly hospital Patient

Council meetings which had patient ward representatives and senior hospital managers in attendance. The registered provider also held a Welsh Site Service User Forum, roughly every quarter. This provided an opportunity for patients and staff from hospitals within the organisation to discuss what was going on in their own hospitals and provide an opportunity to share learning.

Improvement needed

The registered provider must ensure that information on how to raise a complaint is clearly displayed on all wards.

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 refurbishment of the hospital had provided a well maintained and suitably furnished environment with furniture, fixtures and fittings appropriate 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.

There are specific areas of improvement required in the use of the Mental Health Act and completion of associated documentation.

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

Managing risk and health and safety

Cefn Carnau had established processes in place to manage and review risks and to maintain health and safety at the hospital. This enabled staff to continue to provide safe and clinically effective care.

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

Staff wore personal alarms which they could use to call for assistance if required. There were also nurse call points around the hospital and within patient bedrooms so that patients could summon assistance if required.

The refurbishment of the hospital, which had commenced at the time of our previous inspection, had been completed. As a result ward environments looked well maintained and suitably furnished. The furniture, fixtures and fittings at the hospital were appropriate for the patient group.

There was a ligature point risk assessment in place, this identified potential ligature points and what action had been taken to remove or manage these. This was due for review in the month following our inspection.

Staff confirmed that the number of incidents had reduced in the previous months. The clinical records, including the incident recording system, evidenced this, clearly documenting each incident and how they were managed.

The training statistics provided evidenced that 63% of nursing staff were up to date with Breakaway Training and Management of Violence and Aggression Training but only 40% of healthcare support workers had completed these. 79% of nursing staff had completed their Immediate Life Support training. The registered provider evidenced that forthcoming training sessions were in place to provide staff with update training in these areas.

The hospital Security Lead held monthly Security Committee meetings. The meetings reviewed and addressed security incidents arising during the previous month and other matters arising at the hospital.

Improvement needed

The registered provider must confirm that the hospital ligature point audit is reviewed and completed within the required timescales.

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 personal protective equipment (PPE) when required.

Training statistics evidenced that 85% of clinical staff had completed levels 1 and 2 of Infection Control training and 100% of support staff had completed level 1.

We received comments from some patients that on occasions the toilet and shower facilities were not always as clean as they could be. We noted that

some toilets and showers were stained. The kitchen windowsill on Sylfaen Unit was also in need of attention.

Improvement needed

The registered provider must ensure that showers and toilets are maintained to an appropriate standard of cleanliness.

The registered provider must repair or replace the kitchen windowsill on Sylfaen Unit.

Nutrition

Patients were provided with meals at the hospital which included breakfast, lunch, evening meal and supper. 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 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 and we could see that these had improved in appearance since our previous inspection.

Patients give mixed views on the meals provided at the hospital. Some patients complained that food was repetitive and there was limited choice to meet their tastes. Other patients and staff confirmed that kitchen staff were flexible; providing additional options or variations on menu options to meet patient needs and preferences. We also noted that each ward had a kitchen communication book that patients could use to provide feedback on the catering at the hospital. In addition a member of kitchen staff regularly attended the Patient Council meetings to discuss catering feedback directly with patients.

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 a patient's behalf if they did not have leave.

Medicines management

Overall medicines management at the hospital was safe and effective. Medication was stored securely within cupboards and medication fridges that were 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 samples of Medication Administration Record (MAR) charts across the three wards. All the MAR Charts reviewed contained the patients name and their mental health act legal status.

On Bryntirion Unit and Sylfaen Unit charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. However, there were incomplete MAR charts on Derwen Unit with omissions on recording administration or when medication had been refused by the patient.

The Drugs Liable to Misuse stock and log on Sylfaen Unit did not tally; the log was overstating stock of one medication by three tablets. The ward manager investigated this during the inspection and identified that the log had not been completed when the three tablets were administered during a medication round; other clinical records evidenced that this had occurred. However, this error had not been identified by the registered nurses during their daily stock check.

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 were 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)[2].

[2] 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 Administration Record (MAR) charts are accurately completed.

The registered provider must ensure staff carry out Controlled Drugs and Drug Liable to Misuse stock checks accurately.

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.

The training statistics provided by the registered provider evidenced that 100% of staff were up to date with their child safeguarding training and 99% with adult safeguarding training.

However, with regards to a recent safeguarding incident the registered provider had not clearly documented the safeguards that they had implemented whilst the incident was under investigation. Some of the staff members we spoke with were able to describe the arrangements that were supposed to be in place. However, there was no record of these arrangements and through our observations on the ward it was not evident that these were being maintained. We raised our concerns with the Registered Manager and these were addressed during the inspection.

Improvement needed

The registered provider must ensure that there is a clear record of any new or additional safeguarding arrangements that are put in place to direct staff on the actions required of them.

Medical devices, equipment and diagnostic systems

There were regular audits of resuscitation equipment undertaken on each of the wards when required which documented that all resuscitation equipment was present and in date. Each ward had ligature cutters that were stored in designated places.

On Bryntirion Unit the emergency equipment was stored within the clinic room which only registered nurses could access. This meant that if there was an

emergency a healthcare support worker would not be able to access the equipment themselves which may cause a delay.

Improvement needed

The registered provider should review the location where the emergency equipment is stored on Bryntirion Unit so that all staff are able to access it without delay.

Safe and clinically effective care

Overall, we found governance arrangements in place that helped ensure that staff provided safe and clinically effective care for patients. The arrangements for the hospital fed through to Elysium Healthcare governance arrangements which facilitated a two way process of monitoring and learning.

As detailed elsewhere within the report the registered provider needs to address deficiencies in some National Minimum Standards for Independent Health Care Services in Wales and these are detailed, along with the registered provider's actions, in Appendix B.

Records management

Patient records were mostly electronic which were password-protected to prevent unauthorised access and breaches in confidentiality. Paper documentation was stored securely within locked offices and we observed staff updating and storing the records appropriately during our inspection.

Mental Health Act Monitoring

We reviewed the statutory detention documents of patients across two wards, Dderwen Unit and Sylfaen Unit. We also reviewed the governance and audit processes that were in place for monitoring the use of the Mental Health Act at the hospital.

Medication was provided to patients in line with Section 58 of the Act, Consent to Treatment; with consent to treatment certificates always 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.

It was positive to note that on Sylfaen Unit there were information leaflets displayed that provided patients with information on medication that they may

be receiving on the ward. This included information on what the medication is used for, side-effects and how to pronounce the name. However, this information was difficult to read due to the size of the font and because it was displayed behind meshed glass. The registered provider should consider the format of the information so that the font is larger and displayed in a location that would ease reading. The registered provider should consider replicating this across other wards within the hospital and other hospitals.

All patient leave had been authorised by the responsible clinician on Section 17 Leave authorisation forms. Section 17 Leave clearly stated the conditions of leave, i.e. escorted or unescorted, location and duration.

It was not documented within patient records whether the patient had been offered or received a copy of their Section 17 Leave form to evidence compliance with the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 (the Code), paragraph 27.18. We have recently identified this at another hospital within the registered provider's organisation. The registered provider has confirmed that an audit is now in place to monitor Section 17 Leave forms; this needs to be implemented across all their hospitals.

Staff had access to a range of patient information leaflets to help assist discussions with patients regarding their care and treatment in hospital. It was documented within patient records that they had been informed of their rights (Section132 of the Act), however there was little information recorded in the patient records we reviewed to evidence regular re-presentation of rights. There was also little detail recorded of what was discussed and whether the patient understood the information. The registered provider must ensure that there is a record of what information the patient has received as guided by the Code, chapter 4.

We raised concerns regarding the legislative powers and the use of the Act for patient(s) within the low-secure environment who were not detained under the Act (commonly known as an informal patient). Documentation for the application of Section 5 of the Act, Holding Powers[3], did not always clearly document the process or outcome of the application. In one instance the

[3] The powers in Section 5 which allow hospital inpatients to be detained temporarily so that a decision can be made about whether an application for detention should be made.

completed statutory documentation indicated that Section 5(4)[4] was used following the expiry of a Section 5(2)[5]; this is not the correct use of holding powers.

Reviewing patient documentation and speaking to staff it was evident that for one informal patient, when they requested to leave the hospital, staff would default to the use of Section 5 holding powers to prevent the patient leaving the hospital. This is a clear indication that in fact whilst the patient is an informal patient they are not at all free to leave and therefore De Facto Detained[6].

The registered provider is required to review their policies and practices to ensure that if an informal patient is being cared for at the hospital that appropriate legislation is followed and no De Facto Detentions occur.

During the review of one Section 3 application it was evident that the nearest relative[7] had been identified. The nearest relative could not be contacted to be consulted with at the time of the detention; there was no record of any further attempts to contact the nearest relative to inform them of their rights under the Act.

Improvement needed

The registered provider must ensure that there is a record of whether the patient has been offered or received a copy of their Section 17 Leave form.

The registered provider must ensure that there is a record of what information the patient has received under Section132 of the Act, along with the details and outcome of the discussion, as guided by the Code, chapter 4.

The registered provider must ensure that patient records (including statutory

[4] Holding powers applied by a registered medical practitioner or approved clinician in charge of the treatment for the patient, for up to a period of 72 hours.

[5] Holding powers applied by a nurse (of the prescribed class), for up to a period of six hours.

[6] A patient that is detained within hospital but not necessarily by legal right

[7] A person defined by the Act who has certain rights and powers under the Act in respect of a patient for whom they are the nearest relative.

documentation) clearly document the use and outcome of holding powers under the Act.

The registered provider must review their policies and practices for informal patients to prevent any De Facto Detentions occurring.

The registered provider must ensure that nearest relatives are informed of their rights under the Act

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

We reviewed the care plans for a total of five patients.

There was evidence that care co-ordinators had been identified for the patients. The Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed.

Individual Care and Treatment Plans drew on the patient's strengths and focused on recovery, rehabilitation and independence. These were developed with members of the multi-disciplinary team and based on evidence based practice. Care and Treatment Plans also included good physical health monitoring and health promotion.

To support patient care plans, there were a range of patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them. However, as detailed earlier, there was no clear documentation on the management of an individual patient following an incident to ensure that safeguards were in place. This was addressed during our inspection.

Patients confirmed that they were encouraged to be involved in developing their care with a focus on discharge to a less restrictive environment. However, as detailed earlier, there was no discharge care plan in place for a patient who was due to move to a community placement. Staff confirmed at the inspection feedback that this would be developed following the inspection.

It is necessary that care plans are developed and updated promptly to reflect changes in individual patient's circumstances to provide clarity for staff and the individual patients.

It was also common that staff were not clearly 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 needs. These can

include difficulties in identifying suitable placement for discharge from the hospital.

With the permission of the individual patients we attended a number of care reviews and observed staff conducting an inclusive patient focused meeting. When a patient decided to be involved in the meeting we observed that the patient's views and wishes were listened to and staff provided clear reasons for decisions taken.

Improvement needed

The registered provider must ensure that care plans are developed and updated promptly to reflect changes in individual patient's circumstances.

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

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 clear management and leadership which was supported by Elysium Healthcare organisational structures.

We observed a committed staff team who had a good understanding of the needs of the patients at the hospital. Improvements are required in some mandatory training areas.

Recruitment was undertaken in an open and fair process with appropriate employment checks being carried out prior to and regularly during employment.

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.

Identified senior managers had specific responsibilities for ensuring that the programme of governance remained at the forefront of service delivery. Those arrangements were recorded so that they could be reviewed both within the hospital and the wider organisational structure.

There was a clear organisational structure for the hospital, which provided clear lines of management and accountability. These arrangements were clearly defined during the day with senior management and doctor on-call arrangements in place for the night shift. However, some staff raised concerns that there were not clear hospital management arrangements during the night shift. We found that whilst one of the registered nurses on shift would be the

designated nurse in charge of the hospital, the roles and responsibilities of this person were not sufficiently defined.

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. The hospital director spoke of good peer links and support from other local Elysium hospital directors through regular meetings or remotely by telephone or email.

Staff spoke positively about the support from colleagues across the disciplines and they stated that morale had increased significantly since the previous inspection. We found that staff were committed to providing patient care to high standards.

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

Improvement needed

The registered provider must ensure there are clearly defined roles and responsibilities for hospital management during the night shift.

Dealing with concerns and managing incidents

There was a complaints policy and procedure in place at the hospital. The policy provides a structure for dealing with all patients' complaints for services within Cefn Carnau.

Complaints were categorised as informal or formal complaints. Informal complaints, that were raised and resolved at ward level, were recorded within a paper complaints log with formal complaints logged on the registered provider's electronic system. Formal complaints were monitored and reviewed through clinical governance arrangements which ensured that the complaints process was followed and completed.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system that included the names of patient(s) and staff involved, a description, location, time and length of the incident. Any use of restraint was documented.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and

reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed.

Arrangements were in place to disseminate information and lessons learnt from complaints and incidents to staff both at the hospital and the wider organisation.

Workforce planning, training and organisational development

We reviewed the staffing establishment at Cefn Carnau and it was evident that the registered provider had undertaken recruitment to fill any vacancies at the hospital. At the time of the inspection all vacancies had been appointed to; there were some staff in the process of completing their induction and pre-employment checks prior to commencing their roles at the hospital.

As per our previous inspection the hospital was reliant on the use of agency staff to fulfil rotas, it was positive to note that this was reducing month on month. With vacancies appointed to and a significant reduction in staff sickness over the previous six months (from 11% to under 1%), at the time of the inspection, agency staff were predominantly being required to assist facilitating enhanced observations.

We reviewed the mandatory training statistics for staff and found that completion rates for e-learning were on the whole high. However, significant improvement is required in the following classroom courses: Managing Violence and Aggression (45% compliance), Breakaway (47% compliance), Conflict Resolution (44% compliance) and Basic Life Support (35% compliance). The registered provider had set training dates for these courses to address these deficits.

Clinical supervision and managerial supervision were available to staff; statistics provided reflected high uptake. However, speaking with some staff at the hospital they raised their concern that managerial and clinical supervision is not always separate and that the overlap of the two impacts negatively on the effectiveness of both. Staff also raised concerns that over recent months, due to the pressures on ensuring sufficient staff are available on the wards that supervision was being undertaken during lunch breaks, which is not appropriate.

Improvement needed

The registered provider must ensure that staff complete their mandatory training, including: Managing Violence and Aggression, Breakaway, Conflict Resolution and Basic Life Support.

The registered provider must review the provision of clinical supervision and managerial supervision to ensure that they are completed effectively.

The registered provider must ensure that staff are not required to access supervision during their lunch breaks.

Workforce recruitment and employment practices

Staff explained the recruitment processes that were in place at Cefn Carnau and we reviewed a sample of five staff files. It was evident that there were systems in place to ensure that recruitment followed an open and fair process; with records of application, interviews and communication held on each file. Prior to employment staff references were received, professional qualifications checked and Disclosure and Baring Service (DBS) checks were undertaken, and then renewed every three years.

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, Mental Health (Wales) Measure 2010 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

Date of inspection: 13 – 15 August 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	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The registered provider must increase the range of information displayed for patients to include more on health promotion.	3. Health promotion, protection and improvement 9. Patient information and consent	Health promotion board will be made available on each ward. Easy health website will be used to source information. Health promotion to be added to the agenda of community meetings.	Clinical Services Manager Clinical Services Manager Clinical Services Manager	30.11.2018
The registered provider must ensure that information is displayed and available in a suitable format for patients, such as Easy Read and Welsh.	3. Health promotion, protection and improvement 9. Patient information and consent	As above Health promotion will be discussed during 1:1 sessions, patients will be asked if there is any information they require. Request for welsh information will be	Clinical Services Manager Clinical Services	30.11.2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	18. Communicating effectively	documented in care plans.	Manager	
The registered provider must ensure that patient information displays are appropriately secured.	3. Health promotion, protection and improvement 9. Patient information and consent	Existing notice boards to be replaced with notice boards that that have covers.	Business Support Manager	15.12.2018
The registered provider must ensure that unwanted items are not discarded in communal rooms.	10. Dignity and respect	All unwanted items will be placed in storage or disposed of. This will be documented on property lists.	Clinical Services Manager	31.10.2018
The registered provider must ensure that toys for children visitors are appropriately stored.	10. Dignity and respect	Closed storage box to be source and will not be located in toilet area.	Clinical Services Manager	31.10.2018
The registered provider must ensure that information on how to raise a complaint is clearly displayed on all wards.	5. Citizen engagement and feedback 9. Patient information and consent	How to make a complaint poster to be displayed on all wards.	Business Support Manager	31.10.2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The registered provider must confirm that the hospital ligature point audit is reviewed and completed within the required timescales.	22. Managing risk and health and safety 12. Environment	The ligature audit is currently being reviewed and will be completed by the end of October.	Clinical Services Manager	31.10.2018
The registered provider must ensure that showers and toilets are maintained to an appropriate standard of cleanliness.	13. Infection prevention and control (IPC) and decontaminatio n	Cleaning schedule will be reviewed and updated. This will be communicated to housekeeping and ward staff.	Business Support Manager	31.10.2018
The registered provider must repair or replace the kitchen windowsill on Sylfaen Unit.	13. Infection prevention and control (IPC) and decontaminatio n	Maintenance team to be informed and complete repair.	Business Support Manager	31.10.2018
The registered provider must ensure that all Medication Administration Record (MAR) charts are accurately completed.	15. Medicines management	Weekly audit to be completed by ward managers. Errors to be addressed via managerial supervision. Medication management training to be	Clinical Services Manager Clinical Services Manager Clinical Services	31.10.2018 31.10.2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		facilitated by Ashtons.	Manager	30.11.2018
The registered provider must ensure staff carry out Controlled Drugs and Drug Liable to Misuse stock checks accurately.	15. Medicines management	All entries to be double signed. Stock checks to be completed daily. Hospital Director / Clinical Services Manager to monitor entries in the books weekly.	Clinical Services Manager Hospital Director	31.10.2018 31.10.2018
The registered provider must ensure that there is a clear record of any safeguarding arrangements that are in place to direct staff to the actions required of them.	11. Safeguarding children and safeguarding vulnerable adults	Safeguarding information is available in reception. Referral form has been made available to all nursing staff.	Clinical Services Manager	31.10.2018
The registered provider should review the location where the emergency equipment is stored on Bryntirion Unit so that all staff are able to access it without delay.	16. Medical devices, equipment and diagnostic systems	Location to be reviewed by Clinical Services Manager and Physical Health Practitioner.	Clinical Services Manager	31.10.2018
The registered provider must ensure that there is a record of whether the patient has been offered or received a copy of their Section 17 Leave form.	Mental Health Act Monitoring	This will be documented in care notes once section 17 leave has been updated.	Clinical Services Manager	31.10.2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that there is a record of what information the patient has received under Section132 of the Act, along with the details and outcome of the discussion.	Mental Health Act Monitoring	Summary of discussion to be completed on form which is located on care notes.	Clinical Services Manager	31.10.2018
The registered provider must ensure that patient records (including statutory documentation) clearly document the use and outcome of holding powers under the Act.	Mental Health Act Monitoring	Mental Health Act office to scrutinise the completion of paper work. Paper work will be uploaded to care notes.	MHA office	31.10.2018
The registered provider must review their policies and practices for informal patients to prevent any De Facto Detentions occurring.	Mental Health Act Monitoring	If a patient is discharged from section, the community team will be notified. The responsible clinician will be responsible for liaising with the patient to see if they are wish to remain informally at Cefn Carnau whilst a placement is sourced. If not an emergency referral will be made to the community team. Mental Health Act Office to be informed and will support the completion of documentation.	Responsible Clinician	31.10.2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that nearest relatives are informed of their rights under the Act	Mental Health Act Monitoring	Information leaflets to been sent to nearest relatives following the admission process.	Mental Health Act Office	31.10.2018
The registered provider must ensure that care plans are developed and updated promptly to reflect changes in individual patient's circumstances.	Mental Health (Wales) Measure 2010	Members of the multi-disciplinary team have been informed of the responsibility to update care plans. Care plans are reviewed during monthly MDT meetings.	Clinical Services Manager	Completed
The registered provider must ensure that patients' unmet needs are documented in their Care and Treatment Plans.	Mental Health (Wales) Measure 2010	This will be documented in the monthly Individual Care Review and discussed during MDT meeting and 6 monthly review meeting.	Responsible Clinician	31.10.2018
Quality of management and leadership				
The registered provider must ensure there are clearly defined roles and responsibilities for hospital management during the night shift.	1 Governance and accountability framework	A manager on call rota is displayed within the hospital. A nurse is allocated to support wards during the night.	Clinical Services Manager Clinical Services Manager	Completed Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Hospital director to consider the implementation of a night co-ordinator post.	Hospital Director	30.11.2018
The registered provider must ensure that staff complete their mandatory training, including: Managing Violence and Aggression, Breakaway, Conflict Resolution and Basic Life Support.	25. Workforce planning, training and organisational development	There is a training schedule in place and face to face training is being arranged and allocated as and when required.	Hospital Director	30.11.2018
The registered provider must review the provision of clinical supervision and managerial supervision to ensure that they are completed effectively.	25. Workforce planning, training and organisational development	Clinical supervision provision is being reviewed and all staff will be allocated a managerial supervisor and all clinical staff will be allocated a clinical supervision. Staff will be asked to complete a feedback sheet every quarter.	Hospital Director/ Clinical Services Manager	30.11.2018
The registered provider must ensure that staff are not required to access supervision during their lunch breaks.	25. Workforce planning, training and organisational development	The delivery of supervisions being reviewed and a time will be confirmed with staff once deemed suitable.	Hospital Director	31.10.2018

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: **5 October 2018**