Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

NHS Mental Health Service Inspection (Unannounced)

Ty Llywelyn

Branwen, Gwion & Pwyll

Betsi Cadwaladr University Health Board

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

Our purpose

To check that people in Wales 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 mental health inspection of Ty Llywelyn within Betsi Cadwaladr University Health Board on the evening of 27 January 2020 and following days of 28 and 29 January 2020. The following sites and wards were visited during this inspection:

- Gwion – Medium Secure Psychiatric Intensive Care Unit
- Pwyll – Medium Secure Acute Ward
- Branwen – Medium Secure Rehabilitation Ward

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

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

HIW explored how the service met the Health and Care Standards (2015). Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

HIW previously inspected Ty Llywelyn in December 2016.

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

2. Summary of our inspection

We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed that staff interacted with patients respectfully throughout the inspection.

There was clear leadership for the service and evidence of service development plans.

Patients had good access to a range of occupational therapy activities within the hospital and community.

We identified some improvements required in relation to medicines management.

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Patients were provided with a good range of therapies and activities
- Care plans were individualised and focused on patient rehabilitation
- Established governance arrangements that provided safe and clinically effective care.

This is what we recommend the service could improve:

- Provision of information for patients
- Safe and effective medicines management
- Recordkeeping arrangements.

3. What we found

Background of the service

Ty Llewelyn provides NHS medium secure mental health services at Bryn y Neuadd Hospital, Aber Road, Llanfairfechan, Conwy LL33 0HH within Betsi Cadwaladr University Health Board.

The service has three male wards:

- Gwion, a five bed Medium Secure Psychiatric Intensive Care Unit
- Pwyll, a ten bed Medium Secure Acute Ward
- Branwen, a ten bed Medium Secure Rehabilitation Ward

At the time of inspection, there were 23 patients at the hospital.

The service employees a staff team which includes a service manager, three ward managers who are supported by deputy ward managers and a team of registered nurses and healthcare assistants.

The multidisciplinary team included three psychiatrists, an occupational therapy team and a psychology team of two psychologists and a psychology assistant as well as long term student placements. The Forensic Community Team was also located at Ty Llywelyn who worked collaboratively with the wards, this included two social workers, a registered nurse and two healthcare assistants. The service can refer to other health board services as required.

The operation of the hospital is supported by a team of administration staff. The hospital employs a team of domestic and catering staff. The hospital is supported by the management and organisational structures of Betsi Cadwaladr University Health Board.

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 Llywelyn and accessed within the community. These provided patients with recovery and rehabilitation opportunities.

A range of information was available for patients, however this needs to be displayed consistently across the hospital.

Staying healthy

There was strong emphasis at the hospital to provide patients with a wide range of activities to help support their independence and aid recovery.

Each patient had a plan of therapies and activities. Input from the occupational therapy team provided an appropriate range of assessments and activities, within the hospital and the community. We observed patients to be regularly engaged in activities and therapies, on the wards, around the hospital and accessing the community.

The hospital exercise facilities included a gym with cardo-exercise machines and free-weights, a sports hall that was used for sports such as football and badminton. In additional, the hospital was set within large grounds that enabled patients to use these for exercise, which included the twice weekly morning mile, a positive initiative where patients and staff would work a mile around the

grounds. There were also some patients participating in the couch to 5k well-being initiative[1].

From each ward patients had direct access to an enclosed garden area so that they could regularly access fresh air. However, Gwion and Pwyll shared the same garden area and therefore there were set times when each ward had access to the area. During the inspection senior managers shared service development plans that included extension of hospital facilities that would not only provide further on-ward therapeutic spaces but also enable each ward to have its own garden area. These developments sounded positive and would provide additional therapeutic facilities to aid rehabilitative care for patients at the hospital.

There was arts and craft facilities at the hospital and a woodwork room. Each ward had an Activities of Daily Living[2] (ADL) kitchen which enables patients to learn and maintain cookery skills whilst in hospital. However, at the time of the inspection staff and patients informed us that the use of these had reduced,as there was no policy in place to support staff with the use of the ADL kitchens. Adraft policy is now in place, which the health board must ensure ratified to enable patients to access these valuable facilities as part of their rehabilitative care. The freezer on Gwion was out of order and awaiting replacement, we were informed that this was due imminently.

Each ward also had laundry facilities which could be used by patients to learn and maintain skills as part of ADL activities. However, at the time of the inspection the tumble drier on Gwion was out of order as was the washing machine on Pwyll. We were informed that both these appliances had only recently become unavailable and that a work request was being processed to repair or replace these appliances. There were appropriate arrangements in place to ensure that patients could still use laundry facilities whilst minimising inconvenience.

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[1] A programme of exercise of increasing increments of activity with the aim for the person to be able to complete 5km run/walk https://www.nhs.uk/LiveWell/c25k/Pages/couch-to-5k.aspx

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

Improvement needed

The health board must:

- Update HIW on the additional therapeutic space
- Ensure a ratified policy is in place to support the use of the ADL kitchens
- Ensure that all non-working appliances are repaired or replaced in a timely manner.

Dignified care

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

We observed staff taking time to speak with patients and address any needs or concerns the patients raised, this demonstrated that staff had responsive and caring attitudes towards the patients. The patients we spoke with were complimentary about the staff engagement and the care that was provided at the hospital.

Each patient had their own bedroom that provided patients with a good standard of privacy. There was one bedroom on each ward that had en-suite facilities, however at the time of the inspection the en-suites were out of use to support the safety of patients whilst awaiting the completion of anti-ligature work. It was explained that work was due to be completed but unfortunately there had been delays with the external contractors which was out of the control of the health board. We were informed that this work would be completed within the coming months.

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. Any items that were considered a risk to patient safety, such as razors, aerosols, etc. were stored securely and orderly on each of the wards and patients could request access to them when needed.

The hospital had suitable rooms for patients to meet ward staff and other healthcare professionals in private. There were visiting arrangements in place for

patients to meet visitors at the hospital, this included facilities to support child-visiting arrangements.

There was no internet/Wi-Fi access at Ty Llywelyn. It is acknowledged that there can be risks to the protection of patients and other persons with unrestricted access to the internet and associated communication technologies. However, risk should be based on individual patient basis and the use of the internet and communication technologies can be used to support patients with appropriate contact with family and friends. The health board can also use access to the internet to educate patients in staying safe whilst online and building skills to use the internet as part of their rehabilitative care.

Improvement needed

The health board must:

- Ensure that the anti-ligature works are completed to reinstate the en-suite facilities.
- Consider how to provide appropriate access to Wi-Fi at Ty Llywelyn.

Patient information

There was a range of information for patients displayed at the hospital.

Information was displayed on how patients and their families can provide feedback about their experiences of the care provided on the wards; this included how to raise a concern through the NHS Wales Putting Things Right[3] arrangements. There was also information displayed regarding advocacy arrangements.

Information was also displayed in some ward areas to promote well-being and healthy lifestyles, such as healthy eating and smoking cessation.

[3] Putting Things Right is the process for managing concerns in NHS Wales. http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

However, the range of information was not consistently displayed across all ward areas, and therefore not visible for all patients. There was also no information available on the role of HIW and how patients can contact us.

Improvement needed

The health board must ensure that each ward area displays information about:

- NHS Wales Putting Things Right
- Advocacy arrangements
- Well-being and healthy lifestyles
- The role of HIW and how patients can contact us.

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff ensured 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.

There was a daily morning meeting on each ward where staff arranged the activities, within the hospital and the community, alongside other activities and meetings, such as care planning meetings, tribunals and medical appointments.

The hospital had a regular patient forum where patients had the opportunity to provide feedback on the care that they receive at the hospital and discuss any developments or concerns.

There was a positive initiative “Together for Recovery” which included the advocacy service, patients and their families, to discuss the service and future developments with members of the hospital and health board.

Individual care

Planning care to promote independence

There was a clear focus on rehabilitation with individualised patient care that was supported by least restrictive practices, both in care planning and hospital practices.

Each patient had their own individual weekly activity planner, this included individual and group sessions, based within the hospital and the community.

As detailed above, the activities were varied and focused on recovery, either at the hospital or in the community. Individual patient activity participation was monitored and audited. Where patients declined, we observed staff offering alternatives; this was recorded in the patient record.

People's rights

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

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).

As detailed earlier, there were suitable rooms where patients could meet with visitors. Patients were also able to use telephone to contact family, friends and professionals. As also stated, improvements could be made to support patients, based on individualised risk assessments, in the use of internet technology to support external contact whilst at the hospital.

The hospital had submitted a capital funding bid to develop the reception area to meet national medium secure standards and therefore enhance patient and visitor experience. The proposed improvements would aid the hospital safety arrangements for patients, staff and visitors. In addition providing disabled toilet facilities that were not present within the reception area.

Improvement needed

The health board must provide an update on the redevelopment of the Ty Llywelyn reception area.

Listening and learning from feedback

As detailed earlier, the health board had arrangements in place for patients and their families to provide feedback about their experiences and to raise a concern.

Governance documentation evidenced how this information was monitored and reviewed, in addition how learning from feedback could be shared across the health board's services.

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 with the storage of medication at the hospital.

Safe care

Managing risk and promoting health and safety

Ty Llywelyn 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, this included the controlled egress from each ward. As stated earlier, there were plans in place to improve the reception facilities for the benefit of patients, staff and visitors.

Staff wore personal alarms which they could use to call for assistance when necessary. We observed on a number of occasions that when alarms were activated staff attended promptly. 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, an improvement since our previous inspection.

On the whole the hospital was well maintained and suitably furnished. However, apart from the non-working appliances detailed earlier, there were also some torn seating on Pwyll; this poses potential infection control and safety risks.

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. At the time of the inspection there were some ligature points remaining that had been identified to be removed, in the meantime, these risks were managed by monitoring the areas with staff. This however does impact upon the freedom of movement of patients on the ward, who are reliant on staff to be able to observe these areas. Addressing these ligature points would be a benefit to the patient experience on the wards.

Strategies were described for managing challenging behaviour to promote the safety and well-being of patients. We were told that preventative techniques were used and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the physical restraint of patients was used, but this was rare and only used as a last resort.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed so that the occurrence of incidents could be reviewed and analysed. Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation.

Improvement needed

The health board must ensure that the damaged seating on Pwyll is repaired or replaced.

Infection prevention and control

Throughout the inspection we observed the hospital to be visibly clean and free from clutter. A system of regular audits in respect of infection control was in place. Cleaning equipment was generally stored and organised appropriately. However during the first evening of the inspection we observed mops being inappropriately stored within the ADL kitchen on Gwion; this issue was resolved during the inspection.

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.

Nutrition and hydration

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

However, some staff and patients we spoke with stated that meals could become repetitive when patients are typically at the hospital for long periods; this was compounded by the restricted use of the ADL kitchens.

Improvement needed

The health board must look at providing a more diverse menu for patients at Ty Llywelyn.

Medicines management

Improvements required were identified with the storage of medication at the hospital.

Whilst there was evidence that there were regular temperature checks of the medication fridge, there were no measuements of clinic room temperatures being completed to ensure that non-refrigerated medication was stored at the manufacturer's advised temperature. There was also no means apparent to reduce the temperature of the clinic room if required. This was an issue during our previous inspection and remains unaddressed.

Medication was stored securely within cupboards that were locked, however medication fridges on each of the wards were unlocked during the inspection.

Ward clinic rooms were small but reasonably well organised. There was another clinic room with an examination bed within the hospital. This area was not well kept and we observed areas of high level dust in the room; the health board need to ensure that this area is maintained.

Medication Admission Record (MAR) charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. It was positive to note that each MAR chart was accompanied by an up-to-date photograph of the relevant patient to aid staff with identification. However, MAR charts were not always complete with important patient details being omitted from the MAR charts, such as weight, height, date of birth and legal status under the Act.

Improvement needed

The health board must ensure that:

- The ambient temperature of clinic rooms is monitored and arrangements are in place to alter the temperature of the room as required
- Medication fridges remain locked when not being accessed
- All clinic rooms are organised and free from dust and clutter
- MAR charts contain all required patient information.

Safeguarding children and adults at risk

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

Medical devices, equipment and diagnostic systems

There were regular audits of resuscitation equipment undertaken which documented that all resuscitation equipment was present and in date. Each ward had ligature cutters that were stored in designated places so that staff could access these if required.

Effective care

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 health board's governance arrangements, which facilitated a two way process of monitoring and learning.

Record keeping

Patient records were a combination of electronic and paper records. Electronic records these were password protected and paper documentation were stored securely within locked offices to prevent unauthorised access and breaches in confidentiality. We observed staff storing the records appropriately during our inspection.

During our review of patient records we found that some documentation being stored in the paper records were not the most up-to-date versions, with the current version being stored electronically. This meant that there was a risk that staff could refer to out-of-date care documentation in error.

Improvement needed

The health board must review the record keeping arrangements at Ty Llywelyn to minimise the number of systems in place.

Mental Health Act Monitoring

We reviewed the statutory detention documents of four patients across the three wards.

The records reviewed evidenced that the patients were legally detained. However one set of patient detention records were incomplete, not all documents were received by the health board when the patient was transferred to the hospital from another setting. It is essential that all detention papers are available to be scrutinised to ease the validation of detentions.

It was documented within patient records that they had been informed of their rights in line with Section 132 of the Act. However, it was not evident how frequently this was being undertaken to remind patients of their rights on a regular basis.

Records evidenced that appeals against the detentions were held within the required timescales. However, it was reported that on regular occasions there have been delays in receiving required reports from varying disciplines involved with the care of the relevant patient. Timely reports are required to ensure that these are available for review and scrutiny in the reviews that are essential in safeguarding patients' rights of the review of their detention in hospital under the Act.

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 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. However, expired leave

authorisation forms were not always marked as no longer valid, therefore there is a risk that staff may refer to these in error.

We also reviewed the governance arrangements for monitoring the application of the Act across the hospital. It was positive to note that a Mental Health Act Action Plan had been devised to aid the internal monitoring process. It was also reported that the Mental Health Act department met regularly with the ward teams and provided training and updates at the hospital.

Improvement needed

The health Board must ensure:

- A full set of detention papers is present for each patient
- That there is a clear record of patients being offered the provision of their rights on a regular basis
- That professional reports for appeals against detentions are submitted in a timely manner.

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

We reviewed the care plans of a total of four patients. For three of the patients their Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed. However one patient's Care and Treatment Plan was brief and did not reflect the in-patient care plans held within the electronic records.

To support in-patient care plans, there were a range of patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them. However, for one patient there was not a fully completed violence risk assessment in place despite the clinical records indicating this was required.

Individual care plans drew on the patient's strengths and focused on recovery, rehabilitation and independence. These were developed with members of the multi-disciplinary team and utilised evidence based practice. There was evidence of discharge planning where appropriate for patients on that pathway.

There were regular individual care reviews completed. It was encouraging that the hospital had recently reviewed the format of these care reviews to actively

encourage patient attendance so that they are able to voice their views alongside members of the multi-disciplinary team.

It was positive to note that since our previous inspection the health board have been able to establish the weekly attendance of a community General Practitioner (GP) at the hospital to aid with the physical health care of the patients.

Improvement needed

The health board must ensure that:

- All patients have up to date Care and Treatment Plans
- Required patient risk assessments are completed in a timely manner.

Quality of management and leadership

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

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

There was clear focus on reviewing service provision and ongoing service development of both the hospital and the wider health board mental health services.

There was dedicated and passionate leadership from managers who were supported by committed ward teams and multi-disciplinary team members.

Governance, leadership and accountability

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.

There was dedicated and passionate leadership from the ward managers and deputy ward managers who were supported by committed a ward team and support from senior managers. Staff commented that team-working and staff

morale on the wards was good and we found that staff were committed to providing patient care to high standards.

Through conversations with senior managers there was clear focus on service development and improvement. These discussions not only focused on Ty Llywelyn service but also the development of other health board services to help support patients, when ready, in less secure environments.

There were a number of potential developments that would benefit the care provided at the hospital and wider health board services, these were positive to hear and we would encourage the health board to pursue these developments.

The hospital was also part of a national peer review programme, which included external review of the hospital and enabled staff to partake in reviews of other services and share best practice and learning.

Staff and resources

Workforce

The staffing levels appeared appropriate to maintain the safety of patients across the three wards at the time of our inspection. Staff explained that they worked flexibly across each ward to support each other when required.

During the inspection there were two registered nurse vacancies and three healthcare assistant vacancies; these vacncies were in the process of being filled. However, there had also been a number of absences due to sickness which had caused some difficulty in fulfilling the staff rota. Where possible the ward utilised its own staff and regular staff from the health board's staff bank to fill these shortfalls. This helped with the consistency of care at the hosptial.

The training information we reviewed, showed that staff were expected to complete mandatory training on a range of topics relevant to their roles. Training compliance was regularly monitored to ensure compliance was maintained; at the time of the inspection this was at 87%. Staff also attended additional training and conferences relevant to their roles.

Staff completed annual performance appraisals and these were documented to evidence that these had been completed. 84% of staff had received their annual appraisal and there was plans to ensure all staff had theirs completed.

Improvement needed

The health board must ensure that all staff complete their mandatory training and annual appraisals.

4. What next?

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

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

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, 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 NHS mental health services

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

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

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
During the first evening of the inspection we observed mops being inappropriately stored within the ADL kitchen on Gwion.	Infection control risk	Escalated to ward manager	Relocated to appropriate storage area.

Appendix B – Immediate improvement plan

Service: Ty Llywelyn

Date of inspection: 27 – 29 January 2020

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

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No immediate assurance issues identified during the inspection	Not applicable	Not applicable	Not applicable	Not applicable

Appendix C – Improvement plan

Service: Ty Llywelyn

Date of inspection: 27 – 29 January 2020

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

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must update HIW on the additional therapeutic space	1.1 Health promotion, protection and improvement	Business Case has been developed to enhance the therapeutic space. Plan is currently within BCU governance processes for approval. Once approved HIW will be notified. In the interim all clinical areas have been reviewed in order to optimise clinical space available for patients to use.	Head of Operations Head of Planning	September 2020
The health board must ensure a ratified policy is in place to support the use of the ADL kitchens	1.1 Health promotion, protection and improvement	Draft policy has been developed and is in use whilst the policy goes through Health Board processes for final ratification. The draft policy was recently presented at the Policy Group on 12th March 2020	Clinical Services Manager	June 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		further amendments were required. The policy was due to be presented at next Policy Group on 30th April 2020 for final ratification however this meeting has been stood down due to Covid-19.		
The health board must ensure that all non-working appliances are repaired or replaced in a timely manner.	1.1 Health promotion, protection and improvement	The required works have been completed	Clinical Services Manager	February 2020 Completed
The health board must ensure that each ward area displays information about: • NHS Wales Putting Things Right • Advocacy arrangements • Well-being and healthy lifestyles • The role of HIW and how patients can contact us.	4.1 Dignified Care 4.2 Patient Information 3.2 Communicating effectively	All required information has been put in place. This is monitored and reviewed on a monthly basis within the Matron Walkabout audit	Clinical Site Manager	February 2020 - completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must provide an update on the redevelopment of the Ty Llywelyn reception area.	6.2 Peoples rights	Planning is in progress with several potential proposals being explored Once approved by Senior Leadership team, an option appraisal will be presented to the Board.	Clinical Services Manager	June 2020
Delivery of safe and effective care				
The health board must ensure that the damaged seating on Pwyll is repaired or replaced.	2.1 Managing risk and promoting health and safety 2.4 Infection Prevention and Control (IPC) and Decontamination	Couches have been ordered and are awaiting delivery	Clinical Site Manager	May 2020
The health board must look at providing a more diverse menu for patients at Ty LLywelyn.	2.5 Nutrition and Hydration	The kitchen are now providing a 3 week cycle of menu's rather that a 2 week cycle Clinical Site Manager has arranged to meet with the Kitchen manager regularly to discuss the menu and food quality	Clinical Site Manager Clinical Site Manager	February 2020 - completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that the ambient temperature of clinic rooms is monitored and arrangements are in place to alter the temperature of the room as required.	2.6 Medicines Management	Thermometers were ordered and are now in place. The temperature is recorded on a daily basis. This is audited as part of the Matron's monthly walkabout	Clinical Site Manager	February 2020 - completed
The health board must ensure that medication fridges remain locked when not being accessed.	2.6 Medicines Management	The fridges are checked daily to ensure that they are locked.	Clinical Site Manager	February 2020 - completed
The health board must ensure that all clinic rooms are organised and free from dust and clutter.	2.6 Medicines Management	The clinic rooms are checked for cleanliness on a daily basis	Clinical Site Manager	February 2020 - completed
The health board must ensure that MAR charts contain all required patient information.	2.6 Medicines Management	The charts are reviewed and rectified as required on a weekly basis during the ward rounds	Clinical Site Manager	February 2020 - completed
The health board must review the record keeping arrangements at Ty Llywelyn to minimise the number of systems in place.	3.5 Record keeping	Patient record systems to be reviewed in line with best practice guidance to include review of IT systems to support	Head of Operations Head of Nursing Clinical Services Manager IT manager	June 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health Board must ensure a full set of detention papers is present for each patient.	Application of the Mental Health Act	The admitting Doctor and nurse in charge check the MHA paperwork on admission/transfer MHA manager to ensure that previous information in relation to detentions is obtained and correct on arrival of patients to the unit Ward management teams to ensure all relevant paperwork is located in the patients notes	Medical and Nursing team MHA Manager Ward Manager	February 2020 - completed
The health Board must ensure that there is a clear record of patients being offered the provision of their rights on a regular basis.	Application of the Mental Health Act	Patients are given their rights on admission to the unit and based on capacity to receive the information following any Tribunal, Managers Hearing, change of ward and every three months if no movement. To be highlighted in weekly planning meeting.	MHA Manager and Ward Managers	February 2020 - completed
That professional reports for appeals against detentions are submitted in a timely manner	Application of the Mental Health Act	MHA administrator attends the weekly planning meeting and all upcoming reports are identified for completion MDT Reports not received in time will be highlighted to the Matron and service	MHA Manager and Ward Managers	February 2020 - completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		manager as part of the action plan. These are also highlighted in the planning meeting. Compliance with reports being provided in a timely manner is reported and monitored through QSE and MHAC.		
The health board must ensure that all patients have up to date Care and Treatment Plans.	Monitoring the Mental Health Measure	Care and Treatment plans are audited on a monthly basis	Ward Managers Clinical Site Manager Clinical Service Manager	February 2020 - completed
The health board must ensure that required patient risk assessments are completed in a timely manner	Monitoring the Mental Health Measure	The CTP's and Risk assessments on the unit have been reviewed and we are 100% compliant Risk assessments are audited on a monthly basis	Ward Managers Clinical Site Manager Clinical Service Manager	February 2020 - completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The health board must ensure that all staff complete their mandatory training and annual appraisals.	7.1 Workforce	Mandatory training and annual appraisals are reviewed monthly in the ward manager's supervision and the monthly service operational meeting. Mandatory training is currently 84% and PADR are 85.71% this is within BCUHB targets.	Ward Managers Clinical Site Manager Clinical Service Manager	February 2020 - completed

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): **Hilary Owen**

Job role: **Head of Governance and Compliance, Mental Health & Learning**

Date: **23 March 2020**