Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Ty Grosvenor

Alwen Ward, Brenig Ward, Flat 1 & Flat 2

Elysium Healthcare Ltd

Inspection date: 14 - 16 October 2019

Publication date: 16 January 2020

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
Website: www.hiw.org.uk

Digital ISBN 978-1-83933-857-1

Contents

1. What we did 5

2. Summary of our inspection 6

3. What we found 8

Quality of patient experience 9

Delivery of safe and effective care 14

Quality of management and leadership 22

4. What next? 27

5. How we inspect independent mental health services 28

Appendix A – Summary of concerns resolved during the inspection 29

Appendix B – Improvement plan 30

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 Grosvenor on the evening of 14 October and following days of 15 and 16 October 2019. The following sites and wards were visited during this inspection:

- Alwen Ward,
- Brenig Ward
- Flat 1
- Flat 2

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

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

There was a focus on least restrictive care to aid recovery and support for patients to maintain and develop skills.

Established governance arrangements were in place that aided staff to provide safe and clinically effective care. However, improvements are required in medicine management.

Staff were dedicated and knowledgeable of the individual patients and interacted with them in a dignified manner. However, some staff felt they required further training and support in providing care for female patients.

The registered provider needs to ensure that staff rotas are fulfilled with regular staff to maintain consistency of care and to alleviate the concerns of patients regarding being supported by unfamiliar staff.

This is what we found the service did well:

- Maintained an environment of care that was appropriate for the patient group
- Therapies and activities within the hospital and community supported patients to maintain and develop skills
- Established governance arrangements that provided safe and clinically effective care
- Staff interacted and engaged with patients respectfully
- Maintained detailed patient records and Care and Treatment Plans reflected the domains of the Welsh Measure.

This is what we recommend the service could improve:

- Medicine management arrangements
- Use more appropriate language when documenting patients' views on their care

- The support and training given to staff to help them provide more effective care for female patients
- Less use of non-regular staff to ensure consistency of care.

We identified regulatory breaches during this inspection regarding medicine management. 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

Ty Grosvenor is registered to provide an independent hospital at 16 Grosvenor Road, Wrexham, LL11 1BU.

The total number of persons accommodated in the establishment at any one time must not exceed 34 (thirty four) as specified below:

- Alwen ward – Locked rehabilitation – single gender – 15 beds
- Brenig ward – Locked rehabilitation – single gender – 15 beds
- Flat 1 - Locked rehabilitation – single gender – 2 beds
- Flat 2 - Locked rehabilitation – single gender – 2 beds

The service is registered only to provide, medical and psychiatric treatment to rehabilitate male and female adults who are between 18 (eighteen) and 65 (sixty five) years of age, who are diagnosed with a mental disorder and who may be liable to be detained under the Mental Health Act 1983.

The service must not admit:

- Patients requiring high or medium secure accommodation.
- Patients whose primary need is severe or profound learning disability.
- Patients whose primary need is drug and alcohol withdrawal/treatment.

At the time of inspection, there were 22 of patients.

The hospital director is the registered manager for the service. The multi-disciplinary team includes a consultant psychiatrist, an associate specialist doctor, psychologist and psychology assistants, social worker, occupational therapist and occupational therapy assistants with a team of registered nurses, including two ward managers and four charge nurses, and healthcare workers.

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

The service was first registered on 25 May 2018.

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 that staff interacted and engaged with patients appropriately and treated patients with dignity and respect.

There were a range of suitable activities and therapies available at Ty Grosvenor and accessed within the community. These provided patients with recovery and rehabilitation opportunities as part of Activities of Daily Living[1] and Real Work Opportunities[2].

A range of information was available for patients and visitors, however the registered provider must ensure that this is kept up to date and remains on display.

Health promotion, protection and improvement

Ty Grosvenor had a range of facilities to support the provision of therapies and activities. There was a hospital vehicle which assisted staff to facilitate patient activities and medical appointments in the community.

Patients' records evidenced that patients were supported to be independent through a positive risk taking philosophy of care. Patients were engaged and supported in undertaking Activities of Daily Living that promoted recovery and rehabilitation, such as preparing meals and other domestic activities. Patients

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

[2] Real work opportunities are ward based roles such as ward librarian, administrative assistant, and assistant housekeeper.

also have access to the Real Work Opportunities initiative lead by the occupational therapy team.

Each ward had an occupational therapy kitchen which patients could access to prepare meals. Each ward also had a laundry room with a washing machine and tumble drier. Both flats had their own kitchen area which also contained these appliances. These facilities enable patient within all areas of the hospital to learn and maintain skills in these areas.

Throughout the inspection we observed patients taking part in a range of therapeutic and leisure activities, with many patients regularly using Section 17 Leave[3] from hospital to access the local community. Staff and patients confirmed that community leisure facilities are accessed regularly; this was also documented within patient records. Both wards also had cardio-gym equipment that patients were able to use to take part in exercise within the hospital.

Both wards had a large communal area separated in to a lounge space and dining area which provided space for patients when not involved in activities; both flats had a small lounge and dining area. There were garden areas for each ward which patients residing in the flats could also access.

Each ward had an occupational therapy room that provided a suitable place for staff-led activities and therapies. Patients also had access to a range of books, games and other activities on the wards. There was computer and internet access available on both wards; this was restricted and monitored for each patient based on individual risk assessments.

There were pool tables on each ward, however they were unable to be used so were currently stored within side-rooms on each ward. The registered manager confirmed that the pool tables were due to be secured within the main communal areas, this would enable them to be used without the risk of them being moved and injuring patients or staff.

There was information displayed at the hospital for patients which included details on how to raise a complaint and contact external organisations including

[3] Section 17 of the Mental Health Act is the authorisation of a detained patient's leave from hospital.

independent advocacy. However, at the time of the inspection there was not information displayed for patients on HIW and how to contact us. We were informed that information was normally displayed, however this had been removed at some point. The registered manager confirmed that this information would be re-displayed on the wards.

Improvement needed

The registered provider must:

- Confirm that The pool tables are available for use
- Confirm that Information about HIW and how to contact us is displayed on the wards
- Ensure that there is routine check that relevant information for patients is up to date and displayed.

Dignity and respect

We observed that all 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.

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, it was evident that patients were able to personalise their rooms and that there was sufficient storage for their possessions.

The hospital had suitable rooms for patients to meet ward staff and other healthcare professionals in private. However, some rooms were unkempt and were being used to store items of furniture awaiting removal from the hospital.

There were visiting arrangements in place for patients to meet visitors at the hospital; this included a designated child visiting room.

Improvement needed

The registered provider must ensure that unwanted items of furniture are promptly removed from patient areas.

Patient information and consent

As detailed above, there was information displayed for patients at the hospital. There was also a range of information available in Easy Read format to aid understanding for some patients.

Information leaflets were also available and provided to patients to assist them in understanding areas of their care, such as the Mental Health Act and medication.

There was a range of information displayed and available within the hospital reception for patients and visitors, including family members and friends. However, we noticed that one piece of information referred to the hospital as male only, which was no longer the case. This needs to be updated as this incorrect information may cause concern to the reader if they are a female patient or a visiting family member or friend.

Improvement needed

The registered provider must ensure all formats of hospital information is kept up to date.

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.

Each ward had a weekly patient meeting which gave an opportunity for patients 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 carers were also included in some meetings.

Care planning and provision

Care was individualised, focused on recovery and was supported by least restrictive practices, both in care planning and ward or hospital practices.

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.

Ty Grosvenor provided patients with a locked rehabilitation environment to prepare them for discharge to a less secure environment. This was in part assisted with the two flats located within the hospital that can provide patients the opportunity to receive care within an environment with minimal support from staff.

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 Elysium Healthcare policies and systems which ensured that the patients' equality, diversity and rights were maintained. The design of the hospital and organisational policies ensured an accessible environment for people who may have mobility needs.

Legal documentation to detain patients under the Mental Health Act (the Act) was compliant with the legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code).

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 hospital environment was equipped with suitable furniture, fixtures and fittings for the patient group.

There were established processes and audits in place to manage risk and health and safety. This enabled staff to provided safe and clinically effective care for patients. However, improvements are required in medicines management at the hospital.

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

Managing risk and health and safety

Ty Grosvenor had established processes in place to manage and review risks and to maintain health and safety at the hospital. These supported staff to provide safe and clinically effective care.

Access to the hospital was direct from the hospital car park and street, this provided suitable access for people who may have mobility difficulties. Visitors were required to enter the hospital via a reception area and intercom system. This helps to deter unauthorised persons from entering the building. Access through the hospital was restricted to maintain the safety of patients, staff and visitors.

Staff wore personal alarms which they could use to call for assistance when necessary. There were also nurse call points around the hospital and within patient bedrooms that were within reach of the beds, this ensure patients can summon assistance if required.

The hospital 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.

The hospital had a dedicated maintenance staff member who we were informed was responsive; throughout the inspection, we saw them responding and

undertaking maintenance work to rectify environmental issues. Where required referrals to external contractors were completed.

However, whilst there was a maintenance requisition system in place, we were informed that a significant number of requests are made verbally. This meant that there was not a comprehensive record to monitor what works have been completed, what was outstanding and how to prioritise these. We were informed that this was under review with the aim to ensure that a systematic process was implemented to enable this.

Improvement needed

The registered provider must ensure that there is a systematic process for requesting and prioritising estates and maintenance requests.

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 was an infection control champion at the hospital, being the nominated person with responsibility for this area. A system of regular audits in respect of infection control was in place. These were completed with the aim of identifying areas for improvement so that appropriate action could be taken where necessary.

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. Designated plastic bins were used for the safe storage and disposal of medical sharps, for example, hypodermic needles; these were assembled correctly and stored safely.

Clinic room basins were not fitted with appropriate taps to help maintain infection control. The taps required to be operated by hand which can result in cross-contamination. Basins in clinical areas should have elbow or wrist lever operated mixer taps or automated controls[4] to aid infection prevention and control.

[4] Royal College of Nursing guidance: Good Practice in infection prevention and control

Training statistics evidenced that 95% of clinical staff had completed levels 1 and 2 of Infection Control training and 90% of support staff had completed level 1.

Improvement needed

The registered provider must ensure:

- Clinic room taps aid infection prevention and control arrangements in line with the Royal College of Nursing guidance, *Good Practice in infection prevention and control*
- All staff complete the required Infection Control training.

Nutrition

We found that patients were provided with a choice of meals. We saw a varied menu and patients told us that they had a choice of what to eat. Patients had fresh fruit readily available and access to drinks.

As part of patient rehabilitation care, patients were able to use the occupational therapy kitchens to prepare their own meals which enabled them to maintain and learn culinary skills. Where patients had Section 17 Leave authorised they could also undertake food shopping as part of their community focused rehabilitation activities.

There was a dietician who attended the hospital when required; this includes providing specialist advice for an individual patient's diet and assessments of patients' eating and drinking needs. Patient records evidenced weight and body mass index (BMI) monitoring as part of patients' care and when food and fluid intake monitoring was completed.

Medicines management

There was a regular external pharmacy audit undertaken that assisted the management, prescribing and administration of medication at the hospital. However, improvements are required in medicines management 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.

Medication was stored securely within cupboards and medication fridges that were locked. However, when we entered the clinic room on Alwen Ward the medication trolley was not secured to the wall and it was unlocked whilst not

being accessed by a registered nurse. Therefore the medication was not appropriately secured against unauthorised removal.

There were regular medication stock checks completed. During the inspection there was out-of-date medication identified by the ward staff, however this had been left on the work-surface within a clinic room awaiting collection and disposal. Medication awaiting disposal must remain secured within a locked cupboard or trolley and identified as being for disposal to ensure that it is not mistakenly used.

There were appropriate arrangements in place to ensure that the Controlled Drugs (Supervision of Management and Use) Regulations 2013 were followed. A stock check of the controlled drugs on Alwen Ward identified a discrepancy between the stock available and the log. We saw how this had been highlighted and investigated and how this resulted in the quick identification of the situation that caused a stock error. We confirmed that no controlled drugs had been misplaced.

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

Whilst PRN medication[5] was recorded on MAR Charts as being dispensed, there was not always a record within the patient's records that PRN medication had been administered and the reason why. This means that there wasn't a clear rationale to document the reason why PRN medication was given to a patient.

Training statistics evidenced that 78.6% of relevant staff had completed their annual Safe Administration of Medicine. This requires improvement to ensure that staff are up-to-date and maintain their skills and knowledge.

It was positive to note that during an observation of the medication round on Brenig Ward we witnessed professional and engaging interactions between the registered nurse and the patients.

[5] PRN Medication is administered as and when required as opposed to medication administered at regular times.

Improvement needed

The registered provider must ensure that:

- Medication trollies are secured to the clinic room walls and locked when not being accessed
- Medication is stored securely whilst awaiting disposal
- Patient records document the use of PRN medication and the reason for its use
- Staff to complete their Safe Administration of Medicine training.

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 91% of staff were up to date with both their child and adult safeguarding training.

Improvement needed

The registered provider must ensure that all staff complete their child and adult safeguarding training.

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.

Safe and clinically effective care

We found governance arrangements in place that helped ensure that staff provided safe and clinically effective care for patients.

Clinical governance arrangements for the hospital fed through to Elysium Healthcare governance arrangements which facilitated a two way process of monitoring and learning.

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. We observed staff updating and storing the records appropriately during our inspection.

Mental Health Act Monitoring

We reviewed the statutory detention documents of five patients across both Alwen Ward and Brenig Ward. We also reviewed the governance and audit processes that were in place for monitoring the use of the Mental Health Act at the hospital.

The five sets of statutory documentation verified that the patients were legally detained. It was evident that detentions had been renewed within the requirements of the Act. The renewal of detention was correctly applied on statutory forms and copies of legal detention papers were available.

It was documented within patient records that they had been informed of their rights in line with Section132 of the Act. Records evidenced that appeals against the detentions were held within the required timescales.

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.

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 also documented whether the patient had been offered and received a copy of their Section 17 Leave.

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

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

The Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and on the whole were regularly reviewed.

Individual Care and Treatment Plans drew on the patient's strengths to aid recovery, rehabilitation and independence. These were developed with members of the multi-disciplinary team and based on evidence based practice. Patient records also included appropriate and detailed physical health care plans and completed monitoring documentation.

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.

There was evidence in some patient care plans that documented the views of the patient. However, this was not consistently included and in some case the wording used contained medical and technical jargon that did not reflect the use of language by the patient which would not aid understanding.

For one set of patient care plans we reviewed, whilst these were comprehensively written, there was no evidence that these had been reviewed by the patient's current care team at Ty Grosvenor despite the patient transferring from another Elysium Healthcare hospital over a month prior to the inspection. This means we could not be assured that the care plans in place were still applicable for the patient at the current hospital.

This patient's records also did not include the most recent Positive Behaviour Support (PBS) plan[6]. Staff confirmed that they had received a paper copy of the PBS plan when the patient was transferred, however this was not available within the patient's records during the inspection and could not be found by staff at the hospital.

Improvement needed

The registered provider must ensure that:

[6] Positive behaviour support (PBS) is 'a person centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing, behaviours that challenge. Guide to positive behaviour support

- The views of patients are captured in their care plans with appropriate use of language
- There is a record of care plan reviews within patient records when a patient is transferred to the hospital
- Patient records have a copy of their PBS plan.

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.

There were defined Elysium Healthcare structures and systems that provided clinical and corporate governance to direct the operation of the hospital.

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

There was a core of dedicated and knowledgeable staff that had a good understanding of the individual needs of the patients at the hospital. However, some patients and staff raised concerns about the use of non-regular agency staff members to fulfil staff rotas and their unfamiliarity of the patients' needs.

Mandatory training was regularly monitored and compliance rates were generally very high. However, some staff felt they required further training and support in providing care for female patients.

Governance and accountability framework

We found that there were 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 well defined during the day and during the night-shift there were management and doctor on-call arrangements in place.

However, during the night shift, no nurse on shift was specifically identified as having overall oversight of the hospital to make key decisions, such as changes to allocation of staff across the wards. Whilst staff confirmed that the wards assisted each other, which was observed, staff we spoke with were unclear on how many staff were present at the hospital, only knowing the staffing for their own ward. It has been noted at other multi-ward Elysium Healthcare establishments that to resolve this issue, one of the registered nurses on night shift would be the designated nurse in charge of the hospital, with defined roles and responsibilities to oversee the management of the hospital during the night shift.

The hospital was registered and operational from May 2018, this commenced with the opening of Alwen Ward, to provide care for male patients. The hospital had a designated multi-disciplinary team and ward staff to provide a male only service. Brenig Ward become operational in March 2019, providing care for female patients.

During our discussions with some ward staff and some multi-disciplinary team members they expressed that providing care for the female patients was a different set of challenges to that of the male patients. Some of the staff stated that on commencing their role they expected to be working at a male only hospital and that they felt less equipped and required further support to provide care for female patients. Some staff stated that this had impacted negatively on the morale of the staff. The registered provider must identify and provide additional support and specific training to enable staff to better support female patients.

It was positive that, throughout the inspection, the staff at Ty Grosvenor 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
- Provide staff with additional support and specific training to staff to aid providing support to female patients.

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 complaints for services within Ty Grosvenor.

Complaints were categorised as informal or formal complaints. Informal complaints were raised and resolved at ward level. Formal complaints are logged on the registered provider's electronic system. 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 the 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.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. This routinely occurred at each management morning handover by the members of the multi-disciplinary team involved in the individual patient's care.

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 look 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.

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

Each ward had an enhanced care room, which provided a bedroom for a specific patient to be supported more intensively. When an enhanced care room is not being used to provide care for a specific patient these rooms could also be used as an area to redirect a patient from communal space as part of de-escalation. However, staff stated that if the enhanced care room on the ward is being occupied by a patient, there is limited areas to redirect a patient to de-escalate in a private manner that would help maintain the patient’s dignity. Some of the staff we spoke with provided a range of options to that could be implemented to aid de-escalation in these circumstances.

Improvement needed

The registered provider must consider the options put forward by staff to improve the management of incidents within the communal areas.

Workforce planning, training and organisational development

We reviewed the staffing establishment at Ty Grosvenor; at the time of the inspection there were four registered nurse vacancies. The registered manager described the hospital's future workforce planning arrangements to fill these positions.

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. Agency registered nurses were typically regular individuals who were familiar with working at the hospital and the patient group; this assisted with the continuity of care for patients.

However, despite the efforts to provide continuity of staff with regular agency staff, some patients stated that there were unfamiliar agency staff present on the ward. This meant the patient felt less assured and concerned whether the agency staff members could met their needs and maintain the safety on the ward. Some staff members we spoke with also raised their concerns with the use of non-regular agency staff and their unfamiliarity with the individual patients; which meant that they were not best placed to support with the individual patients and therefore felt that the needs of the patients were not being comprehensively met.

In addition, despite staffing in accordance with the devised rotas, some staff stated that due to the number of enhanced observations, particularly during the night when there are fewer staff present, ensuring that staff receive their shift break can be difficult, and on occasions this does not happen. The rota must ensure that staff are able to have their allocate break; without which may lead to fatigue and could potentially affect their well-being and/or compromise their professional judgements and impact on patient safety.

We reviewed the mandatory training statistics for staff at Ty Grosvenor and found that completion rates were above 85% with the majority over 95%. The one exception being Safe Administration of Medicine highlighted earlier in the report. The electronic system provided hospital management with the course and individual staff compliance details which enabled ease of monitoring.

Staff completed annual performance appraisals and these were documented to evidence that these had been completed. However, whilst staff were able to access clinical supervision we were informed that generally, the uptake was low.

Improvement needed

The registered provider must:

- Ensure that rotas are filled with regular members of staff
- Ensure that rotas are sufficiently staffed to enable staff members to have their shift break
- Consider how to encourage and support ward staff in undertaking clinical supervision.

Workforce recruitment and employment practices

Staff explained the Elysium Healthcare recruitment processes that were in place at Ty Grosvenor. 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

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 identified on this inspection	Not applicable	Not applicable	Not applicable

Appendix B – Improvement plan

Service: Ty Grosvenor

Ward/unit(s): Alwen Ward, Brenig Ward, Flat 1 & Flat 2

Date of inspection: 14 – 16 October 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 confirm that the pool tables are available for use.	3. Health promotion, protection and improvement	The provider can confirm that both pool tables that were awaiting repair have now been fully refurbished and are in situ for patient therapeutic benefit on both wards.	Edward Rowlands, Hospital Director	Completed October 2019
The registered provider must confirm that information about HIW and how to contact us is displayed on the wards.	3. Health promotion, protection and improvement	The provider has identified the Mental Health Act (MHA) Administrator as the person who will formulate a checklist of pertinent and relevant information to support patients on the ward, to include information on HIW and how they can be contacted. The MHA	MHA Administrator	Completed November 2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Administrator will audit the noticeboards on a weekly basis to ensure that no information has been removed and if so to duplicate.		
The registered provider ensure that there is routine check that relevant information for patients is up to date and displayed.	3. Health promotion, protection and improvement	The provider has identified the Mental Health Act (MHA) Administrator as the person who will formulate a checklist of pertinent and relevant information to support patients on the ward, to include information on HIW and how they can be contacted. The MHA Administrator will audit the noticeboards on a weekly basis to ensure that no information has been removed and if so to duplicate. All information relating to Ty Grosvenor being male only service has been withdrawn so as to mitigate any confusion to patients, commissioners and external stakeholders that the service does indeed provide care and treatment to both men and women.	MHA Administrator	Completed November 2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that unwanted items of furniture are promptly removed from patient areas.	10. Dignity and respect	Both pool tables that were temporarily being stored in a therapy room awaiting repair have now been allocated to both Alwen and Brenig wards and all therapy related equipment has been transferred to the Occupational Therapy department now that building works are complete. There will be regular Walk-The-Wards by the Clinical Lead Nurses and the housekeeping department t ensure that no unwanted items of property are stored in any of the patient areas.	Edward Rowlands, Hospital Director	Completed November 2019
The registered provider must ensure all formats of hospital information is kept up to date.	9. Patient information and consent	All information relating to Ty Grosvenor being male only service has been withdrawn from the reception area and a regular audit process has been commissioned to ensure that all relevant information is readily available and that it reflects current business objectives.	MHA Administrator	Completed November 2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The registered provider must ensure that there is a systematic process for requesting and prioritising estates and maintenance requests.	22. Managing risk and health and safety 12. Environment	Ty Grosvenor has an established maintenance work requisition process in situ, however in order to make that system more robust and to offer a quality assurance process in being able to identify the timeframe duration that requests are taking a tracker system has now been introduced which gives a global overview of response times.	Maintenance	Completed October 2019
The registered provider must ensure clinic room taps aid infection prevention and control arrangements in line with the Royal College of Nursing guidance, *Good Practice in infection prevention and control*	13. Infection prevention and control (IPC) and decontamination	The provider will seek to get a quote for the installation of appropriate elbow lever taps for both clinics and instruct the installation of same	Maintenance	Complete by 25 February 2020
The registered provider must ensure all staff complete the required Infection Control training.	13. Infection prevention and control (IPC) and decontamination	The provider can confirm that Infection Control Level 1 is 100% complete for both Clinical and Support staff.	PA to Hospital Director	Completed November 2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that medication trollies are secured to the clinic room walls and locked when not being accessed.	15. Medicines management	The provider has ensured that all Registered Nurses are fully compliant with Medicine Management training and the Medicine Management Policy, that indicates that the medicine trolleys are secured to the clinic room walls and locked when not being accessed. The provider has also incorporated this as an action on the Clinic Room Check List so that all Registered Nurses, including Agency Registered Nurses, must sign to confirm that they are compliant in checking that the medication trolley is locked and anchored in the clinic wall when not in use. The provider has provided signage for both the clinic areas that are attached to the medication trolleys and clinic walls above the medication trolleys, directing the registered nurses to ensure the medication trolleys are locked and anchored to the clinic room walls when not in use. The provider has also introduced	Hospital Director Clinical Lead Nurses	Complete by 30 November 2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		management checks by the Clinical Lead Nurses so as they check that the medication trolleys are locked and securely anchored to the clinic walls when not in use. These checks will be carried out following medication rounds.		
The registered provider must ensure that medication is stored securely whilst awaiting disposal.	15. Medicines management	The provider has instructed the Clinical Lead Nurse to liaise with all registered nurses to ensure their comprehension and compliance of the safe and secure disposal of medication.	Clinical Lead Nurses	Completed November 2019
The registered provider must ensure that patient records document the use of PRN medication and the reason for its use.	15. Medicines management	The provider has instructed the Clinical Lead Nurse to liaise with all registered nurses to ensure that any administration of PRN medication is clearly recorded and documented within the patient electronic record. The provider has also formulated a morning handover checklist to support the compliance of this action.	Clinical Lead Nurses	Completed November 2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that staff to complete their Safe Administration of Medicine training.	15. Medicines management	All registered nurses to completed Level 2 Safe Administration of Medicine and all non-registered nurses to complete Level 1. Currently 100% compliance with all registered nurses and awaiting 2 non-registered nurses to complete theirs.	Clinical Lead Nurses	Complete by 30 November 2019
The registered provider must ensure that all staff complete their child and adult safeguarding training.	11. Safeguarding children and safeguarding vulnerable adults	The provider is currently 97% concordant with child and adult safeguarding training with another training session scheduled for 13 December with both (2) of those staff numbers requiring training having scheduled to attend.	Edward Rowlands, Hospital Director	Complete by 31 December 2019
The registered provider must ensure that the views of patients are captured in their care plans with appropriate use of language.	Monitoring the Mental Health (Wales) Measure 2010	The provider has commissioned the support of the Regional Compliance and Regulation Lead to support the team in care planning. The Compliance and Regulation Lead has delivered training in care plan writing and this is currently being rolled out within the service. It is envisaged that all care plans will be reviewed in	Clinical Lead Nurses	Complete by 31 December 2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		regards to them being non-jargon and reflecting the patient's spoken language.		
The registered provider must ensure that there is a record of care plan reviews within patient records when a patient is transferred to the hospital.	Monitoring the Mental Health (Wales) Measure 2010	The provider has instructed the MDT to ensure that all newly admitted patients to the service are reviewed within the first week of admission to ensure that the package of care reflects the patient's needs, commissioner views and any formal assessment undertaken.	Dr Thushara Stanly, Consultant Psychologist	Ongoing
The registered provider must ensure that patient records have a copy of their PBS plan.	Monitoring the Mental Health (Wales) Measure 2010	The provider has directed the MDT to ensure that all patients have a positive behaviour support plan in situ.	Dr Thushara Stanly, Consultant Psychologist	Complete November 2019
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	The provider is advertising for 2 Night Service Coordinators in order to assume the out of hours coordination of the service.	Edward Rowlands, Hospital Director	Complete by 29 February 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must provide staff with additional support and specific training to staff to aid providing support to female patients.	1 Governance and accountability framework	The provider has liaised with Andrea Saunders, Training Lead Wales, to commission an NVQ provider so as to offer staff more bespoke training. The Elysium Learning and Development platform will also be reviewed so as to identify relevant online learning, for example self-harming behaviours, ASD, DBT skills.	PA to Hospital Director	Ongoing
The registered provider must consider the options put forward by staff to improve the management of incidents within the communal areas.	23 Dealing with concerns and managing incidents	The provider has gathered the views of the Nursing Department as to how to improve the management of incidents within the communal areas of the wards. One of these options has been to develop a low stimulus area on one of the wards utilising a large and airy area of one of the corridors and to furnish it with appropriate furniture that will support de-escalation. It has also been proposed that privacy screens be purchased to maintain the privacy and dignity of patients required de-escalation. Another option proposed	Hospital Director	Complete by 31 January 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		on another ward is to provide a settee in one of the lesser used day areas that will support seated de-escalation if required and again privacy screens to be purchased in order to maintain privacy and dignity. However whenever possible the enhanced care suites will be the preferred option. The provider will therefore source appropriate furniture and privacy screens so as to support the staff team in their interventions when de-escalation of a disturbed patient is required and the enhanced care suite is unavailable.		
The registered provider must ensure that rotas are filled with regular members of staff.	25. Workforce planning, training and organisational development	The provider is actively recruiting registered and non-registered team members. There are currently 3 registered nurses on-boarding and 10 non-registered on-boarding. Inductions for some of these employees is scheduled for 2 December 2019 and they will then be reflected within the rotas. The provider	Edward Rowlands, Hospital Director	Ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		will continue to work with Firs Tier Agency to ensure regular staff to promote continuity and consistency in service provision. The provider has also explored recruiting 6 oversee nurses.		
The registered provider must ensure that rotas are sufficiently staffed to enable staff members to have their shift break.	25. Workforce planning, training and organisational development	The provider has two weekly resource meetings chaired by the Clinical Lead Nurses so as to ensure the wards are adequately covered and also so as to be able to facilitate breaks for all staff members.	Clinical Lead Nurses	Ongoing
The registered provider must consider how to encourage and support ward staff in undertaking clinical supervision.	25. Workforce planning, training and organisational development	The provider has asked the Clinical Lead Nurses to diarise 4-6 weekly supervisions for all their team members, in addition to this Schwartz Rounds have also been incorporated within the service which offers team members within the service group supervision and reflection. The clinical psychologist is also available to provide 1:1 reflection.	Dr Persa Maerz, Counselling Psychologist	Ongoing

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): **Edward Rowlands**

Job role: **Hospital Director**

Date: **29 November 2019**