Independent Mental Health Service Inspection (Unannounced)

Llanarth Court Hospital

Partnerships in Care Ltd

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

Our purpose

To check that people in Wales 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 focussed independent mental health inspection of Llanarth Court on the evening of 25 January 2021 and following days of 26, 27 January 2021. The following sites and wards were visited during this inspection:

- Awen Ward - Female Medium Secure Mental Health Ward

Our team, for the inspection comprised of one HIW inspector, three 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.

HIW explored how the service complied with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and met the National Minimum Standards (NMS) for Independent Health Care Services in Wales. Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

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

2. Summary of our inspection

We found a dedicated staff team that were committed to providing a high standard of care to patients.

We observed staff interacting with patients respectfully throughout the inspection.

Patients we spoke to told us they were happy and receiving good care at the hospital.

Staff were positive about the support and leadership they received.

However, some improvements were required in relation to mandatory training compliance.

This is what we found the service did well:

- 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 and Treatment plans were completed in line with the Welsh Measure
- Established governance arrangements that provided safe and clinically effective care.

This is what we recommend the service could improve:

- Cleanliness and redecoration of some areas on Awen Ward
- Completion and monitoring of mandatory training
- Regular staff meetings.

3. What we found

Background of the service

Llanarth Court is registered to provide an independent mental health service at Llanarth, Raglan, Abergavenny, Monmouthshire NP15 2YD.

The hospital comprises of seven wards and an open rehabilitation bungalow:

- Awen - A medium secure service for a maximum 16 (sixteen) female adults aged between 18 (eighteen) and 65 (sixty-five) years who are diagnosed with a mental illness or have a treatable personality disorder or a combination of both
- Deri - A low secure service to provide assessment for a maximum of 11 (eleven) male adults over the age of 18 (eighteen) years. The service provides assessment, treatment and rehabilitation for adult males suffering from mental disorder who are detainable under the Mental Health Act or related legislation
- Teilo - A low secure service to provide rehabilitation for a maximum 20 (twenty) male adults over the age of 18 (eighteen) years who require rehabilitation for a mental disorder
- Treowen - A low secure service to provide rehabilitation for a maximum 11 (eleven) male adults over the age of 18 (eighteen) years who require rehabilitation for a mental disorder
- Howell - A medium secure service to provide assessment, treatment and short-term rehabilitation for a maximum 17 (seventeen) male adults over the age of 18 (eighteen) years for the assessment, treatment and short-term rehabilitation of men aged over the age of 18, who suffer from mental disorder
- Iddon - A medium secure service to provide assessment and short-term rehabilitation for a maximum of 17 (seventeen) male adults over the age of 18 (eighteen) years for the assessment and short-term rehabilitation of men who suffer from mental disorder
- Woodlands Bungalow - An open service to provide rehabilitation for a maximum of 4 (four) male adults over the age of 18 (eighteen) years who suffer with a mental disorder.

The hospital was first registered in December 1992.

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.

The inspection specifically focussed on Awen Ward, this was due to the Coronavirus pandemic (COVID -19) and the need to reduce the number of people attending the hospital to minimise any risk to patients and staff in other areas of the hospital.

The hospital employs a staff team which includes a Hospital Director, Director of Clinical Service, Medical Director along with ward based multi-disciplinary teams including a ward manager, charge nurses, occupational therapists and a therapy support workers. The ward teams had support from the hospital's responsible clinicians, psychologists, social workers, sport therapists and an adult tutor.

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

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

Quality of patient experience

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

We observed staff interacting and engaging with patients appropriately, and we observed staff treating patients with dignity and respect.

Patients we spoke to told us they were happy and receiving good care at the hospital.

There were a range of suitable activities and therapies available on Awen Ward, to aid patients' rehabilitation.

Health promotion, protection and improvement

There was a range of health promotion, protection and improvement information and initiatives available to the patients on Awen Ward which assisted in maintaining and improving patients' wellbeing.

Patients were able to access GP, dental services and other physical health professionals as required. Patients' records evidenced detailed and appropriate physical assessments and monitoring.

During our last inspection the hospital director told us of future plans for medical coverage to be available on a 24 hour basis at the hospital. It was positive to see that this plan was now in place and patients and staff had access to 24 hour medical advice and support.

We observed that patients on the wards were involved in a range of activities throughout the inspection. These activities included arts and crafts, board games, and computer games, reading books and watching TV. Patients also showed us arts and craft activities they'd created, and during our inspection we observed a number of activities being undertaken on the ward. We observed staff engaging and participating in patient activities.

There was also a ward based gym on Awen Ward which provided the female patients with an area where they could exercise. The facilities available outside the ward also included a patient café, Horticultural and Craft Centre (HCC) which

facilitated various workshops for patients such as woodwork and access to green houses and large garden areas for horticultural activities. The patient café was not open due to Coronavirus (COVID - 19) restrictions, however the café was providing a take away service for patients.

A new group room, internet room, and child visiting centre had been recently been built and plans were in place to convert the old child visiting room into a G.P practice area. This area would be available for the local G.P and nurses to hold clinics with the patients.

Patients with Section 17[1] leave could also access the spacious hospital grounds for walks within their designated ward area.

Dignity and respect

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.

Hospital policies and the staff practices we observed contributed to maintaining patients' dignity and enhancing individualised care at the hospital. There were regular ward meetings to review and discuss practices to minimise the restrictions on patients on Awen Ward based on individual patient's risks.

The registered provider’s statement of purpose also described how hospital staff would support patients in ways which would maintain their privacy and dignity.

Each patient had their own bedroom. Patients were able to lock their bedroom doors which staff could override if required. Patients on Awen, had bedrooms with en-suite facilities consisting of a toilet, sink and a shower which they could access throughout the day. The bedrooms provided patients with a high standard

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

of privacy and dignity. The bedrooms offered adequate storage and patients were able to personalise their room with pictures and posters.

Patients had sufficient storage for their possessions within their rooms which included a lockable cupboard and a safe. Any items that were considered a risk to patient safety, such as razors or aerosols were stored securely and orderly on each of the wards and patients could request access to them when needed.

Bedroom doors had viewing panels so that staff could undertake observation without opening the door and potentially disturbing the patient. It was positive to note that viewing panels were in the closed position and opened to undertake observations and then returned to the closed position. This helped maintain patients' privacy and dignity. The registered provider had also installed curtains over the observation panels to prevent any light disturbing the patients' sleep.

Awen Ward had suitable rooms for patients to meet ward staff and other healthcare professionals in private.

There were suitable arrangements for telephone access on Awen Ward so that patients were able to make and receive calls in private. Depending on individual risk assessment, patients were able to have access to their mobile phone. Patients signed a mobile phone contract with the registered provider to agree to terms of use to confirm that the mobile phone would not be misused and allow staff to monitor mobile phone use and content. At the time of our inspection no visitors were allowed at the hospital, however patients could maintain contact with family and friends through virtual technology.

Awen Ward has two Intensive Care Suite (ICS), one of which was in use at the time of our inspection. These areas could be monitored by staff via CCTV, through conversations with staff and after reviewing care plans we were assured that the use of CCTV in the ICS was used when deemed clinically necessary for the safety of patients and staff.

Patient information and consent

The hospital had a written statement of purpose and a patient information guide which was made available to patients and their relatives/carers.

On Awen Ward, we saw advocacy posters which provided contact details about how to access the service. Advocacy information and registration certificates from Healthcare Inspectorate Wales, along with information on complaints process and how to raise a complaint were also on display. Due to Welsh Government restrictions associated with the Coronavirus (COVID-19) legislation, Advocacy were no longer visiting patients, however 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 video calls.

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff made sure they communicated appropriately and effectively with patients. Staff took time to undertake discussions using words and language suitable to each 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.

We frequently observed patients and staff engaged in activities together. The hospital director and clinical director were also observed talking to patients who responded well to them both, evidencing that they had spent time getting to know the patients on an individual basis. It was clear to see that the hospital director and clinical director were familiar and friendly faces to the patients.

All patients we spoke with, stated that they felt safe and able to speak with a staff member should they need to and patients told us they were happy at the hospital and that staff were kind and helpful. There was clear mutual respect and strong relational security between staff and patients.

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

There were a number of meetings that involved patients and staff, this included formal individual care planning meetings and group community meetings.

Care planning and provision

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 (when required authorisation was in place).

We saw evidence that monthly multidisciplinary reviews were being undertaken with patients fully involved in the process. We also saw that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals. Through our findings there was clear evidence of

multidisciplinary involvement in the care plans, this helped support the hospital in being able to deliver comprehensive care to the patients.

Equality, diversity and human rights

Staff practices aligned to established hospital policies and systems ensured that patients' equality, diversity and rights were maintained. Mental Health Act detention papers had been completed correctly to detain patients at the hospital.

Citizen engagement and feedback

There were regular patient meetings and surveys to allow for patients to provide feedback on the provision of care at the hospital. Information was also available to inform relatives and carers on how to provide feedback. We saw evidence of recent patient surveys and action plans demonstrating how the hospital was implementing improvements and changes based on the outcome of the patient survey.

There was a complaints policy and procedure in place. The policy provided a structure for dealing with all complaints within the hospital. It was evident that an independent person was assigned to investigate complaints and actions were taken in line with the registered provider's complaints policy to ensure that complaints were dealt with appropriately.

A sample of informal and formal complaints established that an independent person was assigned to investigate the complaint and actions were taken in line with the organisation’s complaints policy to ensure that complaints were dealt with appropriately at the hospital.

Complaints were also recorded in individual patient's records along with the outcome of the complaint. The complaints process and associated actions were overseen by the hospital director.

Delivery of safe and effective care

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

We found that staff were completing clinical processes and documentation as required.

There were established processes and audits in place to manage risk, health and safety and infection control. This enabled staff to continue to provide safe and clinically effective care.

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

Some areas of the kitchen on Awen Ward were in need of redecoration and cleaning.

Improvements are required in relation to training compliance for trainers and staff in prevention and management of violence and aggression training.

Managing risk and health and safety

Llanarth Court 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.

Awen Ward had security procedures in place to minimise the risk of restricted items being brought on to the wards. Each shift had an allocated security nurse that was responsible for maintaining the security protocols on each ward.

The ward had a list of prohibited items displayed before entry and there were secure lockers available to store any items that cannot be taken on to the ward, for example, mobile phones, lighters, flammable liquids, etc.

There were nurse call points around the ward and within patient bedrooms so that patients could summon assistance if required. Staff wore personal alarms which they could use to call for assistance if required. There was a system for alarms to be allocated to staff and visitors when they entered a ward.

The majority of the furniture, fixtures and fittings on Awen Ward were appropriate for the patient group. However the dining tables in Awen Ward did not seem consistent with the dining chairs, the dining tables did not appear robust enough for the patient group. It would be useful if the registered provider could provide assurances to HIW on the suitability of the tables if they plan on continuing to use the current tables.

There were up-to-date ligature point risk assessments in place which were kept on Awen Ward. These identified potential ligature points and what action had been taken to remove or manage these. There were weekly audits of resuscitation equipment, staff had documented when these had occurred to ensure that the equipment was present and in date.

The hospital had a business continuity plan in place that included the service's responses to such things as adverse weather, utility failures and outbreak of infectious disease.

Improvement needed

The registered provider should consider replacing the tables or provide HIW with assurances that the tables are safe to use in Awen Ward.

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 found that the dining room floor on Awen Ward had lots of scuff marks, making the flooring appear untidy and dirty. The kitchen wall behind the cutlery storage area was marked with food stains and the plastic fittings on the servery were dirty and required cleaning. This unfortunately left the kitchen, in parts, looking scruffy and a little unkempt.

In addition the paint was worn and faded on the shelf hatch of the medication clinic and requires re-painting.

Cleaning equipment was stored and organised appropriately. There were hospital laundry facilities available so that patients could undertake their own laundry with appropriate level of support from staff based on individual needs.

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

We saw evidence to confirm that Llanarth Court 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.

On the first night of the inspection we noted a designated infection control area with masks and hand sanitisers available in the air lock foyer on Awen Ward. In addition we were requested to sign a COVID-19 information disclaimer. We also examined COVID-19 document checklist which had been produced to support staff and ensure that staff remained compliant with policies and procedures.

Additional hand hygiene training had been introduced for patients and staff and some staff had also been trained in how to fit the FFP3[2] face masks. This demonstrated that the hospital had good policies and procedures in place to prevent the spread of COVID-19 on the ward.

Awen 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. Additional cleaning schedules were also in place and posters were available to display for red areas to highlight if the ward had any cases of COVID-19. None of these areas or posters were in use at the time of inspection because there were no symptomatic cases.

Regular communication via meetings, information boards, and emails ensured everyone has up to date advice and guidance on COVID-19.

During our discussions no issues were highlighted in relation to access to Personal Protection Equipment (PPE). PPE including masks and gloves were available at the ward entrance with bins were provided for the disposal of equipment. Staff were wearing masks in communal areas and throughout ward, however we did observe some staff wearing masks incorrectly with the mask

[2] **FFP3** face **masks** are used to provide protection from viruses, bacteria, and solid or liquid toxic aerosols.

positioned under the nose. The registered provider must ensure that staff comply with PPE requirements regarding the wearing of masks.

Improvement needed

The registered provider must ensure that:

- The dining room floor is cleaned or replaced
- The kitchen wall is cleaned
- The plastic fittings on the servery are cleaned or replaced
- The shelf hatch on the medication clinic is re-painted
- Staff wear PPE masks correctly at all times.

Nutrition

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

As well as the meals provided, patients were able to use the occupational therapy kitchen to prepare their own meals and order take-away deliveries to the hospital.

Staff told us that patients with specific/special diets were catered for, including vegan, gluten intolerant and religious requirements. Menu choices were colour coded to assist patients in identifying healthy options.

Awen Ward had hot and cold drinks dispensers that patients could access to make their own drinks. Patients we spoke to told us they regularly used these facilities.

Medicines management

Medicines management on each of the wards was safe and effective. Medication was stored securely with cupboards and medication fridges locked. There was regular pharmacy input and audit undertaken that assisted the management, prescribing and administration of medication at the hospital. There was also a process in place if emergency medication orders were required.

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

There were appropriate arrangements in place on the ward for the storage and use of Controlled Drugs and Drugs Liable to Misuse. Records viewed evidenced that twice daily checks were conducted with the appropriate nursing signatures certifying that the checks had been carried out.

It was positive to note from the records we reviewed that we did not see any excessive use of antipsychotic or PRN[3], and when PRN was used the reasons were recorded in patient records.

We observed a number of medication rounds, and saw that staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

The Medication Administration Records (MAR Charts)[4] reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages, their Mental Health Act legal status and all consent to treatment forms were also present with the charts.

The placement of the medication clinic in Awen doesn't afford patient privacy and it was noted on the first night of the inspection that patients could be seen receiving their medication. The registered provider should undertake a review of the suitability and location of the clinic to ensure the dignity and privacy of patients receiving medication is maintained at all times.

Improvement needed

The registered provider must undertake a review of the position of the medication clinic on Awen Ward to ensure the dignity and privacy of patients is maintained at all times.

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

[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.

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. As highlighted earlier, the new child visiting was available off the ward in a designated area. The team of social workers took the lead on safeguarding processes, child contact/visiting arrangements and care planning.

Medical devices, equipment and diagnostic systems

There were regular clinical audits undertaken 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

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 only as a last resort. We noted good evidence of the use of de-escalation techniques and recognition of triggers in the documentation we inspected. Debriefs take place following incidents and this process is used as a learning and reflective practice technique supported by psychology.

For every restraint or verbal de-escalation there is an incident form completed; the incident is then discussed at governance meetings and any lessons learnt are shared with staff.

There is dedicated Prevention and Management of Violence and Aggression (PMVA lead) practitioner employed on site who is responsible for reviewing all incidents of violence and aggression at the hospital with the clinical teams.

Typical physical intervention needs on Awen ward include the prevention of self-harm behaviours. When a restraint takes place, patients are encouraged to complete patient incident questionnaires which are reviewed at ward level and by the PMVA lead.

Training figures indicate that the training compliance rates show low compliance rates for restraint training. In addition to low staff training compliance it was also apparent during the review that the PMVA lead trainer was also out of compliance with regard to his trainer's certificate. This requires addressing as it means we can't be assured staff are appropriately trained and up to date with relevant restraint techniques and as a consequence the trainer should not be delivering training until the training certificate is updated and revalidated. The registered provider must make sure all staff have up to date training which is provided by a qualified and certified trainer.

We were advised that weekly training schedules are now back in place but due to COVID-19 restrictions, class numbers have been reduced which has an impact on the staff numbers who can attend. However, any training which is delivered must be delivered by a qualified and certified trainer.

Through interviews with staff there seemed to be uncertainty over the future of the PMVA training model, this is a reoccurring staff concern which featured in our last inspection. The registered provider needs to provide staff with some certainty around what model of PMVA will continue to be used at the hospital.

Improvement needed

The registered provider must ensure that:

- The PMVA trainer's certificate is updated to enable them to continue to train staff
- All staff who require training are trained by a certified trainer whose training certificate is in compliance
- Reassurance is provided to staff on provide staff what model of PMVA will be used at the hospital.

Participating in quality improvement activities

During our discussions with the hospital director, we were provided with numerous examples where they were reviewing the provision of service, and looking to develop some aspects of the hospital. At the time of our inspection there were a number of ongoing improvements being made across the hospital site.

We were told that staff at the hospital who spoke Welsh were issued with lanyards identifying them as Welsh speakers.

Information management and communications technology

The computerised patient record systems were well developed and provided high quality information on individual patient care. The system was comprehensive, and easy to navigate.

There were good electronic systems in place for incident recording, clinical and governance audits, human resources and other hospital systems, which assisted the management and running of the hospital.

Records management

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

We reviewed a sample of patient records across all wards. It was evident that staff from across the multi-disciplinary 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 planning and risk assessment documentations in full.

We reviewed the use of ICS and noted that it is used regularly, however we were reassured that there is a clear focus on minimising its use and looking at alternative less restrictive options.

Mental Health Act Monitoring

We reviewed the statutory detention documents of two patients on Awen Ward, all records were found to be compliant with the Mental Health Act and Code of Practice. Electronic documents on wards and 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.

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. The

Mental Health Act Manager is also member of the All Wales Mental Health Act Managers' Forum.

We were told that hospital manager hearings have fallen behind during the COVID-19 pandemic with tribunals being prioritised. Efforts must therefore be made to ensure that hospital manager hearings are brought up to date as soon as possible.

Section 17[5] 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.

Improvement needed

The registered provider must make efforts to ensure hospital managers' hearings are brought up to date as soon as possible.

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

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

We reviewed a sample of care files and found that they were generally maintained to a good standard. Entries were comprehensive and recognised assessment tools were used to monitor mental and physical health.

There were comprehensive needs and risk assessments completed throughout the patient admission which directly linked to the plan of care and risk

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

management strategies implemented on the ward. There was clear evidence of multidisciplinary involvement in the care plans which reflected the domains of the Mental Health (Wales) Measure.

Risk management plans were also personalised and identified potential triggers for patients, enabling staff to identify changes in behaviours. Management of patients' behaviours were reflected in their care plans and risk management profile, along with staff training to use skills to manage and diffuse difficult situations. Any restraint that occurred during the previous 24 hours was reported and discussed at the daily meeting and then reviewed through the hospital's clinical governance structure.

We saw evidence of comprehensive risk assessments on patients' records and in some cases we saw the development of positive behavioural support plans with summary sheets included to identify risk. This was identified as a good area of professional practice as the document provided staff with a quick accessible guide to identify risks and management strategies appropriate to the individual.

It was really positive to see that care files clearly demonstrated patient involvement in care discussions which were patient focussed and signed by the patient. Overall the nursing documentation viewed was very good and physical assessments were well completed.

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 observed a committed staff team who had a good understanding of the needs of the patients at the hospital.

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

There was dedicated and passionate leadership displayed by the hospital director who was supported by committed multidisciplinary team.

Mandatory training, supervision and annual appraisal completion rates were generally high. However improvements were required in training compliance for restraint training and basic life support.

Governance and accountability framework

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

There was dedicated and passionate leadership displayed by the hospital director who was supported by committed multi-disciplinary teams. The team was a cohesive group of leaders and interviews with them demonstrated that they valued and cared for the staff and patients.

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

Dealing with concerns and managing incidents

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

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.

Workforce planning, training and organisational development

We reviewed the mandatory training and clinical supervision statistics for staff at the hospital and found that the majority of completion rates were high. Training compliance for PMVA were low, this is commented upon earlier in the report. In addition, figures were low for basic life support. We were provided with additional evidence which indicated that staff had already been booked onto basic life support courses, however the registered provider must ensure that mandatory training compliance rates are maintained.

There was a programme of training so that staff would receive timely updates. The electronic records provided the senior managers with details of the course completion rates and individual staff compliance details.

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.

In addition a rota was in place for the Senior Management Team to check in with the night shift staff via a zoom meeting on a fortnightly basis to provide updates to regular night shift workers. Staff are also encouraged to join in virtually with the Senior Management Team meetings which take place on a fortnightly basis. This demonstrated that the hospital management were making efforts to engage and involve staff in meetings and decision making.

To cover any shortfalls in fulfilling the staffing rota that may occur due to vacancies, the registered provider had a staff bank system in place along with the use of agency staff.

Staff 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. Staff told us that team meetings were not taking place as often and this was something the hospital director was looking to improve upon. The registered provider must ensure that regular team meetings can take place, this should be planned in order to make this a more meaningful, supportive and valuable process for staff.

Improvement needed

The registered provider must ensure that:

- Mandatory training figures are improved
- Regular team meetings take place for staff.

Workforce recruitment and employment practices

Staff explained the recruitment processes that were in place at Llanarth Court. 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 a 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 Llanarth Court and the agency staff member, and these were then filed with the human resources team.

The clinical director also told us that efforts are always made to review the skill mix of staff. When placing new staff onto the wards consideration around deployment of staff is always taken to provide new staff with support and experienced mentors.

The hospital and clinical director told us about a new recruitment forum which had been set up to discuss recruitment initiatives and creative ways to try and increase staff recruitment and retain staff who already work at the hospital.

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
No immediate concerns were identified on this inspection.			

Appendix B – Improvement plan

Service: Llanarth Court Hospital

Ward/unit(s): Awen – Female Medium Secure Mental Health Ward

Date of inspection: 25 – 27 January 2021

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				
Delivery of safe and effective care				
The registered provider should consider replacing the tables in the dining room or provide HIW with assurances that the tables are safe to use in Awen Ward.	22. Managing risk and health and safety	Process in place for the replacement tables. Site are in liaison with the patient council for colour scheme and design.	SSM	May 2021
The registered provider must make sure that the dining room floor is cleaned or replaced.	13. Infection prevention and control (IPC) and	Flooring is being replaced. Patients are being consulted regarding design.	SSM	May 2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	decontaminati on			
The registered provider must make sure that the kitchen wall is cleaned.	13. Infection prevention and control (IPC) and decontaminati on	The kitchen wall has been cleaned and environmental audit in place to monitor.	SSM	March 2021
The registered provider must make sure that the plastic fittings on the servery are cleaned or replaced.	13. Infection prevention and control (IPC) and decontaminati on	Hinges will be replaced	SSM	March 2021
The registered provider must make sure that the shelf hatch on the medication clinic is re-painted	13. Infection prevention and control (IPC) and decontaminati on	Plans in place to move clinic to ensure suitability and provide privacy whilst staff dispense medication to patients.	SSM	May 2021
The registered provider must make sure that staff wear PPE masks correctly at all times.	13. Infection prevention and control (IPC) and	This is currently a hot topic in staff supervision. Guidance on the correct donning and doffing of PPE to be sent to	Docs	May 2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	decontaminati on	all staff. Review by management on a regular basis		
The registered provider must undertake a review of the position of the medication clinic on Awen Ward to ensure the dignity and privacy of patients is maintained at all times.	15. Medicines management	Plan in place to move clinic to a more suitable location to ensure patient privacy is maintained.	SSM	May 2021
The registered provider must ensure that the PMVA trainer's certificate is updated to enable them to continue to train staff.	7. Safe and clinically effective care	Current trainers have been assigned refresher training courses in May 2021. Plan in place to increase the number of tutors across site.	Docs	May 2021
The registered provider must ensure that all staff who require training are trained by a certified trainer whose training certificate is in compliance	7. Safe and clinically effective care	See above. Schedule in place for refresher courses for current trainers to ensure compliance	Docs	June 2021
The registered provider must ensure that reassurance is provided to staff on provide staff what model of PMVA will be used at the hospital	7. Safe and clinically effective care	We will be using Priory Healthcare PMVA. See embedded document for details.	HD /Docs	June 2021
The registered provider must make efforts to ensure hospital managers' hearings are brought up to date as soon as possible.	20. Records management	System in place to complete paper reviews where appropriate and plan virtual hearings whilst considering current C-19 restrictions.	SSM	June 2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The registered provider must ensure that mandatory training figures are improved	25. Workforce planning, training and organisational development	Schedule in place to increase face to face training to coincide with PMVA	HD/DOCs/SSM	June 2021
The registered provider must ensure that regular team meetings take place for staff.	25. Workforce planning, training and organisational development	We have reviewed the process that is currently in place and DOCS will audit monthly compliance for regular staff meetings. This will coincide with the SMT vision for 2021 i.e supporting staff	SSM	June 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): Ross Morris

Job role: Hospital Director

Date: 12 March 2021