Independent Mental Health Service Inspection (Unannounced)

Tŷ Catrin

Partnerships in Care (Cardiff) Ltd

Inspection date: 30 November – 2 December

Publication date: 3 March 2021

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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 978-1-80082-995-4

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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 independent mental health inspection of Tŷ Catrin on the evening of 30 November and the following days of 1 and 2 of December 2020. The following sites and wards were visited during this inspection:

- Victoria Ward - Female Low Secure – 11 beds
- Sophia Ward - Female Low Secure – 8 beds

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

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

The purpose of this inspection was to gain assurance on whether sufficient attention is being given by the registered provider on the following areas:

- Patient Care
- Infection prevention and control
- Safeguarding
- Staffing
- Governance and leadership.

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) and the Mental Capacity Act (2005).

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

2. Summary of our inspection

Overall, we found a committed staff group that were working hard to ensure that patients' care needs were being met.

However, improvements are required in the completion of seclusion care plans, specifically the staffing requirements and the use of CCTV in the intensive care suite.

The use of handcuffs and the handcuffing policy requires review and updating.

The level of cleanliness in some patient areas require improvements.

This is what we found the service did well:

- Staff interacted and engaged with patients respectfully
- Staff we met were committed to providing effective care
- Monitoring the use of the Mental Health Act
- High compliance in mandatory training, supervision and appraisals.

This is what we recommend the service could improve:

- The completion of seclusion care plans
- Robust risk assessments and specific guidance for staff working in the intensive care suites
- Review use of handcuffs and handcuffing policy
- Glucose monitoring and recording
- Levels of cleanliness in some patient areas.

We identified regulatory breaches during this inspection regarding blood glucose monitoring for patients being cared for on Victoria Ward.

We raised concerns relating to glucose monitoring and the management of diabetic patients because blood glucose levels were not recorded in some glucose charts. We found the processes in place for recording and monitoring blood glucose levels was inconsistent. This matter was brought to the attention of the Registered Manager and prior to our departure a more consistent process was implemented. We will require further documentary evidence to ensure that the new system is being managed and monitored appropriately.

Further details can be found in Appendix A. 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.

We identified the service was non-compliant with Regulation 15 (1) (a) and (b) of the Independent Health Care (Wales) Regulations 2011 regarding quality of treatment and other services provided and Regulation 18 (1) (a) regarding the privacy and dignity of patients.

This was because there were significant deficiencies in the seclusion care plans provided to the inspection team. Staffing requirements were unclear and the care plan did not contain sufficient detail to enable staff to care for the patient safely and effectively as the patient was being cared for in a seclusion suite on an empty ward.

There was a CCTV camera located on the ward that was being used to monitor the patient when using the toilet and shower area. The Registered Provider could not provide any documentation to evidence the need and rational for using CCTV for this purpose.

These are serious matters and resulted in the issue of a non-compliance notice to the service. At the time of publication of this report, HIW has received sufficient assurance that appropriate action has been taken to address the improvements needed. Details of the action taken are provided in Appendix B

3. What we found

Background of the service

Tŷ Catrin is registered to provide an independent mental health hospital at Tŷ Catrin, Dyfrig Road, Cardiff CF5 5AD.

The setting is a mixed gender unit with 45 beds. At the time of inspection, there were 28 patients.

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

The hospital employs a team of maintenance, catering and domestic staff. The operation of the hospital is supported by a team of administration staff. The hospital is supported by the management and organisational structures of The Priory Group.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We 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.

However we identified that patients' privacy and dignity was not always maintained in line with their care plans.

The standard of cleanliness in some parts of the hospital required improving.

Dignity and respect

On the first night of the inspection we noted that 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. Most staff we spoke to also demonstrated a good level of understanding of patients they were caring for.

On both wards there were communal areas which provided sufficient space for patients to have personal quiet time away from their rooms. Each patient had their own en-suite bedroom which included a toilet, sink and shower. The bedrooms provided patients with a high standard of privacy and dignity. Bedroom doors had observation panels so that staff could undertake observation on patients without opening the door and potentially disturbing the patient. Patients were able to close the observation panels from inside their bedroom. Patients were able to lock bedroom doors to prevent other patients entering; staff could override the locks if required.

Empty bedrooms inspected on Victoria and Sophia Wards had chipped paintwork and marks on the walls which needed decorating. There was also an accumulation of dust on the window sill areas and curtains in these bedrooms.

The Registered Provider's statement of purpose described how hospital staff would support patients in ways which would maintain their privacy and dignity. However we identified an incident where a female patient was observed

undertaking personal care by two male staff with no female staff present. This did not comply with the staffing requirements documented in the patient's care plan. The Registered Provider must ensure staffing requirements are complied with.

In addition we were also told that a female patient had been refused access to female hygiene products. This incident was reported by the patient to the inspection team and an incident report was submitted for investigation.

Improvement needed

The Registered Provider must ensure that:

- Patient bedrooms are maintained to an acceptable standard
- Patients' privacy and dignity is maintained at all times in line with their care plans
- Staffing requirements documented in patient care plans are complied with
- The allegation of refusing access female hygiene products is investigated fully.

Patient information and consent

Patients were able to contact a representative of the statutory advocacy service either by telephone or making an appointment to speak to a representative which would be facilitated via Zoom[1] calls.

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

[1] Zoom is a social and communication application that offers video-calling and instant messaging for groups of people

communicate was misunderstood, staff would patiently attempt to clarify what they had said.

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. Staff told us about the patients' forum – 'you said, we did', this is a positive initiative to provide service users with a platform to discuss any issues or improvements they wanted to make at the hospital.

We spoke with one patient who stated that the communication and involvement regarding their access to Section 17 leave had not been handled well. The patient stated that they had not received any information as to why leave had been cancelled. The Registered Provider must ensure patients are fully updated and provided with explanations when leave is cancelled, especially in light of Welsh Government restrictions associated with the Coronavirus (COVID-19) legislation.

Due to COVID-19, visiting restrictions were in place and visiting was only taking place in exceptional circumstances which would be risk assessed. Mobile phones and iPads were used by patients to enable contact with family and friends. Staff spoke positively of the benefits of the technology measures implemented at the start of the pandemic. The new measures had given patients the opportunity to have virtual contact with family members on a regular basis and some patients were also meeting family members in local parks whilst adhering to social distancing protocols.

Improvement needed

The Registered Provider must ensure that reasons for cancellation of leave is communicated and understood by patients.

Delivery of safe and effective care

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

There were established processes in place to support staff to provide safe and effective care. We found that staff were completing clinical processes and documentation as required.

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

We found that improvements are required with seclusion care plans relating to staffing and the use of CCTV in the intensive care suite (ICS). In addition the use of handcuffs and the handcuffing policy require review and updating.

Managing risk and health and safety

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

The hospital entrance was secured to prevent unauthorised access with all staff and visitors registering at reception. The hospital had security procedures in place to minimise the risk of restricted items being brought on to the wards. The hospital had a list of prohibited items displayed at reception and there were secure lockers available to store any items that cannot be taken on to the ward, e.g. mobile phones, lighters, flammable liquids.

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

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system that included the names of patient(s) and staff involved, a description, location, time and length of the incident. Any use of restraint was documented, including who was involved and the body positions of each person involved in the restraint. Incident reports were automatically linked to the individual patient's electronic care notes which

ensured that these were up-to-date. It was positive to see that improvements had been made in this area since our last inspection.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner by a member of the clinical team involved in the individual patient's care and an employee responsible for hospital health and safety.

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 as required to look at specific areas. The incident reporting system and reporting schedules ensured that incidents were recorded, reviewed and monitored to assist in the provision of safe care at Tŷ Catrin.

As part of the hospital's strategy for managing challenging behaviour, there were two Intensive Care Suites (ICS), both of which were being used at the time of the inspection.

The decision to use the ICS was the final stage in managing patient behaviours, and could be used for patient Seclusion[2]. If a patient's risk determined it a requirement, anti-rip clothing and bedding was provided to help maintain their dignity whilst being cared for within an ICS. The Registered Provider had a policy in place for the use of the ICS and Seclusion which stated that patients could be in ICS for a brief period of time (e.g. a few minutes) or for prolonged periods of days or weeks.

The use of ICS and seclusion at the hospital was recorded and monitored however the seclusion care plan we reviewed for a patient being cared for in the ICS in Roath ward did not adequately cover the following areas :-

- The care plan did not cover the use of CCTV cameras when a patient is using the toilet and shower

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

- No date of review was recorded on the care plan
- The care plan did not detail how seclusion would be terminated for this patient and no exit strategy was recorded
- The layout of the care plan provided to inspectors was not consistent with other care plans viewed on inspection.

In addition the seclusion care plan we reviewed did not record the risk assessment, rationale or justification as to why a registered nurse would not be present on the Ward. This is contrary to the registered provider's statement of purpose which states that "a minimum of one experienced registered nurse should be present per ward on each shift".

Our concerns regarding seclusion care plans, CCTV and staffing in the ICS were dealt with under our immediate assurance process. This meant that we wrote to the Registered Provider immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified and the action taken by the Registered Provider are detailed in Appendix B.

The hospital had a Business Continuity Plan in place that included such things as adverse weather, utility failures and outbreak of infectious disease.

Staff we spoke with described changes made to the environment as a result of COVID-19. Staff and patients no longer have meal times together, additional hand sanitiser stations had been placed on the Wards, and staff had to bring a change of clothing into work to minimise the potential spread of COVID -19. The visitor's toilet had been converted into a hand washing station and unannounced management checks were also being undertaken to ensure staff compliance with PPE and cleaning schedules.

Infection prevention and control (IPC) and decontamination

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

We saw evidence to confirm that Tŷ Catrin conducted necessary risk assessments and updated relevant policies and procedures to meet the

additional demands of the COVID-19 pandemic. Staff we spoke to were aware of infection control obligations. Each ward had areas set aside where if a patient became symptomatic they could be isolated and barrier nursed in their bedroom within a protected area. None of these areas were in use at the time of inspection.

At the time of the inspection we were told the service had no reported cases of COVID-19 or any other infectious diseases. Staff we spoke with stated that at the start of the pandemic some staff and patients tested positive, action was taken in line with government and hospital guidance; no further cases were confirmed at the time of our inspection. Regular communication via meetings, information boards, and emails ensured everyone has up to date advice and guidance on COVID-19.

Staff told us that PPE is provided on a daily basis, stock is stored centrally so all wards can have easy access, and daily stock checks occur. During our discussions no issues were highlighted in relation to access to PPE.

There was evidence of staff wearing face masks however it was noted that there were occasions where staff were within 2 metres of a patient and were not wearing a face mask. This issue was raised with the Registered Manager to resolve.

Training specific to COVID-19 had been delivered to all staff and plans were in place to deliver fit testing training for FFP3 ventilated masks[3].

Generally we observed the hospital to be visibly clean and free from clutter, however there are some areas of the hospital that required improvements. There were stains on a carpet in the quiet room on Victoria Ward and stained ceiling tile near the lift on the ground floor near to the reception area.

Hospital laundry facilities are available so that patients could undertake their own laundry with appropriate level of support from staff based on individual needs. However, the laundry area on Victoria Ward was disorganised with no system in place stop patient's clothing becoming mixed together. In addition the cupboards containing patients' belongings were untidy and disorganised and on the first

[3] FFP3 ventilated masks are used to protect against respiratory borne pathogens. To use these **masks**, relevant staff must be 'face fit tested' to ensure that they can achieve a suitable face fit of the **mask** and that it operates at the required efficiency

night of the inspection there was an unpleasant odour in the patients' kitchen on Victoria Ward.

We were told that additional hand hygiene stations were in place, however some of these stations were empty or it was difficult to dispense the hand sanitiser product from the station.

We identified a full medical sharps bin which had not been disposed of correctly in the clinical room shared by Sophia and Victoria Wards. In addition the safety lid was not closed on one sharps bin and on another sharp bin the tracking label had not been filled in. Safety lids must be closed to prevent injury and harm and the tracking label must be filled in prior to first use, and completed when the bin is full to ensure appropriate and safe tracking at the point of disposal. There was also clinical waste on the floor of the clinical room which had not been disposed of correctly.

Improvement needed

The Registered Provider must make sure that:

- Staff comply with Welsh Government guidelines in relation to wearing of face masks
- The cleanliness of patient areas within the hospital is maintained.
- Patients' laundry is easily identifiable in the laundry room
- Sharps boxes are stored correctly and that the tracking label is completed.
- Clinical waste is disposed of correctly

Nutrition

We reviewed care records and confirmed that assessments of patients' eating and drinking needs had been completed. Patient records documented specific individual dietary needs to maintain sufficient nutrition and fluid consumption, and monitoring documentation we reviewed was completed appropriately.

Medicines management

We reviewed the hospital's clinic arrangements and found that on the whole medicines management was safe and effective. Medication was stored securely within cupboards, however the medication fridge shared between Victoria and Sophia Wards was unlocked.

There was evidence that there were regular temperature checks of the medication fridge and clinic room to ensure that medication was stored at the manufacturer's advised temperature. There was regular pharmacy input and audits were undertaken that assisted the management, prescribing and administration of medication at the hospital.

During medication administration we noted that staff performed these duties appropriately and professionally, and interacted with patients respectfully and considerately.

The clinic room shared between Sophia and Victoria Wards was disorganised which inhibited staff from easily performing their duties within the room. The clinical room appeared cluttered and messy. As highlighted above clinical waste and sharp boxes had not been appropriately disposed of.

Overall the prescription charts we reviewed were signed appropriately. However, we did identify four separate incidents where it was not signed if patients' medication had been administered. In addition one patient's record on Victoria Ward failed to record in clinical records the reason for administration of PRN (as required) medication, this happened on a number of occasions. However on Sophia Ward there was evidence of the rationale for PRN medication being clearly recorded.

There were appropriate arrangements for the storage and use of Controlled Drugs and Drugs Liable to Misuse. These were accurately accounted for and checked daily.

The Medication Administration Record[4] (MAR charts) reviewed contained the patient's name, photograph of the patient and their Mental Health Act legal status. MAR charts included copies of the consent to treatment certificates and MAR charts were consistently signed and dated when medication was prescribed and administered.

[4] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

There was good evidence of charts being reviewed by the Multi-Disciplinary Team and the medication charts for December were already in patients' files.

Patients' names are noted throughout. Patients' legal status was clearly recorded, however on some patients' charts it was hard to see their allergies as the text was very faint and faded, making them difficult to read. The Registered Provider must ensure that records and patient information are clear and easy to read.

There was evidence of three patients regularly having their insulin as prescribed but when the records regarding the blood glucose sugar levels for three patients were reviewed there were several gaps. This was dealt with during the inspection and the Registered Provider completed an incident form. An appropriate action plan was also produced to ensure that these issues do not happen again. The Registered Provider must ensure that new process for recording of blood sugar levels is monitored and supervised correctly.

Improvement needed

The Registered Provider must ensure that:

- The clinic room shared between Victoria and Sophia Wards are orderly
- Medication not administered is recorded and reasons why medication has not been administered is documented
- The rationale for use of PRN medication is recorded for patients on Victoria Ward
- Text in patients charts is clear and easy to read
- The new blood glucose recording process is monitored and supervised correctly.

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

Medical devices, equipment and diagnostic systems

There were regular clinical audits at the hospital and a nightly audit of resuscitation equipment. Staff had documented when these had occurred to ensure that the equipment was present and in date. During staff discussions it was evident that staff were aware of the locations of ligature cutters in case of an emergency. There were up-to-date safety audits in place, including ligature point risk assessments.

Safe and clinically effective care

Generally, we found that systems and governance arrangements were in place, which helped ensure that staff provided safe and clinically effective care for patients. We reviewed a sample of policies and procedures that were available to help support staff in managing challenging behaviour.

The handcuff policy we reviewed was brief and did not make reference to the Mental Health Act[5] (MHA) Code of Practice for Wales or mention the difference between the use of handcuffs for patients on forensic[6] or civil sections.

There were two reported incidents from the care team of a patient detained on Section 3 of the MHA being placed in handcuffs to go to hospital. The Registered Provider must ensure that any use of handcuffs on patients is proportionate and necessary in the circumstances, and complies with guidance set out by the Mental Health Act Code of Practice for Wales. Any use of handcuff restraints must be risk assessed, documented and justified, and consider the dignity and respect of the patient.

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[5] Mental Health Act 1983 Code of Practice for Wales (Revised 2016) provides guidance to professionals about their responsibilities under the Mental Health Act 1983. As well as providing guidance for professionals, the Code of practice also provides information for patients, their families and carers. https://gov.wales/topics/health/nhswales/mental-health-services/law/code-of-practice/?lang=en

[6] Compulsory admission consists of parts **2 & 3 of the Mental Health Act 1983**. Part 2 of the Act deals with patients who are detained in hospital but have no criminal proceedings against them. These are referred to as **civil sections**. Part 3 of Act, known as the 'Forensic Sections', deals with patients who have been involved in criminal proceedings

Improvement needed

The Registered Provider must review the hospital handcuffing policy

The Registered Provider must ensure patient records document that the use of handcuffs is proportionate and consider the dignity and respect of the patient.

Records management

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

We reviewed a sample of patient records across the hospital. It was evident that staff from across the multidisciplinary teams were writing detailed and regular entries which provided a live document on the patient and their care.

We saw that staff were completing care documentation and risk assessments in full. Overall the nursing documentation viewed was very good and physical assessments were well completed.

Mental Health Act Monitoring

We reviewed the statutory detention documents of two patients across Victoria and Sophia Wards. All records were found to be compliant with the Mental Health Act and Code of Practice. The paper records were stored securely and held in the Mental Health Act administrator's office. The records we viewed were well organised, easy to navigate and contained detailed and relevant information.

Robust systems of audit were in place for management and auditing of statutory documentation and the Mental Health Act forms a part of the clinical governance meetings. It was positive to see that improvements had been made in this area since our last inspection. All staff have Mental Health Act training as part of the induction programme and specific Mental Health training is part of staff mandatory training modules.

Section 17[7] leave forms were completed appropriately, risk assessed, and there was evidence of patient involvement. All patients are provided with information relevant to their section on admission and patients are introduced to the Mental Health Act Manager. In addition the patients' rights are discussed with them on a monthly basis. There was clear compliance with the Second Opinion Appointed Doctor (SOAD) process, for example timescales and administration had improved significantly and this was evidenced through their audit process.

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

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

On the whole patients' Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed. Overall individual Care and Treatment Plans drew on a patient's strengths and focused on recovery, rehabilitation and independence. Physical health needs were clearly identified and clear plans were in place to optimise the patient's physical well-being

However it was noted that one patient's treatment plan was brief and did not give clear objectives and outcomes to enable the patient to move forward.

In addition we also noted that the unmet needs of patients in some care plans were not recorded in the notes we viewed. It is important that unmet needs are documented so that these can be regularly reviewed by the multidisciplinary team to look at options for meeting those needs.

As highlighted in the above managing risk section of this report, our concerns regarding seclusion care plans were dealt with under our immediate assurance process. This meant that we wrote to the Registered Provider immediately

[7]Section 17 leave allows the detained patient leave from hospital

following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

Improvement needed

The Registered Provider must ensure that unmet needs are evidenced and documented within patient care plans.

Quality of management and leadership

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

We found that staff were committed to providing patient care to high standards. Throughout the inspection staff were receptive to or views, findings and recommendations.

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

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

Governance and accountability framework

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

There was dedicated and passionate leadership from the ward managers who were supported by multidisciplinary teams. We found a friendly, professional staff team who demonstrated a commitment to providing high quality care to patients. Staff were able to describe their roles and appeared knowledgeable about the care needs of patients they were responsible for.

Each discipline had a head of department who provided leadership for their team and linked in collaboratively with other heads of department within The Priory Group.

Members of staff from Tŷ Catrin would also meet regularly with local Priory Group representatives and head office representatives to discuss strategic operations

and planning which was then fed back to the staff team at Tŷ Catrin through regular meetings.

We reviewed a selection of hospital policies. In addition to our observations on the handcuffing and seclusion policy detailed earlier in this report we identified that the staff whistleblowing policy provided to us had passed its review date of 3 September 2020. We also identified that policies were not always clearly cross referenced. The Registered Provider must make sure that all policies are detailed, cross referenced where appropriate, updated and reviewed.

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

Improvement needed

The Registered Provider must make sure that all hospital policies are updated and reviewed.

Dealing with concerns and managing incidents

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

It was evident that the Registered Provider monitored concerns and incidents locally at Tŷ Catrin and corporately through regular reporting mechanisms. During discussions and as a result of reviewing governance meetings and incidents we identified that there appears to be a large number of incidents requiring Police attendance at the hospital. The Registered Provider needs to develop a collaborative working relationship with local Police to devise a local policy and level of agreement on Police attendance at Tŷ Catrin. In addition the Registered Manager should review all incidents and examine the root causes of the problem in order to identify solutions to minimise or prevent such incidents occurring in the future which may negate requiring a Police response.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the service provided.

Improvement needed

The Registered Provider needs to:

- Agree a local protocol on Police attendance at the hospital
- Review incidents to identify the cause of the incident and put measures in place to minimise further incidents occurring.

Workforce planning, training and organisational development

The staffing levels appeared appropriate to maintain patient safety within the hospital unit at the time of our inspection. However as previously highlighted at the beginning of this report we raised concerns with the Registered Manager in relation to no Registered Nurse being present on Roath Ward. Our concerns with this were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

A review of documentation in previous months highlighted that there had been a level of reliance on agency and bank staff at the hospital due to the COVID-19 pandemic. It is recognised that the pandemic is placing additional staffing requirements on health care settings, however the Registered Provider must make best efforts to ensure that staff consistency is maintained to ensure patient safety and patient relationship security with staff.

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

Staff told us that the unit management team were approachable and visible. During interviews with staff they told us they had confidence to speak with management if they needed to raise issues or concerns.

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.

Through our conversations with senior management and reviewing staff records it was evident that the provider was attempting to provide a consistent workforce by block-booking bank and agency staff where ever possible to fill any shortfalls

in the staffing rotas. Inconsistency of staff tended to be a result of short notice sickness or unexpected patient escorts from the hospital.

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

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

Workforce recruitment and employment practices

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

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

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

4. What next?

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

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

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non-compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect independent mental health services

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

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

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

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent mental health services.

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
We raised concerns relating to glucose monitoring and the management of diabetic patients because blood glucose levels were not recorded in some drug charts. We found the processes in place for recording and monitoring glucose levels was inconsistent	Risk to patient health and safety	This matter was brought to the attention of the Registered Manager	This matter was brought to the attention of the Registered Manager and prior to our departure a more consistent process was implemented. We will require further documentary evidence to ensure that the new system is being managed and monitored appropriately.

Appendix B – Immediate improvement plan

Service: Ty Catrin

Ward/unit(s): Sophia and Victoria Wards

Date of inspection: 30 November - 2 December 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.

Description of non compliance / Action to be taken	Regulation	Service action	Responsible officer	Timescale
The registered provider must provide assurance that comprehensive and robust risk assessments and care planning documentation are in place for the patient on Roath Ward that reflect their individual risks and care needs. The plan must also document and record: • Staffing requirements and risk assessment for staffing the ward	15 (1) (a) and (b) and 18 (1) (a)	Risk Assessment Review Additional Risk assessment Review	• Dr Maddock (RC) • Samantha James (Ward Manager) • Victoria Wheeler (DOCS) • (Patient)	07/12/2020 **COMPLETED** 31/12/2020 **Risk Reviewed COMPLETED** 08/12/2020 **COMPLETED** 31/12/2020

• Rationale for the use of CCTV within toilet area • Creation and review dates • An exit strategy and plan for the patient leaving seclusion. We would also recommend that Care plan format is made consistent with other care plans used by the hospital.		Seclusion Care Plan for TYC129 currently nursed in ICS (Ground Floor) to be further reviewed to provide more detail as follows: • Staffing requirements and risk assessment for staffing of ICS • Rationale for the use of CCTV within toilet area • Cross reference with Access to Risk Items document • Creation and Review Dates • *Registered Nurse supervision whilst ICS is in use have now introduced 1 x Registered Nurse and 1 x HCA as observing staff to support TYC129. This is in line with Ty Catrin Statement of Purpose.* *Please note, there are still 2 x Registered Nurses by Day and a Supernumerary Ward Manager (Mon-Fri) to support Victoria Ward. There are 2 x Registered Nurses by night and a Supernumerary Registered Nurse acting as the Night Coordinator too* ***NEW ICS/Seclusion Care Plan and Local Procedure for Use of CCTV provided to HIW***	• Therisa Galazka (HD) • Dr Maddock (RC) • Samantha James (Ward Manager) • Victoria Wheeler (DOCS)	**Care Revised COMPLETED** 04/01/2021 **Care Plan Revised COMPLETED**

Appendix C – Improvement plan

Service: Ty Catrin – Partnership in Care (Cardiff) LTD

Ward/unit(s): Sophia and Victoria Wards

Date of inspection: 30 November – 2 December 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	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The Registered Provider must ensure that patients' bedrooms are maintained to an acceptable standard.	10. Dignity and respect	Review of all Patient areas to establish works required. Additional `specific` SSM Maintenance Improvement Plan implemented to ensure measures in place to monitor and maintain good standards of décor, cleanliness and repair.	SSM (David Perry)	30/01/2021 30/01/2021
The Registered Provider must ensure that patients' privacy and dignity is maintained at all times in line with their care plans.	10. Dignity and respect	Ty Catrin allocate gender appropriate staff to patients specifically for enhanced observations and personal care.	MDT Ward Managers & Night Co-ordinators	04/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Assurance of the agreed supporting staff will be discussed at the daily MDT Handover and captured in the patients Care Plans. At times when the appropriate staff (gender specific) are not available on a particular ward; collaborative working to redeploy staff across the site will take place to allow for the patient to carry out their personal hygiene (for example) and maintain their privacy and dignity. Use of CCTV is used in line with Policy and Patient Risk (proportionate). This is clearly documented in the patients Care Plan with specific reference to maintaining privacy and dignity.	MDT	04/01/2021 04/01/2021
The Registered Provider must ensure that reasons for cancellation of leave is communicated and understood by patients	18. Communicating effectively	Section 17 leave is authorised on the basis of level of risk and therapeutic benefit. Expectation is that all patients are subject to the Priory `5 point` Risk Assessment prior to any Section 17 Leave from the Hospital of which is generally assessed by a Registered Nurse.	Registered Nurses Responsible Clinicians &	26/01/2021 26/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Patients are provided with an explanation as to why the Section 17 Leave is postponed, cancelled or revoked. All Section 17 Leave changes are discussed by the MDT every day in the MDT Handover and recorded in the minutes. Any Section 17 Leave postponed, cancelled or revoked is documented in the patient Clinical Notes. The MDT will ensure this clinical entry includes the patients understanding of the reasons for changes to the leave.	Registered Nurses DoCS (Victoria Wheeler) Responsible Clinicians & Registered Nurses	26/01/2021 26/01/2021
The Registered Provider must ensure that unmet needs are evidenced and documented within patient care plans	8. Care planning and provision	Review all Care Plans to ensure they reference `unmet` needs. If there are no `unmet` needs identified. The care plan will state this also.	Ward Manager Michelle Mason (Sophia) Ward Manager Sam James (Victoria Ward)	22/01/2021 29/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		The Care Plans will continue to be reviewed at the patients four weekly ICR (In-Patient Care Reviews)	MDT	n/a
Delivery of safe and effective care				
The Registered Provider must make sure that staff comply with Government guidelines in relation to wearing of face masks.	13. Infection prevention and control (IPC) and decontamination	All staff are expected to wear FFP2 (fluid resistant) masks for the duration of their duties. Staff are directed to the hand wash station in the Reception area on first arrival at site. They are then expected to change their masks every 4-6 hours thereafter (minimum). Donning & Doffing Competency Assessments are in place. The expectation is reinforced via the following forums on a daily basis at the following forums: • Nursing Handover • MDT Handover Regular updates are also reinforced via:	All Staff Reception Team Practice Nurse and/or Physician Associate. Ward Managers Hospital Director (Therisa Galazka)	11/01/2021 11/01/2021 15/02/2021 11/01/2021 11/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		• Email-Correspondence • Standard Operating Procedures (SOP's) • Health & Safety Forums • Clinical Governance • Senior Management Team Meetings • You Say Forum (Staff Meetings) Any staff observed or reported to be non-compliant with these expectations are managed on an individual basis with the following measures: • Immediate correction of mask (if observed) and reinforcement of expectation • Letter of Concern (if more than one occurrence) • Potential Disciplinary (if there is no evidence of improvement)	Hospital Director (Therisa Galazka) HR Advisor & Asst Hayley Sellers & Vincent Thomas	AS REQUIRED AS REQUIRED
The Registered Provider must make sure that the cleanliness of patients' areas in the hospital is maintained.	13. Infection prevention and control (IPC) and decontaminati on	Complete Housekeeping Audit to identify any areas for improvement and compare against HIW findings. Repeat monthly. Hold meeting with Housekeeping Team *(these take place monthly)* advise re	SSM (David Perry) SSM (David Perry)	15/01/2021 20/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		findings of Inspection and Audit to reinforce a more robust approach to good standard of cleanliness in all areas.		
		Patient Bedrooms and **En-suite Facilities** to be cleaned daily with additional identified areas for a full day `deep cleaning` once each week (per ward).	SSM (David Perry) & Ward Managers	22/01/2021
		Notify ward based staff of the revised and agreed `deep cleaning` days.	SSM (David Perry) & Ward Managers	26/01/2021
		Expectation for ward based staff to support patients to clear floor and surfaces of unnecessary clothing and other personal items to allow the Housekeeping team a more thorough clean of the area.	All Staff	15/01/2021
		All staff to ensure that SSM (DP) is informed in a timely manner as to when a bedroom is vacant to allow for immediate re-décor and repair (as required).	All Staff	15/01/2021
		All staff are reminded to report any concerns re décor and repair via the		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Maintenance Request Log unless it requires urgent attention. Works to be prioritised and completed in line with all works identified on the request log. Cyclical Decoration Schedule produced and reviewed in terms of timing completions, for all areas of the hospital.	SSM (David Perry)	31/01/2021
The Registered Provider must make sure that patients' laundry is easily identifiable in the laundry room.	13. Infection prevention and control (IPC) and decontamination	Laundry Signage to be designed and ordered Laundry Signage to be displayed on entrance doors to patient laundry facilities	SSM (David Perry) SSM (David Perry)	21/01/2021 31/01/2021
The Registered Provider must make sure that sharps boxes are stored correctly and that the tracking label is completed.	13. Infection prevention and control (IPC) and decontamination	Ty Catrin will revise the Weekly Clinic Audit to ensure it provides clear guidance and expectation re Management of Sharps Random audits of Ward clinics throughout the week will be introduced with a view of specifically maintaining good standards of cleanliness, order and management of clinical waste (including sharps)	DoCS (Victoria Wheeler) Ward Managers	29/01/2021 01/02/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Clinics will be monitored by night to ensure all clinical waste (including sharps) is managed appropriately. This audit will be captured on the daily MDT Handover report.	Night Coordinators (Barry Stevens & Richard Keen)	01/02/2021
The Registered Provider must make sure that clinical waste is disposed of correctly.	13. Infection prevention and control (IPC) and decontamination	Ty Catrin will revise the Weekly Clinic Audit to ensure it provides clear guidance and expectation re Management of Clinical Waste Random audits of Ward clinics throughout the week will be introduced with a view of specifically maintaining good standards of cleanliness, order and management of clinical waste (including sharps). These audits will be reportable to the Director of Clinical Services (DoCS) weekly. Clinics will be monitored by night to ensure all clinical waste is managed appropriately. This audit will be captured on the MDT Handover report.	DoCS (Victoria Wheeler) Ward Managers Night Coordinators (Barry Stevens & Richard Keen)	29/01/2021 01/02/2021 01/02/2021
The Registered Provider must ensure that clinic room shared between Victoria and Sophia Wards is orderly.	15. Medicines management	Revisit expectation with identified `Clinic Champions` in regards to roles, responsibilities and accountability.	Interim Clinical Nurse Advisor (Paul Stewart-	06/02/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
			Davies) & Ward Managers	
		Random audits of Ward clinics throughout the week will be introduced with a view of specifically maintaining good standards of cleanliness, order and management of clinical waste (including sharps). These audits will be reportable to the Director of Clinical Services (DoCS) weekly.	Ward Managers	01/02/2021
		Clinics will be monitored by night to ensure all clinical waste is managed appropriately. This audit will be captured on the MDT Handover report.	Night Coordinators	01/02/2021
The Registered Provider must ensure that medication not administered is recorded and reasons why medication has not been administered is documented.	15. Medicines management	Weekly Monitoring by the Site Learning Administrator (SLA) and expectation for all Registered Nurses to be 100% compliant in all modules relating to medication and medication administration.	SLA (Sooraj Joy)	28/01/2021
			Interim Clinical Nurse Advisor	31/03/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Revised Medication Assessment (specific to Ty Catrin) and Competency Assessment to be introduced with the expectation for all registered Nurses to complete. The Prescription & Administration Chart template provides a specific section to record rationale for non-administration of medication. NEW weekly audit of Care Notes (specific to medication administration) to ensure consistency of reporting both on the Prescription & Administration Charts and in the patients electronic records. Audit findings will be reported to Director of Clinical Services (DoCS) and actioned accordingly each week.	(Paul Stewart-Davies) & Ward Managers Ward Managers	01/02/2021
The Registered Provider must ensure that the rationale for use of PRN medication is recorded for patients on Victoria Ward.	15. Medicines management	NEW document introduced re Recording of PRN administration – expectation will	Registered Nurses	01/02/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		be to transfer this data to care Notes following each medication round. NEW weekly audit of Care Notes (specific to PRN medication administration) to ensure consistency of reporting both on the Prescription & Administration Charts and in the patients electronic records. Audit findings will be reported to Director of Clinical Services (DoCS) and actioned accordingly each week.	Ward Managers	01/02/2021
The Registered Provider must ensure that text in patients' charts is clear and easy to read.	15. Medicines management	*All Prescription & Administration Charts are typed for clarity.* The quality of the printing will be checked by the Medical Secretary in the first instance to ensure all text is legible. The charts can also be crossed referenced for accuracy by the	Responsible Clinicians (Dr Maddock & Dr Ahmed) Medical Secretary (Sandra Whittaker)	31/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Responsible Clinician and Registered Nurses. Previous month's Prescription and Administration Charts will be placed in the back of each Clinic Medication folder for reference only. It will be clearly sectioned off from new Prescription and Administration Charts. Ty Catrin have agreed for visiting ASHTONS Pharmacist to review the new charts against the old charts as an additional quality assurance measure each month. The old Prescription and Administration Charts will be archived after 4 weeks.	Responsible Clinicians (Dr Maddock & Dr Ahmed) Registered Nurses Registered Nurses ASHTONS Pharmacist (Martin Fortune) Medical Secretary (Sandra Whittaker)	31/01/2021 01/02/2021 31/01/2021 01/03/2021
The Registered Provider must ensure that the new blood glucose recording process is monitored and supervised correctly.	15. Medicines management	The `Blood Monitoring` Record Book will be checked for accuracy against the	Registered Nurses	31/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		prescription & Administration Chart and the Clinical Entry in Care Notes daily. NEW weekly audit of the `Blood Monitoring` Record Book and Care Notes to ensure consistency of reporting and monitoring practice. Audit findings will be reported to Director of Clinical Services (DoCS) and actioned accordingly each week.	Ward Managers Ward Managers & DoCS (Victoria Wheeler)	31/01/2021 31/01/2021
The Registered Provider must review the hospital handcuffing policy.	7. Safe and clinically effective care	Contact Priory Specialist Director (Paul Cowans) regarding review of the Hand Cuff Policy. The amended Policy will make reference to the Welsh Code of Practice.	Hospital Director (Therisa Galazka) Specialist Director (Paul Cowans)	21/01/2021 01/02/2021
The Registered Provider must ensure patient records document that the use of handcuffs is proportionate and consider the dignity and respect of the patient.	7. Safe and clinically effective care	The consideration for the use of handcuffs is used as a final option when all other options of safe conveyance have been exhausted.		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Privacy & Dignity is always a priority. Handcuffs are secured in a private area of the ward and clothing (such as a jacket) is placed over the handcuffs so that they cannot be viewed. The patient would be in soft holds and escorted by two staff at this time. MDT Risk Assessment is undertaken and is generally authorised by the Responsible Clinician and Ward Managers but other senior members of the SMT can also authorise including; Hospital Director and Director of Clinical Services. The following factors are considered as part of the Risk Assessment process; • Venue / Destination • Nature of the Escorted Leave (Court/Medical emergency etc.) • Duration of Travel • Requirement for Escort(s) including Gender and Number of Staff required • History of Absconding / Index Offence and Historical Offences • Risk to Self • Risk to Others (public and staff) • Patient's Physical Health & Abilities	Responsible Clinicians (Dr Maddock & Dr Ahmed)	11/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		• Patient's Mental State & Risk Behaviours • Other (least restrictive) Options (proportionate use) available Handcuffs will only be applied by a member of staff trained in the use of handcuffs. A Handcuff Care Plan will be agreed with the Patient and MDT. *This can be found as an attachment in Care Notes.* **H(FS) Form 08**: The Use of Mechanical Restraint Record and **H(FS) Form 09**: The Use of Handcuff Checklist documents will be completed in full and uploaded to Care Notes for reference. An electronic Incident Record (DATIX) will be completed and the use of handcuffs will also be documented in a Priory 24 hr report and escalated to Regional and Divisional SMT via the Health Care Data Reporting Upwards system for review.	Security Lead (Lloyd Harries) Responsible Clinicians (Dr Maddock & Dr Ahmed) DoCS (Victoria Wheeler & Security Lead (Lloyd Harries) DoCS (Victoria Wheeler & Ward Managers	11/01/2021 11/01/2021 11/01/2021 11/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Following the use of Handcuffs, a Patient Debrief is recorded to understand their experience and consider any areas of good practice; areas for improvement and lessons learnt.	Security Lead (Lloyd Harries)	11/01/2021
Quality of management and leadership				
The Registered Provider must make sure that the Whistleblowing policy is updated and reviewed.	1 Governance and accountability framework	There are instances where a review takes longer than expected, either due to the number of people involved, or the complexity of the changes, and this can occasionally mean that a policy goes out of date before it can be reissued. In these circumstances. However, it should be noted that; the current policy remains valid until the revised version is ratified. The policy was reviewed and updated on the 09/12/2020 and will be reviewed in 2023.	Sarah Blanch Priory Group Policy Manager	26/01/2021
The Registered Provider needs to agree a local protocol on Police attendance at the hospital	23 Dealing with concerns	`Draft` proforma to be reviewed / completed.	Hospital Director (Therisa Galazka)	12/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	and managing incidents	Multi-Agency Meeting to discuss `draft` proforma re: Police support and attendance (Emergency Response) to Ty Catrin and Fitness to Detain.	Social Worker (Rhys Bradley & Police Mental Health Officer (Claire-Louise Thomas)	31/01/2021
The Registered Provider needs to review incidents to identify the cause of the incident and put measures in place to minimise further incidents occurring	23 Dealing with concerns and managing incidents	*Ty Catrin Team already have robust systems in place to review incidents and we have detailed these here for reference:* All incidents are reported via the electronic incident management system referred to as **DATIX**. *This system generates a unique reference number related to the incident. DATIX Incidents are reported via Handovers processes and reviewed daily for accuracy and quality. The review includes:* • *category of the incident* • *type of behaviours identified* • *people involved in the incident* • *slow and fast triggers*	All Staff	11/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		• *actions and interventions* All incidents are reviewed via • Nursing Handover • MDT Handover • Reducing Restrictive Practice Forums • Health & Safety Forums • Clinical Governance • Reflective Practice • Team Incident Reviews (TIR's) • In patient review Meetings (ICR's) Should the incident be of a `significant nature`, additional reporting is required both within the Priory (24 hr & 72 hr Reports; Team Incident Reviews (TIR's) and to external Agencies that may include*:* • Healthcare Inspectorate Wales Regulatory Notifications • Safeguarding • Health Boards & Commissioners • NHS Wales (CCAPS) • NHS England (STEIS)	MDT Senior Managers	11/01/2021 11/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		• Police **Staff and Patient Diffusion & De-brief** sessions are held and documented following serious untoward incidents. Post incident patient questionnaires are also completed following any use of physical restraint to understand the patient experience. *This is to reflect on the incident; explore triggers; review actions and interventions; identify new behaviours / triggers; lessons learnt etc.* **Weekly Hospital Director Report** details a thematic review of incidents for the previous 7 days. It clearly identifies NHS Wales and NHS England patients. This is submitted to the Operational Director for discussion and review at a regional and/or Divisional SMT forum. **Monthly NHS England Reports** (Contractual Requirement) are submitted providing similar detail to that of the	Security Lead (Lloyd Harries) & Regional PMVA Lead (Adam Careless) Hospital Director (Therisa Galazka) Hospital Director	11/01/2021 11/01/2021 11/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		weekly Hospital Director Reports and includes: • Categories • Themes • Triggers • Lessons Learnt **Monthly `Incident Over Time Analysis` Report** Priory Healthcare Data Team collate a monthly report of which enables the Hospital to funnel down further into the incident data. **NEW Monthly Site Assurance Plan** Using all of the data we have available to us, Ty Catrin will focus on one incident category with a view minimising the risk of re-occurrence. We will review ; • frequency of incidents • times of incidents • patients involved in incidents • quality and accuracy of reporting • identifying areas for improvement	(Therisa Galazka) & DoCS (Victoria Wheeler) Healthcare Data Team Security Lead (Lloyd Harries)	11/01/2021 15/01/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Any actions, interventions, training, supervision, changes to practice, changes to the environment etc. will be agreed by the SMT and monitored. At the end of each month, the team will further review the same incident category for comparison and record findings. The aim is for the number of incidents within the agreed category to have reduced over time. *Ty Catrin have already commenced this action – please see example detailed below:* • *Deliberate self-harm using Velcro* • *8 Incidents in December 2020* • *Removal of Velcro used to display `tree of life` artwork on Sophia Ward* • *Alternative adhesives being considered* • *Further review of Incidents in Jan 2021 to compare those involving use of Velcro.*	SMT SMT	04/02/2021 04/02/2021

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Therisa Galazka**

Job role: **Hospital Director**

Date: **28/01/2021**