Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Ty Catrin

Priory Group

Inspection date: 3, 4, 5 June 2019

Publication date: 5 September 2019

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@gov.wales**

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

Digital ISBN 978-1-83933-171-8

Contents

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

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 Ty Catrin on the evening of 3 June 2019 and the following days of 4 and 5 June 2019. The following sites and wards were visited during this inspection:

- Bute – Male Low Secure – 11 beds
- Roath – Closed
- Victoria – Female Low Secure – 11 beds
- Sophia – Female Low Secure – 8 beds
- Trelai – Female High Dependency Unit – 4 beds
- Heath – Female Locked Rehabilitation step down – 4 beds

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 a HIW inspection manager.

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

HIW explored how the service complied with the Care Standards Act 2000, the 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

Overall, we found evidence that Ty Catrin provided safe care to its patients.

We saw evidence of a management structure at Ty Catrin that was supported by the Priory Group, however we found that ward staff felt disconnected from senior management.

We found that Ty Catrin did not have a model of care appropriate to the patient group being treated at the hospital.

Significant improvements are required around the admissions process, specifically around the appropriateness of patient detention.

This is what we found the service did well:

- The environment of care at Ty Catrin was appropriate to the patient group
- Medicines management was safe and effective
- There is a broad range of clinical and safety audit activity throughout the hospital
- High compliance rates for mandatory staff training, supervision and appraisals.

This is what we recommend the service could improve:

- Identification of unmet needs
- Fulfilment of its statutory responsibilities of the Mental Health Act
- Availability of HIW contact information for patients
- Levels of cleanliness in some patient areas.

We identified the service was not compliant with:

Regulation 30 & 31 Independent Healthcare (Wales) Regulations 2011.

The registered provider must comply with their duty under the Independent Healthcare (Wales) Regulations 2011 to notify the registration authority, Healthcare Inspectorate Wales (HIW), of incidents that fall under those defined by the regulations.

The registered provider must provide assurance that all staff involved in the incident reporting process are aware of the regulatory requirements for notification to HIW.

These are serious matters and resulted in the issue of a non-compliance notice to the service. At the time of publication of this report, HIW have received sufficient assurance of the actions taken to address the improvements needed.

3. What we found

Background of the service

Ty Catrin is registered to provide an independent Mental Health Hospital at Ty Cartrin, Dyfrig Road, Cardiff CF5 5AD.

The service has 44 beds across six gender specific wards. At the time of the inspection there were 35 patients. Roath ward had been closed temporarily due to a lack of male patients.

The service was first registered on 26 October 2009.The service employs a staff team which includes a Hospital Director, a Director of Clinical Services, four ward managers, two night co-ordinators and a team of registered nurses and healthcare workers. There are also multi-disciplinary team members which include consultant forensic psychiatrists, psychologists, occupational therapists and social workers.

The hospital employs a team of maintenance, catering and domestic staff. The operation of the hospital is supported by a team of administration staff.

The hospital is supported by the management and organisational structures of The Priory Group.

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 most staff throughout the hospital interacting and engaging with patients appropriately. We did however see a member of staff sitting watching television on a ward appearing disinterested with a group of patients in the same communal area.

There was a range of information available for patients, however this was inconsistent across the wards. There was also no contact information for HIW displayed.

Health promotion, protection and improvement

There was a range of health promotion, protection and improvement initiatives available to the patients at Ty Catrin which assisted in maintaining and improving patients' wellbeing. This information is displayed at various locations throughout the hospital and wards. There were inconsistencies between wards with regards to how much information was displayed. Where information was not displayed we were told this is as part of managing the risk posed by the patients on individual wards.

Ty Catrin is a non-smoking environment; patients have access to a 12 week smoking cessation course on admission and at any subsequent time should they need it.

Patients were able to access GP, dental services and other physical healthcare professionals in the community. Access to these types of appointments was confirmed through conversations with patients and staff along with being documented in patients' records.

There was a range of facilities to support the provision of therapies and activities at the hospital. The hospital staffing included a team of occupational therapists and occupational therapy assistants. We were told one of the patients had a keen interest in gardening. The hospital supported this patient with this hobby by providing garden tools and time each day outside in the hospital grounds. We were told that this patient also held classes for other patients to teach gardening skills.

There was a communal area for patients known as the Piazza. This provided space where patients could take part in a number of group sessions. These included a breakfast group and therapy sessions. Patients with authorised leave from the hospital were able to access leisure facilities within the community.

The art room provided the opportunity for patients to participate in a range of arts and crafts activities at the hospital. The art room also had computers with internet access. We observed patients (under staff supervision) using these to undertake some internet shopping for personal items.

There was a suitable room available on the first floor for visitors, multi-faith services and relaxation sessions. There was a designated child visiting area on the ground floor accessed through the main hospital reception. This was suitably located so that child visitors were only required to enter the hospital reception area and not the main hospital.

Improvement needed

The registered provider must ensure that health promotion information is consistently available for patients.

Dignity and respect

We observed staff interact and engage with patients appropriately and treating patients with dignity and respect. The staff we spoke to were committed to providing dignified care for the patients.

On the whole we heard staff speaking with patients in calm tones throughout our inspection. We observed staff being respectful toward patients including prompt and appropriate interaction in an attempt to prevent patient behaviours escalating. Generally, when patients approached staff members they were met with polite and responsive caring attitudes. On one occasion however, we saw a staff member react in an impatient manner and ignore the patients' request.

We inspected the two Intensive Care Suites (ICS) at Ty Catrin. There was CCTV available for observing all areas of the ICS. There was no recording facility on this CCTV. The registered provider told us that the use of CCTV is risk based on an individual patient and incident basis to ensure that the privacy and dignity of the patient in ICS is upheld whilst maintaining the safety of the patient and staff.

The registered provider has developed appropriate governance arrangements for the use of CCTV that strikes a balance between maintaining privacy and improving safety.

Most patients that we spoke with told us that they were treated with respect and kindness and were complimentary of the care, treatment and support provided at the hospital. However, some patients commented that they found it difficult to approach unfamiliar staff who may have been working on the ward as an agency member of staff, bank staff or a staff member covering from another ward. It was evident from speaking to senior managers that there is a level of reliance on agency and bank staff at the hospital.

On each ward, patients had their own en-suite bedroom with toilet, sink and a shower. Patients were able to lock bedroom doors to prevent other patients entering; staff could override the locks if required. Patients were able to have personal items in their bedrooms dependent on the level of risk. This was individually assessed for each patient.

During the first night of our inspection we observed one patient's en-suite had damp on the wall next to the toilet. The paint was peeling off a large proportion of the wall and it looked in a poor state of repair. The registered provider must remedy this damp issue in the en-suite and ensure the room is decorated to an appropriate standard.

Improvement needed

The registered provider should ensure regular supervision of staff on the ward to ensure expected levels of professional practice are maintained.

The registered provider must ensure that patient bedrooms are maintained to an acceptable standard with work being carried out promptly.

Patient information and consent

Since our last inspection, weekly advocacy drop in sessions had been re-instated at the hospital. This encouraged patients to access statutory advocacy services without an appointment and receive the input they are entitled to.

Complaints information was available on the wards and patients we spoke to told us they would know how to raise a complaint. However, HIW contact details were not displayed in any patient areas. The four weekly menu was displayed clearly for patients to read as well as information about the hospital activity programme and local community facilities.

Improvement needed

The registered provider must make provision for relevant information to be available for patients whilst managing the risk.

The registered provider must ensure HIW contact details are displayed for patients to use if and when required.

Communicating effectively

Through our observations of staff-patient interactions, it was evident that on the whole 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. Although as stated earlier in the report, we did see a member of staff act impatiently to a patient's request as the staff member was busy doing something else.

Each ward had daily planning meetings every morning to arrange the activities, within the hospital and the community, alongside other activities and meetings, such as care planning meetings, tribunals, medical appointments.

There was a patients' forum. This gave patients the opportunity to provide feedback on the care they receive at the hospital and discuss any concerns with staff members.

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. With patients' agreement, wherever possible, their families and carers were also included in some meetings. Patients were also invited to chair their own Care and Treatment Plan meetings.

Care planning and provision

There was a clear focus on providing safe and effective care for patients at the hospital. Care was individualised and on the whole focused on recovery, supported by least restrictive practices, both in care planning and delivery of care.

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.

During the inspection we spoke with a number of ward staff. We were told that the hospital did not follow a specific model of care. We raised this with senior managers who provided a hard copy of the hospital's model of care which was based on Cognitive Behavioural Therapy (CBT). We were not assured that the model of care adopted by the hospital was communicated effectively to staff delivering that care.

Improvement needed

The registered provider must ensure that they follow and evidence an appropriate model of care being followed that is appropriate to the patient group. And that all staff at the hospital are aware of this model of care

Equality, diversity and human rights

Staff practices aligned to established hospital policies and systems ensured that the patients' equality, diversity and rights were maintained.

We found that Mental Health Act (MHA) detention papers had not all been completed correctly to detain patients at the hospital. The registered provider is currently auditing all MHA documentation and must implement improvements to the application of the Act (at Ty Catrin and the registered provider's other hospitals) to fulfil its statutory duties under the Act and as set out in the Mental Health Act Code of Practice for Wales 2016. More details regarding the issues identified are provided detailed later in this report.

Citizen engagement and feedback

There were regular patient meetings to allow for patients to provide feedback on the provision of care at the hospital. The hospital also undertook patient surveys; however information on the outcomes of the survey, what actions the registered provider has and will be taking were not displayed on the wards for patients or in the reception area for visitors.

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 Ty Catrin.

Complaints were categorised as informal and formal complaints. Informal complaints were logged on each ward within a paper document with formal complaints recorded on a computerised complaints log for the whole hospital.

A sample of informal and formal complaints we reviewed showed that an independent person was assigned to investigate the complaint and actions were

taken in line with the organisation’s complaints policy to ensure that complaints were dealt with appropriately at the hospital.

Delivery of safe and effective care

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

On the whole the hospital well maintained and provided a safe environment for patients. There were some individual patient areas within the hospital that were identified as in need of significant cleaning and repair.

Significant improvements are required in the fulfilment of the registered provider's statutory responsibilities under the Mental Health Act, specifically to develop a robust admission process to cover the appropriateness of patient detentions.

Managing risk and health and safety

Ty Catrin had processes in place to manage and review risks and maintain health and safety at the hospital. The hospital provided individualised patient care that was supported by least restrictive practices.

The hospital entrance was secured to prevent unauthorised access with all staff and visitors registering at reception. The hospital had security procedures in place to minimise the risk of restricted items being brought on to the wards. Each shift had an allocated security nurse on each ward that was responsible for maintaining the security protocols on each ward.

The hospital had a list of prohibited items displayed at reception and there were secure lockers available to store any items that cannot be taken on to the ward, e.g. mobile phones, lighters, flammable liquids.

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

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, including who was involved and the body positions of each person involved in the restraint. Incident reports were automatically linked to the individual patient's electronic care notes which ensured that these were up-to-date.

Although we found the documenting of restraint to be of a good standard, there was very little detail recorded on what led up to a restraint being justified or what occurred following the restraint. For example, what de-escalation techniques were implemented, the impact of a specific approach and whether this particular intervention had the desired effect. The registered provider must improve its recording to evidence why restraint had been necessary and what attempts had been made to de-escalate prior to the restraint.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner by a member of the clinical team involved in the individual patient's care and an employee responsible for hospital health and safety. We found the content of incidents to be inconsistent. Some were very detailed and of a high standard but some were very vague and did not contain sufficient detail to enable to reader to fully understand the incident context and the subsequent actions of staff if these were required.

Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed. Additional reports could be produced to analyse at specific areas as required. The incident reporting system and reporting schedules ensured that incidents were recorded, reviewed and monitored to assist in the provision of safe care at Ty Catrin. We found however that some incidents that should be reported to HIW under regulations 30 and 31 of the Independent Healthcare (Wales) Regulations 2011 were not being reported. This was addressed with the registered provider under our non-compliance procedure. Further details of improvement required and action taken by the registered provider is included in Appendix B.

As part of the hospital’s strategy for managing challenging behaviour, there were two Intensive Care Suites (ICS), one on the ground floor for the male wards and another on the first floor for the female wards. The ICS facilities had appropriate self-contained toilet and shower facilities.

The decision to use ICS was the final stage in managing patient behaviours, and could be used for patient Seclusion[1]. If a patient's risk determined it a

[1] The supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.

requirement, anti-rip clothing and bedding was provided to help maintain their dignity whilst being cared for within an ICS and on the wards. The Registered Provider had a policy in place for the use of the ICS and Seclusion which stated that patients could be in ICS for a brief period of time, or for prolonged periods of days or weeks. The use of ICS and seclusion at the hospital was recorded and monitored.

It was positive to note that there was a dedicated Night Co-ordinator who was the registered nurse in charge of the hospital on each night shift. This role provided leadership and support for ward staff. The Night Co-ordinator that we met with on the first night of the inspection was able to provide essential information regarding the hospital staffing and patient group. This evidenced that there was clear oversight of the hospital's operation at night.

Improvement needed

The registered provider must ensure that the recording of restraint covers events leading up to and justifying the restraint. Also details of aftercare provided.

The registered provider must ensure that incident recording is detailed and consistent across all staff members.

Infection prevention and control (IPC) and decontamination

A system of regular audit of infection control arrangements was described. This was completed with the aim of identifying areas for improvement so that appropriate action could be taken where necessary. Staff confirmed that cleaning schedules were in place to promote regular and effective cleaning of the hospital and they were aware of their responsibilities around infection prevention and control.

There was a team of four hotel service staff who cleaned the wards on a rota basis and responded to any immediate cleaning needs should they be identified.

Generally we observed the hospital to be visibly clean and free from clutter. However, on Trelai we observed two patient bedrooms that were very unkempt and unclean. Bedding was of a very poor standard and dirty. For example one patient pillow was extremely stained. We also noted some toilets on the wards were heavily stained. This was brought to the attention of senior staff at the hospital. The stains were still noted the following day.

Also on Trelai ward the table in the kitchen where patients drinks and snacks are prepared, was damaged and in need of repair as it presented a health and safety risk. The fridge and freezer in this kitchen contained patient food and drinks. None of these items were dated to show when they had been placed there or when they had been opened.

There was an area of carpet within one of the wards that had been damaged by a patient. This had been completely removed prior to inspection but not replaced. We were told that the hospital has ordered the replacement carpet and were waiting for it to be fitted.

It is positive to note that the registered provider has increased the number of laundry facilities available to patients across the hospital since our last inspection.

There were hand hygiene products available in relevant areas of the hospital. Staff also had access to infection prevention and control and decontamination Personal Protective Equipment (PPE) when required.

There were suitable arrangements in place for the disposal of waste. Appropriate bins were available to dispose of medical sharp items. These were not over filled.

Improvement needed

The registered provider must ensure that patient bedding is clean and of an acceptable standard.

The registered provider must ensure that patient facilities such as kitchens, toilets and bathrooms are clean and maintained to an acceptable standard.

The registered provider must ensure that all food in patient fridges is dated when placed in the fridge and opened.

Nutrition

We found that patients were provided with a choice of meals on a four-week menu. We saw that the menu was varied and patients told us that they had a

choice of what to eat. The menus also varied seasonally through the year. As well as the meals provided patients were able to use the occupational therapy kitchen to prepare their own meals and order take-away deliveries to the hospital.

Patient feedback on the meals and menu options were collated and used to inform changes to menu options. The patients we spoke with during our inspection had mixed views on the food provided at the hospital.

The catering team would provide meals for specific dietary requirements. Such as patients whose weight is being managed as part of their treatment.

There were ward kitchens on each of the wards so that patients could access drinks and their snacks throughout the day and night.

Medicines management

We reviewed the hospital clinics and found that medicines management was safe and effective. Medication was stored securely within cupboards and medication fridges were locked with the exception of the medication fridge on Trelai. We were told a replacement had been ordered. There was regular pharmacy input and audit undertaken that assisted the management, prescribing and administration of medication at the hospital.

There was evidence that there were regular temperature checks of the medication fridge and clinic room to ensure that medication was stored at the manufacturer's advised temperature.

There were appropriate arrangements in place for the storage and use of Controlled Drugs and Drugs Liable to Misuse. We found these were accurately accounted for and checked daily.

The hospital had a shared clinics for Bute and Roath, and Sophia and Victoria; whilst these rooms were small they provided a safe and secure space for the administration and storage of medication. They also afforded patients a level of confidentiality when being administered medication.

The Medication Administration Record (MAR) Charts reviewed contained the patient's name and a photograph of the patient. We found the mental health act legal status was not always recorded. MAR charts included copies of the consent to treatment certificates and MAR charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered.

We found that prescribed pro re nata (PRN)[2] medication was being administered routinely and sometimes proactively without a detailed justification. The registered provider must fully evidence and record the reasons for administering PRN medication, every time it is administered.

Improvement needed

The registered provider must ensure that patients MAR charts detail the patients Mental Health Act legal status.

The registered provider must fully evidence and record the reasons for administering PRN medication every time it is administered.

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. As stated above, there were appropriately located child visiting facilities at the hospital.

The hospital had a team of Social Workers who acted as the safeguarding leads for the hospital, and dealt with all safeguarding referrals and subsequent workload.

Medical devices, equipment and diagnostic systems

There were regular clinical audits at the hospital and a nightly audit of resuscitation equipment, staff had documented when these had occurred to ensure that the equipment was present and ready to use. The hospital was redeveloping their checklist to ensure that there was a consistent audit across the hospital.

[2] https://www.answers.com/Q/What_is_PRN_medication

There were a range of ligature cutters located throughout the hospital in case of an emergency. Staff were fully aware of the locations within each nursing office.

Safe and clinically effective care

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

Participating in quality improvement activities

One of the psychology team at the hospital has close links with local university. Through these links a number of medical students attend the hospital's training sessions to share knowledge and experience with hospital staff.

One of the student nurses at the hospital is producing a thesis on obesity and its links to mental health medication. Ty Catrin are supporting this research with a view to the outcome benefiting future patients at the hospital.

Records management

Patient records were electronic and were password protected to prevent unauthorised access and breaches in confidentiality

We reviewed a sample of patient records and concluded record keeping was poor and lacked detail. This was because:

- The notes contained contradictions
- Typing errors
- Lack of evidence to justify the use of PRN medication
- No record of individuals relapse signatures o triggers
- Documenting of pre-post restraint action/de-escalation
- Positive support plans not in place
- Inaccurate section 17 leave recording

It was evident that staff from across the multi-disciplinary teams were writing regular entries which provided a live document on the patient and their care. Psychology risk assessments were good and well documented and there was evidence of regular reviews.

Improvement needed

The registered provider must ensure that medical notes are maintained to a recognised professional standard.

Mental Health Act Monitoring

We reviewed the statutory detention documents of two patients across two wards. We also reviewed the governance and audit arrangements that were in place for monitoring the use of the Mental Health Act across all five occupied wards at Ty Catrin.

Our review of the two sets of statutory documentation confirmed that one of the patients was legally detained by Ty Catrin and the other had recently become an informal patient after it was found the patient's legal detention was no longer valid.

The Mental Health Act administrator was in the process of auditing all statutory documentation held at Ty Catrin. We were told that it was through this audit that the above mentioned detention was found to be no longer valid. We were assured with Ty Catrin's prompt actions to rectify this situation. However it has highlighted a failure within the admission process at Ty Catrin which has allowed this inappropriate detention to occur and continue for an extended period of time.

The registered provider must develop a robust admissions process for all patients to ensure compliance with its statutory responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice for Wales.

Improvement needed

The registered provider must ensure that the admission process at Ty Catrin is robust and covers patients' legal detention status checks.

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

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

The care and treatment plans were inconsistent in how they reflected the domains of the Welsh Mental Health Measure. Some were very detailed with all areas captured, others did not cover all aspects. Some recordings used jargon

and abbreviations that would be difficult to understand. We also found that unmet needs were not always documented

For all four Care and Treatment Plans (CTP) reviewed we were able to easily identify the named care coordinator for the patient.

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.

The patient records we reviewed evidenced good physical health monitoring.

We found in all four care plans that unmet needs that the patient may have whilst being cared for at the hospital were not documented. 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.

Patients and staff we spoke with told us that patients were involved in discussions around their care (when patients wished to engage). We found that this was documented within the care plans.

Improvement needed

The registered provider must ensure that all aspects of the mental health act measure are clearly and consistently recorded in the care and treatment plans.

The registered provider must ensure that unmet needs are documented within the care 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 a senior management structure at Ty Catrin which was supported by the Priory Group.

We observed a ward staff team who had a good understanding of the needs of the patients. However we were made aware of ward staff feeling disconnected from senior managers.

Mandatory training, supervision and annual staff appraisal completion rates were generally high.

We found Ty Catrin is currently going through an extensive recruitment process for various roles within the hospital for both clinical and auxiliary staff.

Governance and accountability framework

Overall there were well defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and its established governance structure which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care. Those arrangements were recorded so that they could be reviewed.

However, as detailed earlier in the report, significant improvement is required to ensure that registered provider fulfils its statutory responsibilities under the mental health act with a specific review of a patients' legal status on admission.

It was positive that through our conversations with staff, observing multi-disciplinary team meetings and engagement, and reviewing patient records there was evidence of strong multi-disciplinary team-working. Staff commented favourably on multi-disciplinary working stating that they felt that their views were listened to and respected by other members of staff.

It was also noted that during a multi-disciplinary team meeting that there was evidence of effective and collaborative multi-disciplinary team working. Each discipline had a head of department who provided leadership for their team and linked in collaboratively with other heads of department within The Priory Group.

We found there were mixed views from staff about the leadership and support provided by senior managers. There was a general feeling that senior managers were detached from staff on the ward and that there was a lack of visibility. Staff were however complimentary of ward managers and support from other colleagues across the disciplines. We found that staff were committed to providing patient care to high standards.

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

Dealing with concerns and managing incidents

As detailed earlier in the report, there were established processes in place for dealing with concerns and managing incidents at the hospital.

It was evident that the registered provider monitored concerns and incidents locally at Ty Catrin and corporately through regular reporting mechanisms.

However we found there to be inconsistencies in the detail contained within the incident records by various members of staff. Some were of a good standard, some were very vague and did not provide enough information for the reader to fully understand the circumstances. A recommendation for improvement has been made earlier in the report in relation to this issue.

We also found that some incidents that would require reporting to HIW had not been. This was dealt with under out non-compliance procedure.

Workforce planning, training and organisational development

We reviewed the staffing establishment at Ty Catrin with that stated within their Statement of Purpose. Ty Catrin had a current recruitment campaign ongoing due to a number of vacancies across the site. These included a Medical Director, two Psychologists, a head chef, a ward clerk and a practice nurse.

There were a number of new registered nurses due to start and we saw evidence of contingency planning to cover maternity leave in the near future. Ty Catrin is actively engaging in local events and using social media to improve recruitment prospects to these vacant roles.

To cover any shortfalls in fulfilling the staffing rota that may occur due to vacancies, the registered provider had a staff bank system in place along with the use of agency staff. Staff rotas evidenced that generally the use of agency registered nurses was of regular individuals who were familiar with working at the hospital and the patient group. This assisted with the continuity of care for patients.

It was positive to note that the hospital director had developed a Ty Catrin Workforce (Employee Retention) Plan. This documented priorities of the organisation in developing and maintaining its workforce along with proposals and initiatives that had been developed or planned.

We reviewed the mandatory training, supervision and annual appraisal statistics for staff at the hospital and found that completion rates were generally high. The electronic system provided the senior managers with details of course completion rates and individual staff compliance details.

We also saw evidence of a detailed induction process for all staff who worked on the wards at Ty Catrin.

Workforce recruitment and employment practices

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

All staff received an induction prior to commencing work on the wards at the hospital. Permanent staff files held certificate of induction following the completion of their corporate induction. Agency staff completed an induction at the hospital prior to starting their shift, the completion of the induction was signed off by a member of staff and Ty Catrin and the agency staff member; these were then filed with the human resources team.

DBS checks were completed after each three year period of employment and systems were in place to monitor professional registrations are up to date.

We were shown support programmes in place for Priory staff to assist staff with many aspects of work and personal life including an independent counselling service.

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, measurable, 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 resolved during the inspection but were dealt with through our non compliance procedure			

Appendix B – Improvement plan

Service: Ty Catrin, Priory Group.

Ward/unit(s): Bute, Roath, Victoria, Sophia, Trelai and Heath

Date of inspection: 3, 4 & 5 June 2019

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

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The registered provider must ensure that health promotion information is consistently available for patients.	3. Health promotion, protection and improvement	The Physician Associate and Practice Nurse to review current health promotion information displayed. Develop Physical health topics and themes. Plans to rotate new information on a monthly basis in line with National screening; Charity events and the patient group. Physical Health Clinic times displayed. Identify Ward based Physical Health Champions.	Physician Associate / Practice Nurse	02/08/19 03/08/19 16/08/19

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Re-launch the Physical Health / Healthy Living Patient Group		31/08/19
The registered provider should ensure sufficient supervision of staff on the ward to ensure expected levels of professional practice are maintained.	10. Dignity and respect	Any concerns regarding staff conduct is initially reviewed via managerial supervision. Expectation is reinforced and additional training may be provided. Persistent issues re: staff conduct is dealt with more formally via Performance Improvement and/or Disciplinary action. We also offer Clinical Supervision and Reflective Practice. Ward managers are encouraged to address staff conduct issues via `compliments and complaints section of the Community Meetings	Director of Clinical Services / Ward Managers	
The registered provider must ensure that patient bedrooms are maintained to an acceptable standard with work being carried out promptly.		NEW Maintenance Request Log introduced for `ad-hoc` maintenance issues.	SSM SSM	29/07/19 02/08/19

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Reminder notice to Ward and Housekeeping staff to report conditions relating to cleanliness and repair. Introduction of the Planned and Reactive Repair Work Allocation system.	SSM	06/08/19
The registered provider must make provision for relevant information to be available for patients whilst managing the risk. The registered provider must ensure HIW contact details are displayed for patients to use if and when required.	9. Patient information and consent	The HIW, Advocacy and Complaints posters are prominently displayed next to the nursing station. Mental Health Solicitor and Designated Safeguarding Officer details are also visible. Patient & Carer Handbook to be re-issued to all patient with the exception of Trelai Ward – a hard copy will be available on request (kept in nursing office). Notice displayed in office window.	Ward Managers HD/Ward Managers	03/08/19 19/08/19
The registered provider must ensure that they follow and evidence an appropriate model of care being followed that is appropriate to the patient group. And that all staff at the hospital are aware of this model of care	8. Care planning and provision	MDT meeting regarding the Model of Care at Ty Catrin - Model of Care document amended to explicitly identify Positive Behaviour Support (PBS) as the model of care.	Director of Clinical Services	01/08/19

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Education and training around currently used PBS and positive support planning approaches and exploration of the evidence base of it within forensic settings for key individuals on each ward	Learning and Development Team & Psychology	09/09/19
		Identified key individuals to be supported in educating and supporting ward based staff in following the model of care	Ward Managers	30/09/19
		Develop and implement a quarterly PBS newsletter that is disseminated and displayed across the service for both staff and service users to view.	Psychology	11/11/19
		Continue to provide PBS training on induction training and Positive Support Planning for registered nurses.	Learning and Development Team & Psychology	Ongoing
		Evaluation of knowledge and understanding of model of care around the service	Learning and Development Team & Psychology	16/12/19
Delivery of safe and effective care				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that the recording of restraint covers events leading up to and justifying the restraint. Also details of aftercare provided. The registered provider must ensure that incident recording is detailed and consistent across all staff members.	22. Managing risk and health and safety 12. Environment 4. Emergency Planning Arrangements	The report indicates that Ty Catrin already capture: Patient(s); Staff; Description of Incident; Location; Time; Duration; Use of Restraint including those involved and body positions. Discussion with MDT regarding HIW expectation and how we can capture the following; • Triggers or events leading up to the Incident • Justification for Restraint • Post restraint Interventions NEW guidance for recording of Incidents issued to all staff Senior Manager DATIX/ Incident Reporting (Quality) Training – this will enable delivery of training to more junior staff. Email guidance to all staff in the interim of providing more detailed training	Hospital Director Director of Clinical Services Quality Improvement Lead Charge Nurse	29/07/19 02/08/19 01/08/19 01/08/19

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Delivery of Training to all Ward based staff	Director of Clinical Services	31/08/19
The registered provider must ensure that patient bedding is clean and of an acceptable standard. The registered provider must ensure that patient facilities such as kitchens toilets and bathrooms are clean and maintained to an acceptable standard.	13. Infection prevention and control (IPC) and decontaminati on	Audit of `anti-rip` bedding (used predominantly on Trelai Ward) re: condition of material with view to purchase replacement bedding. Bathrooms, Kitchens & Toilets will be cleaned daily and monitored using forms HK03 & HK03A. Bedding will be checked and where required, replaced whilst point (a) is being actioned. An e-mail to be issued to staff advising to report all requests for action relating to cleanliness and health & safety, immediately, through the central request log administered by reception. Notice to be placed in staff room advising of this point.	Security Lead SSM	09/08/19 05/08/19

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that all food in patient fridges is dated when placed in the fridge and opened.		Posters to be placed on fridge. Night staff to monitor contents of fridge and date where required. To be added to Satellite Kitchen checklist for monitoring.	Ward Managers	05/08/19
The registered provider must ensure that patients MAR charts detail the patients Mental Health Act legal status. The registered provider must fully evidence and record the reasons for administering PRN medication every time it is administered.	15. Medicines management	Medical staff will review Prescription and Administration Charts on admission; at ICR's (Inpatient Care Reviews) and CTP/CPA's (Care & Treatment Planning Meetings / Care programme Approach Meetings) to ensure the MHA status is clearly detailed. Registered nurses to be informed by email of requirements. Checking of Prescription and Administration Charts to be completed by NIC and issues identified on daily Nursing `handover` report	Medical Staff Ward Managers Ward Managers	05/08/19 02/08/19 09/08/19 09/08/19

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Random audit of Prescription and Administration Charts to be included in QWR (Quality Walk Round)	Director of Clinical Services	
The registered provider must ensure that medical notes are maintained to a recognised professional standard. The registered provider must ensure that the admission process at Ty Catrin is robust and covers patients legal detention status checks. The registered provider must ensure that all aspects of the mental health act measure are clearly and consistently recorded in the care and treatment plans.	20. Records management	Refer to for action relating to maintain professional standards 22. Managing risk and health and safety 12. Environment 04. Emergency Planning Arrangements Prior to admission to Ty Catrin, the Mental Health Act Manager requests copies of detention papers from the transferring MHAA. The detention papers are then scrutinised using Priory MHA scrutiny checklist to ensure the patient is legally detained, and any queries/discrepancies must be resolved prior to admission date. (Scrutiny forms are signed and dated and placed in the patient's legal MHA file) Upon patient's arrival to Ty Catrin, the original detention papers are checked	Director of Clinical Services MHA Manager	31/08/19 01/08/19

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that unmet needs are documented within the care plans.		again by the MHA Manager, once confirmed these are present and correct, the section 19 transfer form is signed to accept the admission. The patient is then admitted onto the ward. Ty Catrin aim to meet all patients needs and capture this in both the Care Plans, ICR Reviews and CTP's/CPA's. In the event that we are unable to meet a patients need we propose to ensure there is reference to this in the Care Plans and the `unmet` needs are reviewed and evaluated once a month via the ICR process. MDT to review current Care Plans to ensure each domain has reference to any unmet needs. Unmet needs identified in the Care Plans will be reviewed and evaluated via the ICR process on a monthly basis thereafter.	Responsible Clinicians	27/09/19 27/09/19

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Further review of `unmet` needs will be looked at in the 12 week Care Planning and Timetable process.	Responsible Clinicians Responsible Clinicians	Cyclical (12 weeks)
Quality of management and leadership				

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): Therisa Galazka

Job role: Registered Manager (Hospital Director)

Date: 02/08/19

Updated: 22/08/19