Arolygiaeth Gofal Iechyd Cymru

Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Cefn Carnau - Bryntirion Ward, Derwen Ward and Sylfaen Ward

Elysium Health 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 independent mental health inspection of Cefn Carnau on the evening of 13 April and days of 14 and 15 April 2021.The following sites and wards were visited during this inspection:

- Sylfaen Ward
- Bryntirion Ward
- Derwen Ward

Our team, for the inspection comprised of two HIW inspectors and three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer). The inspection was led by 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 identified areas of concern under the standards "Managing risk and health and safety", "Infection Prevention and Control", "Safeguarding children and safeguarding vulnerable adults" and "Governance and Leadership". The volume and type of failings identified meant that we were not assured that Cefn Carnau were providing safe and clinically effective care.

We found evidence that showed the increased use of agency staff at the hospital was impacting upon the delivery of safe and dignified care, in particular, on Sylfaen Ward.

We identified concerns regarding the frequency of incidents involving physical restraint and the recording of these incidents.

The governance and audit processes at the hospital were inadequate and failed to monitor and maintain quality and safety at the hospital.

This is what we found the service did well:

- Some patients we spoke with were positive about their experience at the hospital
- We observed that staff interacted and engaged with patients respectfully
- The sample of patient records reviewed evidenced that physical health assessments and monitoring were being completed.

This is what we recommend the service could improve:

- The cleanliness and maintenance of the hospital to ensure safe and effective care
- Governance arrangements to ensure that hospital audits are completed as and when required
- Poor completion rates of staff supervision and appraisals
- Organisation and completion of care plans

- Improve documentation and recording of the use of restraints
- Recruit staff to vacancies which will reduce the reliance on unfamiliar agency staff.

We identified regulatory breaches during this inspection regarding damage to a glass panel door on Derwen Ward. The cracked glass posed a risk to patient and staff safety. This matter was brought to the attention of the interim hospital director who was requested to remedy this issue immediately. This issue was resolved by maintenance whilst the inspection was ongoing. Further details can be found in Appendix A.

We had some immediate concerns about patient safety which were dealt with under our non-compliance process. This meant that we wrote to the service immediately after the inspection, outlining that urgent remedial actions were required. These were in relation to the delivery of safe and effective patient care.

Details of the immediate improvements required are summarised below and the actions the provider has/is taking to address them are provided in Appendix B:

- The hospital failed to provide a clean and safe environment
- HIW were not assured that there were established audit processes in place and had concerns around the transparency and accurate completion of the IPC audits
- The staffing compliment on Sylfaen Ward did not provide sufficient numbers of female staff to maintain the privacy and dignity of female patients when close observation was required
- Inspectors identified that a patient had been required to sleep on a mattress on the floor for an extended period of time
- The system of recording and monitoring of incidents involving the need to restrain patients was not effective and could not provide assurance that the use of restraint was not unlawful or otherwise excessive
- Inspectors identified an incident that had not been referred to the local authority safeguarding process
- Care plan records were not comprehensive and were difficult to find and navigate
- Care and Treatment Plans were not available as required under the Mental Health (Wales) Measure 2010

- There was a high reliance on unfamiliar agency staff to ensure there were sufficient numbers of staff

- Appraisals and staff supervision was not taking place

- Governance and audit processes at the hospital failed to maintain quality and safety at the hospital.

These are serious matters and resulted in the issue of a non-compliance notice to the service. HIW also issued an urgent Notice of Decision to impose a condition on the hospital's registration preventing the admission of new patients until such a time HIW is assured that appropriate action has been taken to resolve the issues set out above. At the time of publication of this report, HIW received assurances that action is ongoing to address the improvements needed.

As a result of the findings from the inspection Cefn Carnau has been designated a Service of Concern as per HIW's enforcement process and we will continue to monitor the service very closely to ensure all improvements required are addressed.

3. What we found

Background of the service

Cefn Carnau is registered to provide an independent learning disability service at Cefn Carnau, Cefn Carnau Lane, Thornhill, Caerphilly, CF83 1LX.

The service was first registered on 11 December 2003. It is a mixed gender hospital with 22 beds, it consists of:

- Sylfaen Ward

  A low secure service only for a maximum 8 (eight) female adults over the age of 18 (eighteen) years diagnosed with a primary diagnosis of a learning disability and who may be liable to be detained under the Mental Health Act 1983.

- Bryntirion Ward

  A low secure service only for a maximum 8 (eight) male adults over the age of 18 (eighteen) years diagnosed with a primary diagnosis of learning disability who may be liable to be detained under the Mental Health Act 1983.

- Derwen Ward

  A low secure service only for a maximum 6 (six) male adults over the age of 18 (eighteen) years diagnosed with a primary diagnosis of learning disability who may be liable to be detained under the Mental Health Act 1983.

At the time of inspection there were 20 patients at the hospital.

The service employees a staff team which includes an interim hospital director, consultant psychiatrist, clinical services manager, a social worker, psychology and therapy teams, a physical health team, along with a team of registered nurses and health care assistants. The team could also access other disciplines such as a dietician, speech and language therapy and physiotherapy.

Quality of patient experience

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

We observed that staff interacted with patients respectfully throughout the inspection.

Most patients that we spoke with told us that they were happy at the hospital.

We identified that a patient had been sleeping on a mattress on the floor. We also identified that patients' privacy and dignity was not always maintained in line with their care plans.

These issues were escalated during the inspection and the registered provider was issued with a Non Compliance Notice in relation to these matters setting out the need for immediate improvements to be made.

Health promotion, protection and improvement

There were good physical health assessments and monitoring recorded in patient notes and staff confirmed that there were good links with external community primary care services.

Patients at the Cefn Carnau had hospital passports; these assist people with learning disabilities to provide staff in general hospitals with important information about the person and their physical health when they are admitted.

Cefn Carnau had a range of facilities to support the provision of therapies and activities along with regular access to the community for those patients that were authorised to leave the hospital. However, due to the restrictions of the COVID-19 pandemic, patients have been accessing leave less frequently following government and organisational guidance.

The hospital had an occupational therapy kitchen which patients could access to prepare meals and a laundry room with a washing machine and tumble drier so that patients could learn and maintain their skills.

The hospital had a gym which patients could use. The gym was located in the occupational therapy unit and at the time of the inspection the heating system was not working correctly. The registered provider assured us that the heating issue was in the process of being resolved.

Improvement needed

The registered provider must ensure that the heating in the occupational therapy building is fixed.

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.

On all wards there were communal areas which provided some space for patients to have personal quiet time away from their rooms. Each patient had their own bedroom which they could access throughout the day; the bedrooms provided patients with an adequate standard of privacy. Patients were able to lock bedroom doors to prevent other patients entering; staff could override the locks if required. We observed a number of patient bedrooms and it was evident that patients were able to personalise their rooms.

On the first night of the inspection when visiting one patient's room we noted that there was no bed in the room and the patient was sleeping on a mattress on the floor. The patient told us that he had been sleeping like this for approximately a month. A staff member then stated that the patient had only been sleeping on a mattress for two weeks. It was later established that the patient had been without a bed for more than a month.

This matter was immediately brought to the attention of the hospital director and dealt with under our non-compliance 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.

We also requested a report outlining a timeline of events to establish how long this patient had been without an appropriate bed and instructed the hospital director to immediately obtain an appropriate bed for the patient. It is

unacceptable that the hospital staff team felt that it was acceptable to leave a patient without a bed.

The report provided to us on how this situation arose raised concerns around the length of time this patient had been without a bed. The registered provider should have resolved this issue in a far timelier manner and the length of time this situation took to resolve is wholly unacceptable.

The registered provider's statement of purpose described how hospital staff would support patients in ways which would maintain their privacy and dignity. However on the first night of our inspection we identified an incident where a female patient was being observed by three male staff with no female staff present.

Staff we spoke with also told us that female patients would often be observed by male staff undertaking enhanced observations when using the bathroom facilities and bedroom areas. We viewed the notes of the patient and the staffing gender requirements in place at the time of the night visit did not comply with those documented in the patient's care plan. The registered provider must ensure staffing gender requirements are complied with.

This matter was also dealt with under our non-compliance process.

Patient information and consent

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

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 the 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 call.

Communicating effectively

Through our observations of staff-patient interactions it was evident that staff ensured that they communicated with patients effectively. Staff took time to undertake discussions using words and language suitable to the individual patient. Where patients remained unclear or misunderstood, staff would patiently clarify what they had said.

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

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

Care planning and provision

Each patient had their own individual activity planner, this included individual and group sessions, based within the hospital and the community (when required authorisation was in place).

Staff and patients spoke very favourably regarding the activities and the occupational therapy team.

Throughout the inspection we observed patients participating in individual and group activities within the hospital.

Equality, diversity and human rights

Mental Health Act detention papers had been completed correctly to detain patients at the hospital. Patients we spoke with during the inspection understood the reason for their detention and had an understanding of their rights and entitlements whilst at the hospital.

Citizen engagement and feedback

There were the opportunities for patients, relatives and carers to provide feedback on the care provided at the hospital; this included individual and communal meetings. Each ward had a complaints book to log informal complaints and the outcome of the complaint. Formal complaints were logged electronically documenting the progress and outcome of the complaint.

Patients we spoke with said that they felt comfortable in discussing any concerns with staff members and that they knew how to raise a complaint if required. As stated earlier, each ward had a daily meeting where patients could raise any concerns that they had. There were monthly hospital Patient Council meetings which had patient ward representatives and senior hospital managers in attendance.

However, during the course of our investigation we identified that issues raised in meetings by patients were not being dealt with effectively and being carried forward for a number of months without any action being taken. Patient minutes

of meetings indicated that easily resolved issues were carried forward over several months; for example

- New toaster, tea, sugar and coffee containers required – Ongoing 3 months
- New basketball hoop for tennis courts – Ongoing 4 months
- Derwen Ward in need of deep clean – Ongoing 2 months.

This lack of response by the hospital is not acceptable and is demoralising for patients. The registered provider must ensure that patients' requests are dealt with promptly and in a timely manner.

Improvement needed

The registered provider must ensure patients' requests are dealt with promptly and in a timely manner.

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 were concerned about the management of risk and health and safety at the hospital. Throughout the hospital, we saw damaged furniture, fixtures and fittings which could impact upon patient and staff safety.

Legal documentation to detain patients under the Mental Health Act or restrict patients leaving the hospital were compliant with the relevant legislation. However Patients' Care and Treatment Plans were not available and therefore not compliant with Welsh Mental Health (Wales) Measure 2010.

The high use of agency staff to maintain required levels of enhanced patient observations, impacted negatively on safety of patients at the hospital, particularly Sylfaen Ward.

Staff were unable to locate patient care plans and some staff were unfamiliar with patient care plans. We were concerned that staff were not taking appropriate and approved actions to maintain the safety of patients.

At the time of our inspection we found that overall medicines management at the hospital was safe and effective. However, clinical rooms were very disorganised and untidy. Some medication was not being stored correctly and medication audits were not taking place regularly.

Additionally, we found weaknesses in maintaining the safety of the building.

There were good physical health assessments and monitoring recorded in patient notes.

Managing risk and health and safety

Access to the hospital grounds was via a secured gate controlled via intercom to reception or staff electronic key fobs. All hospital buildings were also secured via key fob access. We raised concerns regarding the amount of missing keys that were displayed on a board in the reception area which indicated a high number of keys highlighted as being stolen. This demonstrated that there was not a robust governance process in place to manage key security and raised concern more broadly around the management of security more generally at the hospital and the impact this may have on the safety of patients and staff.

All staff had a personal alarm that could be used in an emergency. There were also nurse call alarms in bedrooms and other areas throughout the ward should assistance be required.

During our inspection staff were unable to provide a copy of the most recent Ligature Point Audit on Derwen Ward. The one produced was out of date and there was no evidence to suggest that present ligature points had been considered and what actions were being taken. Due to the unavailability of the most recent audit we advised that another ligature point audit is undertaken for all wards within the hospital.

It was of concern that throughout the hospital there was damage to fixtures, fittings and furniture in patient areas. This included damage to a glass panel on door in Derwen Ward. The cracked glass posed a risk to patient and staff safety. It is of concern that this issue had not been identified in environment checks or reported by staff in an efficient way for maintenance to resolve. The interim hospital director was asked to arrange for the cracked glass to be replaced immediately. This was actioned, and the pane of glass was replaced on the first night of the inspection.

The inspection team considered the hospital environment during a tour of the hospital on the first night and the remaining days of the inspection. The inspectors' observations concluded that the environment of care was not kept in a good state of repair nor was there a clean environment provided on all wards and staff areas. This was because:

- Unpleasant odours were prevalent in a number of the bathroom areas. Toilet bowls were heavily marked and stained, and towels and paper towels were strewn across the floors
- The wards had damaged furniture; sofas and chairs in all patients lounge areas were ripped and marked, carpets flooring and walls were

marked and stained. Flooring to the laundry area was dirty, ripped and damaged

- The patient ward areas were also disorganised; laundry bags and waste bags lined the corridor of Sylfaen Ward and patients' belongings and boxes were stored in the shower area on Sylfaen Ward

- Dust and debris was visible on stairways of the wards and the windowsills of the hospital

- Conservatory roofs throughout the hospital were covered in dirt and debris

- The laundry room was disorganised; a washing machine was placed in the middle of the room, patients' laundry was not organised and not identifiable

- COSHH materials were not stored in a locked cupboard. There was also evidence of rodent issue with pest control traps in view in the laundry room.

The above issues were dealt with under our non-compliance 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.

During the inspection we were provided with data regarding the number of restraints that took place across all wards from 31 October to 14 April 2021. A review of this data showed that significant numbers of restraints were occurring and that a high proportion of restraints were resulting in injuries. This issue was also dealt with under our immediate improvements process.

Following the inspection and in response to the immediate assurance, the registered provider indicated that the restraint data provided to HIW during the inspection was incorrect. Therefore we requested further data from the registered provider in order to determine whether restrictive interventions were being monitored and managed effectively. Further documentation was submitted, however we remain concerned with the accuracy of the data. This is because the revised submission did not reflect information received previously by HIW through our concerns process and regulatory notifications; specifically in relation

to the use of supine restraint and the use of intramuscular PRN[1] medication. Therefore we can only conclude that the system of recording incidents and restraints at Cefn Carnau is ineffective.

The recording system and reviewing of restraint data require immediate review to ensure that this information is being captured accurately and so that it can be used to support the safe running of the hospital. Therefore the registered provider is asked to review this data and provide evidence to HIW that the level and number of restraints is proportionate and always used as a last resort. This further analysis must be shared with HIW as a matter of urgency.

The registered provider must undertake a review of support plans for preventing and responding to incidents of violence and aggression and ensure that the least restrictive options are used.

The registered provider must ensure they have a quality assurance process in place which includes an escalation process for all restraints, in particular those restraints that are over 10 minutes or more. This quality assurance process must include on-going monitoring of the patients wellbeing following restraint.

The registered provider should also consider completing an environmental risk assessment to manage incidents of violence and aggression. Many areas of the hospital were small confined corridors which make restraint techniques difficult and staff we spoke to, told us that it is often difficult responding to behavioural incidents when they occur in small confined spaces.

The registered provider must ensure that:

- Adequate security processes are put in place to prevent keys being removed from the hospital
- Robust governance audit system need to be implemented regarding key security
- Updated ligature point audits are completed of all wards

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

- All damages are rectified promptly to maintain patient safety
- There are regular environmental audits to identify any unreported damaged areas
- Environmental risk assessments are undertaken to support staff in managing violence and aggression in small confined spaces
- A robust governance system is put in place to record, analyse and review restraint data.

Infection prevention and control (IPC) and decontamination

As detailed earlier in the report, the environment of care that inspectors observed was not reflective of a modern inpatient mental health and learning disability service. In addition to the environmental issues highlighted above, we were not assured that there were established IPC audit processes in place and had concerns around the transparency and accurate completion of the Infection Prevention and Control (IPC) audits.

IPC audit records completed for 1 April 2021 and 6 April 2021 indicated that deep cleaning of areas was not required, touch cleaning had been completed, and no areas required decluttering. The completed audits did not accurately reflect the environment observed during the inspection.

For example:

- Medication rooms were cluttered and disorganised
- Patient toilets and bathroom areas were dirty and unpleasant odours were prevalent
- Patient belongings were stored in corridors and bathroom areas
- Surfaces were dusty and carpets and walls were stained and dirty
- Laundry room was disorganised and unclean and the flooring along the corridor leading to the laundry room was marked and damaged
- Conservatory roofs throughout the hospital were covered in dirt and debris.

As a result of these findings HIW could not be assured that there were effective IPC systems in place to maintain appropriate standards of cleanliness and hygiene at the hospital to ensure patient safety. This was dealt with under our non-compliance process.

In addition to the above, no annual IPC action plan was available to review. Staff we spoke with acknowledged lack of attention in regard to IPC overall governance, however they did speak positively about immediate plans to address the failings we had identified.

A newly appointed IPC lead was currently being mentored by Elysium HealthCare's organisational IPC lead and was awaiting enhanced training.

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 was disorganised with no system in place to stop patients' clothing becoming mixed together. The flooring leading to the laundry room was ripped and dirty and there was evidence of rodent traps within the laundry room. In addition to the environmental concerns already highlighted in this report we noted that Control of Substances Hazardous to Health (COSHH) materials were not stored in locked cupboards and posed a danger to patient safety.

The laundry equipment appeared to be working correctly, however there was one machine which was abandoned in the middle of the room, which needed to be placed in a more appropriate location within this room.

We saw evidence to confirm that Cefn Carnau 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 required at the time of inspection.

Regular communication via meetings and emails ensured everyone has up to date advice and guidance on COVID-19. Staff told us that personal protective equipment (PPE) is provided on a daily basis. During our discussions no issues were highlighted in relation to access to PPE.

Nutrition

Patients were provided with meals at the hospital which included breakfast, lunch, evening meal and supper. Patients choose their meals from the hospital menu that was on a four week cycle and changed seasonally. Patients also had access to snacks along with hot and cold drinks. There were mixed reports from patients on the food choices, some patients stated that they were happy and stated the chef would make an alternative option when requested. Whilst others stated that they did not like the food and there were limited choices, especially for vegetarians.

A member of kitchen staff regularly attended the Patient Council meetings to discuss catering feedback directly with patients.

There were patient kitchens on each of the wards and an occupational therapy kitchen within the activities block which enabled patients to make their own meals and develop their skills.

Patients with leave could access the community to purchase food items and ingredients. We also noted that ward staff and kitchen staff would purchase specific food items and ingredients on a patient's behalf if they did not have leave.

Improvement needed

The registered provider must ensure that patients have access to a varied menu which caters for individuals dietary requirements.

Medicines management

The clinical rooms were disorganised and there was limited medication storage space in the clinical areas. During the inspection we observed that surplus medication was being stored in an unlocked cupboard underneath the sink in Bryntirion Ward. When we asked staff about the inappropriate storage of medication, no explanation could be provided. We requested that the medication was immediately removed.

There were numerous examples in the controlled drugs record book on Bryntirion Ward of non-registered staff completing the secondary signature for Drugs Liable to Misuse. The hospital medication policy indicated that secondary signature should be completed by a registered nurse. The registered provider must review its policy and if senior healthcare assistants are being used for secondary signatures then they must receive the appropriate training.

The hospital systems for ordering and returning of medication were not clear. A large amount of medication was stored on Bryntirion Ward which was used to supplement the other wards. We also identified that stock checks were not being completed regularly.

There was no clinic room audit in place; the most recent auditing document we were provided with on Bryntirion Ward was completed in 2017. The registered provider must have a policy in place to ensure a review system is in place for ordering, storage and disposal of medication.

We identified that the room temperature in Derwen Ward was at the higher end of the required range, during warmer seasons the registered provider needs to closely monitor this to ensure medication is still being stored within the required range.

Ligature cutters were stored appropriately and available to staff in the case of an emergency.

Staff had access to all relevant medicine management policies at the hospital along with the current British National Formulary (BNF)*2.

Improvement needed

The registered provider must ensure that:

- All clinical rooms are clean, organised, and clutter free
- Policies are reviewed and updated regarding the use of non-registered nurses being used as secondary signature and provide training to staff
- Clinic room audits are completed at the required frequency
- Improvements are made to the system of ordering and returning of medication
- Regular medication stock audits take place
- The temperature in clinical room on Derwen Ward is within the required range.

Safeguarding children and safeguarding vulnerable adults

The hospital had a social worker who stated that there were good links with the local authority's adult safeguarding team. Whilst there was a process in place for

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*2 British National Formulary is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about individual medicines.

reporting safeguarding concerns we were concerned to find an example of an incident which had not been subject of a safeguarding referral. The registered provider must ensure there is sufficient managerial supervision of ward staff and documentation to ensure that safeguarding referrals are identified and appropriate action taken. We advised the interim hospital director that the matter should be referred to safeguarding and this matter was dealt with under our immediate improvements process.

Medical devices, equipment and diagnostic systems

Weekly audits of resuscitation equipment were taking place and staff documented when these had occurred to ensure that the equipment was present and in date. However we found the oxygen cylinder in Sylfaen Ward had coats hanging off it and was covered in dust. There was also a vacuum cleaner in the office area of Sylfaen which was blocking access to the resuscitation bag. The registered provider must ensure that these items are cleaned and easily accessible in the event of an emergency.

The sharps boxes in Derwen Ward all had lids and were not over filled but there were two large boxes that appeared full which had not been removed adding to the clutter in the clinical room of Derwen Ward. The registered provider must ensure that all medical waste is removed from clinical rooms and disposed of appropriately.

Improvement needed

The registered provider must ensure that:

- Medical devices are cleaned and easily accessible
- Sharp boxes are removed and disposed of when full.

Safe and clinically effective care

From the areas of concern that we identified under the standards "Managing risk and health and safety", "Infection Prevention and Control", "Safeguarding vulnerable adults" and "Governance and Leadership" we concluded that Cefn Carnau Hospital was not providing safe and clinically effective care.

There had been a lack of organisational management of the hospital that allowed for patients to receive inappropriate care and treatment that was not based on multi-disciplinary decisions and policies.

The high usage of unfamiliar agency staff has impacted negatively on the some patients' feelings of security, safety and their dignity.

We have identified areas for improvement throughout this report that require meaningful action in order to ensure safe and clinically effective care is provided at Cefn Carnau.

Records management

Patient records were either electronic, which were password protected or paper files that were stored and maintained within the locked nursing office. We observed staff storing the records appropriately during our inspection.

We had difficulty finding some documentation even with the assistance of staff, this will be documented in the care planning section below.

There were good physical health assessments and monitoring recorded in patient notes and staff confirmed that there were good links with primary care services.

Mental Health Act Monitoring

We reviewed the statutory detention documents of two patients across the hospital.

It was evident that detentions had been applied and renewed within the requirements of the Act. Copies of legal documentation were organised appropriately within patient files. Legal forms were contemporaneous, accurate and comprehensive.

Consent to treatment certificates were kept with the corresponding Medication Administration Record (MAR Charts)[3]. The MAR Charts reviewed recorded 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. This meant staff administering medication could refer to the certificate to ensure that

[3] 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.

medication was prescribed under the consent to treatment provisions of the Mental Health Act.

We could not locate any Care and Treatment Plans (CTP's) for patients. All Welsh patients are legally entitled to have these under the Mental Health (Wales) Measure 2010. CTP's allow patients to set goals and have more input into their treatment and recovery. Staff we spoke with told us that care co-ordinators had been asked for the CTP's but they had failed to comply with the request from staff. The clinical service manager assured us that she would write to the care co-ordinators to resolve this issue

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.

Improvement needed

The registered provider must ensure that all Welsh patients have Care and Treatment Plans in place.

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

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

Care plan records were not comprehensive and it was difficult to establish locations of care plans at the hospital, even with staff assistance, some staff could not direct us to the care plans and the information we required. Attempting to follow the care and treatment of an individual was complex and time consuming across the individual sources. This would be of particular concern for an agency member of staff attending the ward for the first time where it would be very difficult for them to understand patient behaviours and the appropriate actions to take to manage them.

The lack of organisation with patient care plan documentation made it almost impossible for unfamiliar staff to locate the vital information they need to care for patients safely and effectively. We identified through one safeguarding referral that a patient was able to self-harm due to a staff member not being familiar with a care plan and therefore how to manage the individual patient's risks. This issue was dealt with under our immediate improvements process.

We recommend that the registered provider reviews the documentation on each patient so that staff have a succinct record to learn about each of the patients.

Improvement needed

The registered provider must:

- Review patient documentation to ensure that staff have succinct records to learn about each of the patient
- Ensure that agency staff are familiar with patient care plans and risky behaviours.

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.

Throughout the inspection and at the feedback session, the ward staff and management at Cefn Carnau were receptive to our views, findings and recommendations.

However, we found evidence that the requirement to use levels of agency staff at the hospital was impacting upon the delivery of safe and dignified care, in particular, on Sylfaen Ward.

The governance and audit processes at the hospital were inadequate and failed to maintain quality and safety at the hospital.

Governance and accountability framework

The significance of the areas of improvement identified in the "Delivery of safe and effective care" section of this report highlights the need for improvement in audit and governance regarding many aspects of environment of care, patient safety, care planning and the practice of restraint.

Recently there had been a number of significant changes to the management and multi-disciplinary team. An interim hospital director had been appointed along with a regional quality assurance manager and there had been a change of consultant psychiatrist. Through our discussions it was clear that the staffing changes at the hospital had caused some uncertainty amongst the staff and patient group. However, staff spoke positively about the change of management and indicated that improvements had been made to the operational management of the hospital. Staff told us that since the changes in management staff morale had improved.

Discussions held with senior staff, including the interim hospital director and regional quality assurance manager, highlighted that they were aware of service issues which required improvement and had a clear commitment to addressing those. This was in order to raise the standard of the environment and treatment and support to patients.

We found that collaboration between the Multi-Disciplinary Team and ward staff was not taking place. Ward staff we spoke to told us that they did not feel involved in patients' care and treatment decisions and it was evident that the team were no longer working together. Lack of team work and not working collaboratively as a team can negatively impact on patient care and safety. It is vitally important that the registered provider ensures that the staff at the hospital work together and become a more cohesive team who communicate, consult, and make decisions together to optimise patient care.

Improvement needed

The registered provider must ensure that:

- There is an improvement in audit and governance processes across all areas of the hospital
- The registered provider must ensure that the MDT and Ward staff work collaboratively to optimise patient care.

Dealing with concerns and managing incidents

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

Arrangements were in place to disseminate information and lessons learned to staff from complaints and incidents at the hospital and the wider organsiation. This helps to promote patient safety and continuous improvement of the service provided. In addition, the interim hospital director was communicating with staff on any new changes and key events that had taken place via weekly emails and drop in sessions for staff.

Workforce planning, training and organisational development

Staff told us that the new 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.

Training figures indicated that the training compliance rates were low in some areas. For example the compliance rates for Basic Life Support was 50% for nursing staff, Safeguarding Adults and Children was 50%. The training figures provided on the inspection, indicated that healthcare support workers were more compliant with their training than the nursing staff.

We recognised that face to face training has been difficult due to the pandemic, however improvements are still required in these areas and the registered provider must ensure nursing staff have time made available for them to complete their training.

During staff interviews and after requesting documentation to evidence staff supervision and training, inspectors were not provided with sufficient documentary evidence to reflect that regular appraisals and supervision were taking place. Inspectors were provided with one staff supervision record which had been completed on the day of our inspection. The registered provider confirmed that they would ensure staff complete the required training and robustly monitor the completion of supervision and staff appraisals.

At the time of the inspection a new rota management system had been implemented. Staff we spoke with told us that the rota systems had caused confusion amongst staff as they were unclear as to which rota system to use, some staff told us there were four different rotas in use. It is important that staff have training in the new rota system and that hospital staff know which rota to use and refer to.

Improvement needed

The registered provider must ensure that:

- Staff are supported to complete mandatory training
- Staff appraisals and supervision takes place and is monitored
- Staff receive training in the new rota system
- Staff know what rota system to use and refer to.

Workforce recruitment and employment practices

Staff explained the recruitment processes that was in place at Cefn Carnau. 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 Baring Service checks were undertaken and professional qualifications checked. They also confirmed that appropriate processes were in place to check the skillset of agency staff prior to commencing work at the hospital and arrangements to cease using individual agency staff if they performed duties poorly.

Newly appointed staff undertook a period of induction under the supervision of the heads of care.

We were told by the interim hospital director that a staff recruitment campaign was ongoing and that five nursing vacancies and five healthcare support vacancies were currently being advertised.

Concerns were raised by patients and staff over the high usage of unfamiliar agency staff which was felt impacted upon engagement with patients and the consistency of dignified care. As previously highlighted in the delivery of safe and effective care section of this report, we raised concerns regarding the high number of unfamiliar agency staff and how this impacted on patient safety and continuity of care. This matter was dealt with under our immediate improvements process.

During discussions with senior management at Cefn Carnau they acknowledged that there was a reliance upon the use of agency staff and were endeavouring to fulfil vacancies and recruit permanent staff to reduce the requirement to use agency staff. Management need to continue their programme of recruitment to ensure sufficient staffing levels are in place to provide a safe environment and consistent care for patients.

Improvement needed

The registered provider must ensure that:

- The high usage of agency staff is reduced
- Staff vacancies are appointed to.

Given the areas for improvement identified during this inspection, consideration should be given to ensuring that there are more effective and proactive arrangements in place at the service to monitor compliance with relevant regulations and standards. Whilst no specific recommendation has been made in this regard, the expectation is that there will be evidence of a notable improvement in this respect at the time of the next inspection.

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 found a cracked window pane on a door in Derwen Ward.	The cracked glass posed a risk to patient and staff safety.	This was immediately brought to the attention of the interim hospital director who was instructed to replace the glass.	Maintenance attended and resolved the issue.

Appendix B – Immediate Improvement plan

Service: Cefn Carnau Elysium Healthcare

Ward/unit(s): Sylfaen Ward, Bryntirion Ward, and Derwen Ward

Date of inspection: 13 April - 15 April 2021

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	Timescale for completion	Regulation number	Provider Action
The registered provider must make sure all areas of the hospital are thoroughly cleaned and decluttered and evidence ongoing compliance with infection prevention and control standards.	1. Completed 23.04.21	Regulation 26 (2) (a) and (b)	1. External agency engaged and carried out a deep clean across all wards. There are now no unpleasant smells in the bathrooms, the bathroom on Sylfaen has been cleared out and deep cleaned and belongings removed. All the toilet bowls are now clean. All COSSH items were removed from the ward clinics and are stored in the ward COSSH Cupboard. Pest control traps remain in situ as a precautionary measure, however no evidence of any rodent activity.This will be checked daily by maintenance

Description of Non-Compliance/ Action to be taken	Timescale for completion	Regulation number	Provider Action
			laundry bags and waste bags removed from the corridor in the female ward and a new laundry management system put in place.
	2. 04.05.21		2. Programme of declutter instigated across the hospital starting with the patient areas. Male wards completed 23.04.21, Female wards currently being supported to ensure service user involvement and choice are taken into account whilst decluttering their bedrooms.
	3. 19.04.21		3. From the 19th April, a Support Services manager from another Elysium site has been based at Cefn Carnau for a minimum of 4 weeks.
	4. 14.05.21		4. Support Services manager to review support services structure and resources. Has made some significant positive changes and we will appoint new resources to sustain improvements. Adverts have been put in place for head housekeeper and laundry assistant,. maintenance manager and maintenance assistant .

Description of Non-Compliance/ Action to be taken	Timescale for completion	Regulation number	Provider Action
	5. 31.05.21		5. New housekeeper appointed 13.04.21 and further housekeeper on-boarding, start date will be in May 2021. Ongoing support from another Elysium site in the interim period.
	6. 29.04.21		6. The cleaning schedules for the hospital have been revised and new schedules implemented. Support services manager to monitor.
	7. W/C 26.04.21		7. Ward IPC 3 hourly touch point cleaning checks are being audited each week by the clinical services manager (CSM).The 12 hourly IPC checks are reviewed every weekday by the SMT at morning handover meetings supported by the quality walk around by SMT.
	8. Start 29.04.21 - then Monthly		8. IPC themes and actions to be escalated to HD by the site IPC lead and completed actions to be monitored at Clinical Governance meetings
	9. Target completion for decorating 31st May 2021		9. Regional estates lead visited the site 22.04.21 to review all estate issues. A programme of works has been arranged, including painting and decorating to commence on the 4th May 2021 with external contractors.

Description of Non-Compliance/ Action to be taken	Timescale for completion	Regulation number	Provider Action
The registered provider must ensure that there is robust and intrusive supervision and monitoring on IPC audits to ensure they are accurately completed.	10. 24.04.21 - Complete	Regulation 15 (7) 8 (a) (c)	10. Torn furniture replaced 24.04.21
	1. Commenced 26.04.21		1. IPC lead to undertake a review of 3 hourly ward touch point cleaning and the 12 hourly checks. Reviewed monthly in Clinical Governance Meetings.
	2. To commence 04.05. 21		2. Introduce a system of quality walk arounds by key staff. Each ward to be assigned a member of the SMT to complete the walk arounds. Wards will have weekly visits by a member of the SMT or site co-ordinator. They will complete a walk around to review the cleanliness and environment of the ward. Report back to morning meeting and actions agreed and report to Governance
	3. Commenced 26.04.21		3. Ensure all areas have a cleaning schedule. Introduced & implemented cleaning schedules. This programme will be monitored by the interim support services manager and reported through weekly SMT and monthly Clinical Governance to ensure it is fully embedded.
	4. 30.04.21		4. Washing machine moved from the middle of the room, pigeon-hole system put in place to manage patient laundry

Description of Non-Compliance/ Action to be taken	Timescale for completion	Regulation number	Provider Action
			so they can have their own basket slot. An ongoing inspection of the laundry area will be part of the quality walk round and reported to Governance.
	5. 19.04.21		5. New bedding and baskets ordered for all wards due for delivery 07.04.21
	6. 15.05.21.		6. External IPC auditors to be booked to come in for external Audit date to be confirmed.
	7. 15.05.21		7. All clinic rooms, carpets and walls are being reviewed and will form part of the refurbishment programme.
The registered provider must provide assurances that management have oversight on the staffing requirements for female patients on Sylfaen ward. Rotas must be monitored to ensure that there is sufficient female staff to adequately cover the ward and provide dignified care to patients.	1. Commenced 19.04.21 Commence 01.05.21 2. a. Completed for SMT 20.04.21. Roll out to all staff by 15.05.21. b. Completed 23.04.21	Regulation 18 (1) (a), (b)	1. New morning meeting minutes include staffing gender split for each ward to provide greater visibility. To commence weekend morning meetings therefore the on call manager is aware of staffing gender split including any observation requirements. 2. All staff to be given refresher training on the use of the electronic roster system (Quinyx): a. All staff to have completed Quinyx training by the end of the month b. Key responsibilities for Quinyx identified.

Description of Non-Compliance/ Action to be taken	Timescale for completion	Regulation number	Provider Action
	3. 23.04.21 - Complete		3. Templоyer – Review of staff booking system completed to ensure staff cannot override - thus pre-agreed rota to ensure gender balance is maintained.
	4. 29.04.21		4. Rota management guidance clarifying minimum gender mix across wards and a review of staffing for each ward has been developed and will be ratified in Clinical Governance on 29.04.21
	5. 27.04.21 - Complete		5. Mandate for at least one female to be with female patients on enhanced obs at all times reinforced 27.04.21. A daily review of the minimum number of female staff required on each shift will take place to ensure this occurs with support from other wards if required.
The registered provider must provide an in-depth report and timeline on the events leading to a patient being left sleeping on a mattress, awaiting a replacement bed. Assurances must be provided that a bed fit for purpose is provided immediately for this patient.	1. 24.04.21- Complete	Regulation 18 (1) (a), (b)	1. Implementation of a comprehensive Care Plan in the middle of March 2021 completed. The patient's continence management had improved. The Care Plan included, personalising his bedding, waking him to prompt him using the toilet early morning and reducing fluid intake after a certain time in the evening. This care plan was developed and agreed with the patient.

Description of Non-Compliance/ Action to be taken	Timescale for completion	Regulation number	Provider Action
	2. 15.04.21 - Complete		2. Temporary Bed base provided by Interim HD as soon as issue identified on 15th April 2021. Specialist bed ordered on the 1st April
	3. 20.04.21 - Complete		3. Patient transferred to a Medium Secure Unit. Was able to engage in a smooth transition and supported to see this as a positive move for him. Transferred 20.04.21
	4. 30.04.21		4. A clear report including the timeline of events will be provided covering all aspects identified.
The registered provider must undertake a robust governance review of restraint data to ensure that the level and number of restraints is proportionate and always used as a last resort. The Registered Provider must demonstrate that restraints are undertaken for the shortest possible time and staff have regularly evaluated, during the restraint, whether this could have ended earlier. The further information requested must provide comprehensive analysis	1. 30.04.21	15 (1) (a), (b) and (c) and Regulation 16 (2) (b)	1. It has been confirmed the numbers from a report provided on the day of the visit had been misinterpreted however a breakdown of those numbers was provided on 22 April 2021. An updated report is being produced by reviewing each incident report separately thus clarifying the use of restraint including any injuries.
	2. 15.05.21		2. A senior manager from Management of Violence and Aggression (MVA) Team is conducting a further review of staff practice when undertaking a restraint. Site visit has been arranged for Thursday 29th April.

Description of Non-Compliance/ Action to be taken	Timescale for completion	Regulation number	Provider Action
which documents and captures the descriptive detail and context around time of restraints and level of injuries sustained from the restraints.	3. Commence 01.04.21		3. All incidents will also be reviewed within the morning meeting with actions assigned and monitored to completion through this meeting.
	4. 29.04.21 - Complete		4. Restraint data reports prepared for standing agenda item for the Hospital Clinical Governance meeting,
	5. 30.05.21		5. The regional TMVA lead for Wales to undertake additional training sessions so that compliance is achieved. Regional TMVA lead will identify any additional training to meet any specific patient specific training needs of any individual patients.
The registered provider must provide assurances that robust systems and processes are in place for dealing with safeguarding matters and referrals.	1. 23.04.21 - Complete	Regulation 16 (1) (a) (b)	1. A peer Safeguarding review was completed including all processes and documentation. Recommendations will be implemented and monitored by the Clinical Governance Group.
	2. 30.04.21		2. Local safeguarding procedures updated and implemented by 30.04.21 following completion of peer review.
	3. 29.04.21 then Monthly		3. Safeguarding log updated after every event and reviewed within Clinical Governance with any actions identified

Description of Non-Compliance/ Action to be taken	Timescale for completion	Regulation number	Provider Action
			assigned and then monitored for completion.
	4. 30.06.21		4. Face to Face Safeguarding Training rolled out to all staff by the end of June 2021.
The registered provider must ensure that staff have access to an overarching Care Plan for patients to enable unfamiliar staff to adequately provide safe care for patients	1. 15.05.21	Regulation 15 (1) (a)	1. Ensure all patients have an overarching care plan that have been reviewed and are suitable.
	2. 01.05.21		2. Refresher Guidance will be provided to all staff including agency on how to access overarching care plans. This will be in conjunction with a focus on the PBS care plan.
	3. 30.04.21		3. All agency and bank staff receive an orientation and induction with a checklist and this is signed off once complete. This will include directions on how to access a password for the Carenotes system. A copy of the records need to be held in ward file and copy added to HR Files for monitoring.

Description of Non-Compliance/ Action to be taken	Timescale for completion	Regulation number	Provider Action
	4. 15.05.21		4. Consultant and MDT completing a review of all patients on enhanced observations with a plan in place to reduce the amount of agency staff being used through recruitment of more bank staff and recruiting above budget.
	5. 15.05.21		5. Agencies to meet with director of nursing to discuss current challenges and find solutions including locum agency staff.
	6. 01.05.21 - Complete		6. CSM to audit rotas every week to check agency are not working too many shifts in a row. Agencies have been contacted by the interim hospital director to ensure they monitor this for their staff too.
	7. 31.05.21		7. Staff guidance on care planning and training to be rolled out across all MDT and qualified staff by 31.05.21.
The registered provider must ensure Care and Treatment Plans are available in line with Mental Health (Wales) Measure 2010	1. 22.04.21 - Complete	Regulation 15(1) (a) (b)	1. All Welsh patient files have been checked
	2. 31.05.21		2. Confirm that all CTP are complete and uploaded.
	3. 31.05.21		3. Any patient without a CTP in the last year uploaded to have a CTP meeting booked by the end of May 2021. This to

Description of Non-Compliance/ Action to be taken	Timescale for completion	Regulation number	Provider Action
			be audited by the company compliance team before the 11th June.
	4. 31.05.21		4. The admission checklist will be updated to include checking the CTP is in place. If there isn't one, an identified individual is tasked with obtaining it from care coordinators. This will be monitored within the hospitals Clinical Governance meeting.
	5. 15.05.21		5. Staff refresher training on MH Measure to be rolled out by the clinical services manager (CSM).
The registered provider must ensure that they provide a stable workforce and reduce reliance on agency staff, and provide HIW with assurances that systems are in place to ensure unfamiliar staff have a good knowledge on patients to provide safe and effective care.	1. 26.04.21 then every week day - Complete	Regulation 20 (1) (a) (b) (2) (a)	1. Clinical services manager (CSM) and interim consultant psychiatrist to meet every week day to review patients on enhanced observations.
	2. 30.07.21		2. Recruiting permanent consultant psychiatrist. Interim locum is currently undertaking induction.
	3. 24.04.21 - Complete		3. Any staff including bank or agency will be provided with a full handover and required observation levels/other interventions.
	4. 15.05.21		4. Introduction of Patient Safety at a Glance Boards.

Description of Non-Compliance/ Action to be taken	Timescale for completion	Regulation number	Provider Action
	5. Commenced 26.04.21		5. Ward managers to discuss in SMT progress of patients awaiting a move to another provider to update on progress to facilitate the quickest transfer possible to reduce anxiety of patient.
	6. 04.05.21		6. Weekly update on progress at HR Interview slots to be made available in advance by ward managers / SMT.
	7. Commenced 30.04.21		7. Enhanced welcome bonus/refer a friend has been put in place to support recruitment at Cefn Carnau. This is part of a relaunched recruitment programme including a virtual open day for nurses in w/c 10th May. Central recruitment team are targeting job boards plus other business media platforms.
	8. 30.04.21		8. Further focus to increase the bank staff to further reduce agency use.
	9. Commenced 22.04.21		9. Agencies contacted for potential for locum qualified learning disability nurses to support site in the interim whilst recruiting.
The registered provider must make sure that a robust system of monitoring is in place to ensure that	1. Commenced 23.04.21	Regulation 20 (1) (a) (b) (2) (a)	1. New database implemented to accurately record supervision and appraisals

Description of Non-Compliance/ Action to be taken	**Timescale for completion**	**Regulation number**	**Provider Action**
staff appraisals and supervision is regularly taking place for staff.	2. 30.04.21		2. Further embedding of implemented supervision timetable which covers reflective practice, team meetings and managerial supervision with floating staff to support the wards and allow staff to attend.
	3. 17.05.21		3. Clinical Supervision Training being rolled out to all staff booked for 17.05.21.
	4. Commenced 24.04.21		4. Supervision notes to be filed in Staff members' HR files.
	5. 29.04.21 then Monthly		5. HR lead to undertake a monthly audit of all supervision undertaken with a detailed report to the Clinical Governance meeting monthly.
The registered provider must ensure that governance and audit arrangements are adequately embedded throughout the hospital and demonstrate that information is being regularly assessed, monitored and documented, and to ensure the quality of the service and to identify, assess and manage risks relating to safe patient care.	1. Completed 16.04.21	Regulation 19	1. Full oversight of the service is being undertaken with weekly progress and action planning meetings by senior managers including the interim hospital director, operations director, regional quality lead for Wales and regional senior governance manager with reporting on progress to the Elysium directors and both regional and corporate clinical governance.
	2. 29.04.21		2. New governance meeting process in place, reports are requested week before meeting and reviewed by the

Description of Non-Compliance/ Action to be taken	Timescale for completion	Regulation number	Provider Action
			group within the meetings. The chair of the Regional Governance will also attend these meetings.
	3. Commenced 24.03.21		3. The hospital director will chair the Clinical Governance meetings going forwards.
	4. 25.03.21 - Completed		4. Clinical Governance Action Log to track actions implemented
	5. Completed 29.04.21		5. Lessons Learnt and shared experiences reviewed within Clinical Governance and through Learning By Experience Group 29.04.21
	6. 15.05.21		6. All containers identified for the Tea, Sugar, Coffee etc. have been put in place. The toaster has been bought. Issue with Basketball Hoop has been ordered.

Appendix C – Improvement plan

Service: Cefn Carnau -Elysium Healthcare

Ward/unit(s): Sylfaen Ward , Bryntirion Ward, and Derwen Ward

Date of inspection: 13 April – 15 April 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				
The registered provider must ensure that the heating in the occupational therapy building is fixed.	3. Health promotion, protection and improvement	The heating within the therapy building has been repaired and is in working order.	Amanda Sellers	31/05/21
The registered provider must ensure patients requests are dealt with promptly and in a timely manner.	5. Citizen engagement and feedback	Dedicated forums for all patients have been reinstated to provide opportunities to raise requests and have any feedback provided. These are held monthly with representation from across the hospital. An external review by Elysium's patient engagement lead has been undertaken	Amanda Sellers	31/05/21

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		with improvements noted and feedback to Corporate, Regional and Local clinical governance forums. Weekly senior management team (SMT) walk arounds have also provided patients with direct access to the senior team including the acting hospital director ensuring any feedback on progress or issues can be raised and acted upon.		
Delivery of safe and effective care				
The registered provider must ensure that adequate security processes are put in place to prevent keys being removed from the hospital	22. Managing risk and health and safety	New key procedures have been introduced which include checks and systems to ensure the security of the keys is maintained. Weekly reviews of the systems are being carried out to ensure their effectiveness by the SMT.	Amanda Sellers	30/06/2021
The registered provider must ensure that robust governance audit system need to be implemented regarding key security	22. Managing risk and health and safety	The new key procedure is subject to weekly checks and oversight by the SMT to ensure it is working effectively. Any alterations or adjustments will be made and clearly communicated to all staff.	Amanda Sellers	30/06/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that updated ligature audits are completed on all wards	22. Managing risk and health and safety	A full and thorough new ligature audit has been completed for the entire site with rigorous central review. This has been completed on the new Elysium Ligature Audit tools which have been signed off by the group director of nursing following extensive review with external stakeholders across the NHS, Regulators and the independent sector. The ligature audits are in place and available on all wards within the site.	Amanda Sellers	20/06/21
The registered provider must ensure that all damages are rectified promptly to maintain patient safety	22. Managing risk and health and safety	All identified areas have been either rectified immediately, removed or are part of the ongoing site wide refurbishment programme. A reporting system has been introduced for each area and included on SMT walkaround.	Amanda Sellers	31/08/2021
The registered provider must ensure that there are regular environmental audit to identify any unreported damaged areas	22. Managing risk and health and safety	A system, of weekly environmental audits has been implemented with review by the SMT and within the local Clinical Governance Meeting. The audits have been undertaken by suitably experienced and qualified staff members including ad	Amanda Sellers	30/06/21

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		hoc audits by the group director of nursing to ensure there is corporate oversight within the service.		
The registered provider must ensure that environmental risk assessments are undertaken to support staff in managing violence and aggression in small confined areas	22. Managing risk and health and safety	Environmental risk assessments are being reviewed and updated across the service with lessons learnt from other Elysium services following HSE visits. Good practice examples have been provided by the regional health & safety lead which are being used to ensure this best practice is included within these risk assessments.	Amanda Sellers	31/07/2021
The registered provider must ensure that a robust governance system is put in place to record, analyse and review restraint data	22. Managing risk and health and safety	A full review of restraint data was undertaken by the regional senior governance manager as part of the oversight of the service, this was reviewed both in the local clinical governance meeting and by the oversight team for the service. This review supported in the formulation of the actions to ensure ongoing improvement and compliance. The regional TMVA lead for Wales is also undertaking	Amanda Sellers	30/06/21

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		reviews of the service including attending the site to provide oversight, guidance, training and advice to both staff and the SMT. The Corporate Elysium information management team is also reviewing restraint data as part of routine compliance reviews to identify any trends or issues and notifying the regional oversight team as required. The local clinical governance forum and regional oversight team are scrutinising the progress to ensure there is continuous improvement and the completion of any actions.		
The registered provider must ensure that patients have access to a varied menu which caters for individuals dietary requirements.	14. Nutrition	The menu has been reviewed and revamped to ensure it provides a varied menu that caters for any individual requirements. A member of the catering team attends the monthly patient forum to receive direct feedback and respond to any specific requests. A quarterly review of the menus will be undertaken by the Group catering lead to ensure continued progress.	Amanda Sellers	31/05/21

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that all clinical rooms are clean, organised, and clutter free	15. Medicines management	All clinical rooms have been de-cluttered, professionally deep cleaned and form part of the SMT walk around checks and environmental audits.	Amanda Sellers	31/05/21
The registered provider must ensure that policies are reviewed and updated regarding the use of non-registered nurses being used as secondary signature and provide training to staff	15. Medicines management	Training has been provided to those non registered staff undertaking secondary signature roles which also includes a competency assessment. Staff are only permitted to undertake these roles following successful completion of the assessment and training. A list of those staff is available on each ward.	Amanda Sellers	31/08/2021
The registered provider must ensure that clinical room audits are completes at the required frequency	15. Medicines management	The weekly Clinical room checks are reviewed by the SMT on their walk arounds to ensure they are completed as required with feedback to the local Clinical Governance group. Any immediate issues or actions that need further support are escalated to the operations director and monitored within the Local Clinical Governance meeting.	Amanda Sellers	31/05/21

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that improvements are made to the system of ordering and returning of medication	15. Medicines management	Issues around the ordering and returning of medication has been reviewed with the pharmacy supplier. Weekly monitoring of supplies will be undertaken and actioned immediately if required.	Amanda Sellers	30/06/21
The registered provider must ensure that regular audits on medication stock take place	15. Medicines management	Pharmacy provider to be contacted and are supporting with this to ensure the regular audits are completed and any actions are resolved and reported to monthly Clinical Governance meeting.	Amanda Sellers	30/06/21
Temperature in clinical room on Derwen Ward is within the required range.	15. Medicines management	The temperature of the clinical room has been resolved and has been maintained within the required range. Ongoing temperature checks will be part of the clinic room audits and escalated when necessary.	Amanda Sellers	30/06/21
The registered provider must ensure that devices are cleaned and easily accessible	16. Medical devices, equipment and diagnostic systems	A review of all devices has been completed to ensure they have been cleaned and maintained as required. Access to these devices will form part of the SMT walk arounds to ensure they are	Amanda Sellers	15/06/21

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		not blocked, removed or inaccessible to the team when required.		
The registered provider must ensure that sharp boxes are removed and disposed of when full	16. Medical devices, equipment and diagnostic systems	Guidance has been reissued around management of sharps boxes and collection of sharps boxes has been resolved with our waste collection service. This is included in the clinical room audits for continued monitoring.	Amanda Sellers	30/06/21
The registered provider must ensure that all Welsh patients have Care and Treatment Plans in place	20. Records management	A review of all patients was undertaken to establish which patients did not have a CTP on file. Those that did not were updated to ensure they did or meetings are being booked for those where a CTP had not been completed. The admission checklist documentation was updated to capture if a CTP is available upon admission and where not, a CTP meeting can then be booked immediately.	Amanda Sellers	31/08/2021
The registered provider must review patient documentation to ensure that staff have succinct records to learn about each of the patient	20. Records management	All patients will have both a coproduced PBS care plan and a coproduced My Important Plan in place to ensure staff, both familiar and unfamiliar with the patient, have succinct information	Amanda Sellers	31/07/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		available to support them. This information is reviewed on a monthly basis as part of the care review. This would be more frequent in the event of an immediate change in their care needs		
The registered provider must ensure that agency staff are familiar with patient care plans and risky behaviours.	20. Records management	Agency staff will be made aware of and introduced to My Important Plan before each shift to ensure that they have the information needed to support them. Agency staff to sign off reading these plans at start of each shift as part of the handover.	Amanda Sellers	31/07/2021
Quality of management and leadership				
The registered provider must ensure that there is an improvement in audit and governance processes across all areas of the hospital	1 Governance and accountability framework	With the weekly regional oversight panel in place which includes the regional operations director, group director of nursing, acting hospital director, quality assurance lead for Wales and regional senior governance manager, significant improvement has been made around audit and governance process across the hospital. Clear action plans are in place	Amanda Sellers	31/07/21

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		to support these changes and to provide the assurances needed. Further oversight is provided from the regional and corporate operations and Governance frameworks. Lessons learnt have been shared across the region and Elysium.		
The registered provider must ensure that that the MDT and Ward staff work collaboratively to optimise patient care	1 Governance and accountability framework	(a) Guidance provided to all staff around joint working with an emphasis on communication. This is further reinforced within the local clinical governance meeting, SMT meeting and any staff forums. Evidence of team working will be provided by feedback from both staff and patients which will be taken monthly. (b) Plan to be developed to introduce and embed a new model of care across the hospital which will involve clearly identifiable roles and inputs from all disciplines of staff	Amanda Sellers Operations Director	30/06/21 31/10/21

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that staff are supported to complete mandatory training	25. Workforce planning, training and organisational development	A review of ways to support staff in completing the mandatory training has been completed and are in place. Staff have been made aware of these options which include group sessions using Microsoft Teams, 1:1 training (for example Safeguarding) and eLearning. Time is ring-fenced for staff to undertake take this training around the needs of the patients.	Amanda Sellers	31/10/2021
The registered provider must ensure that appraisals and supervision takes place and is monitored	25. Workforce planning, training and organisational development	Supervision and Appraisal progress is being monitored by the SMT monthly. with a significant improvement noted. Further oversight is provided within the local clinical governance forum. A new system for monitoring and recording supervision is being rolled out by Elysium to provide improved oversight and compliance information. Coaching and guidance on supervision is being provided to those who require it to further improve the experience for our staff group.	Amanda Sellers	30/06/21

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that staff receive training in the new rota system	25. Workforce planning, training and organisational development	Training has been provided on the new rota system in place at the site. Ongoing support and training is available for any new staff or those who require a refresher.	Amanda Sellers	20/06/21
The registered provider must ensure that staff know what rota system to use and refer to	25. Workforce planning, training and organisational development	Clear guidance and communication has been given to staff to ensure they know which system to use. All other older systems and templates have been removed to ensure they can't be used in error.	Amanda Sellers	20/06/21
The registered provider must ensure that high usage of agency staff is reduced	24. Workforce recruitment and employment practices	Ongoing recruitment campaigns are in place to target the key vacancies within the service and reduce the reliance on agency staff. A number of key appointments have already been made with further applicants in consideration.	Amanda Sellers	31/12/2021
The registered provider must ensure that vacancies are appointed to.	24. Workforce recruitment and	Ongoing recruitment campaigns are in place to target the key vacancies within the service. This will be monitored monthly by the operations director for progress on an ongoing basis. A number	Amanda Sellers	31/12/2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	employment practices	of key appointments have been made including a new hospital director and clinical services manager, additional housekeepers and maintenance staff.		

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): Amanda Sellers

Job role: Acting Hospital Director

Date: 21/06/21