Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Mental Health and Learning Disability Follow Up Inspection

Cefn Carnau

Derwen Ward and Sylfaen Ward

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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 follow-up inspection of Cefn Carnau Hospital on 6 and 7 May 2021.

The remit of this inspection was to check that progress was being made on a number of areas of non-compliance that were identified during a previous inspection of the hospital on 13-15 April 2021.

Our team, for the inspection comprised of two HIW Inspectors and two clinical peer reviewers. The inspection was led by one of the HIW Inspectors.

Further details about how we conduct follow-up inspections can be found in Section 5.

2. Summary of our focused review

Overall, we found evidence that the registered provider had implemented systems and processes to address areas identified within the Non-Compliance Notice. However, these were yet to be embedded in to practice and therefore we have not yet been assured that improvements in these areas have been realised in full or that they will be sustained.

This is what we found the service did well:

- Care plan following the domains of measure
- Positive behaviour support plans that were person centred
- Standardised patient assessments were completed, including physical health needs.

This is what we recommend the service could improve:

- Monitoring arrangements for incidents
- Patient care plans include SMART objectives

We have not repeated any recommendations for improvement that were made in the previous inspection and that are yet to be addressed fully. However, in some instances we identified further improvements and have made recommendations to address these in this report. No new areas on non-compliance were identified during this inspection.

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.

- Dderwen 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 18 patients at the hospital.

Delivery of safe and effective care

Identified improvements

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.

The registered provider must ensure that there is robust and intrusive supervision and monitoring on Infection Prevention and Control audits to ensure they are accurately completed.

What we found on follow-up

Ward areas had been deep cleaned by an external contractor, this was the first step in an ongoing programme to improve the environment of care. We observed that the bathrooms, showers and toilets were free from unpleasant odours and no longer stained. We did observe that there were some toilets that were dirty/soiled following use, however, housekeeping staff had increased and their daily checklists to ensure bathrooms are regularly checked and cleaned. There were no inappropriately stored items within these areas.

All items requiring storage under the Control of Substances Hazardous to Health (COSHH) Regulations were stored appropriately within COSSH cupboards; there were no items observed to be inappropriately located within other areas of the hospital.

Following our previous inspection the washing machine had been repositioned to a more appropriate location within the laundry. The hospital was in the process of implementing a revised laundry system to address our concerns from our previous inspection. However, during this inspection we again observed that a laundry bag had been left within the communal area on Sylfaen ward and there were items of patient clothing left within communal areas.

Whilst there was evidence of a programme of decluttering across the hospital, ward areas and nursing offices were still cluttered and disorganised. Within Sylfaen Ward we observed that the vacuum cleaner was stored in front of the emergency resuscitation equipment; therefore preventing timely access if required. This was highlighted at the time of observation and staff cleared the access to the emergency resuscitation equipment immediately.

Immediately following our inspection in April a Support Services Manager from another Elysium site has been based at Cefn Carnau to review the support services structure and resources. During this inspection we observed that a

range of structures and processes had been developed and were in the early stages of being implemented. This included cleaning schedules and audits that fed in to the revised hospital governance arrangements.

We were informed that the provider is recruiting to the Cefn Carnau Support Services Manager post to take over from their colleague on appointment.

It was evident that a programme of refurbishment, maintenance and decoration had commenced since our previous inspection. We also noted that the damaged furniture that had been identified in April had been replaced.

Identified improvement

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.

What we found on follow-up

The registered provider held a weekly rota review meeting to identify the staffing requirements for the following week. Staffing requirements are also reviewed every day within the morning meeting to check that there is an appropriate staff gender balance, in particular on Sylfaen Ward. However, when reviewing the Morning Meeting document provided for 5 May 2021 we identified that the staffing gender split section for Sylfaen Ward was incomplete.

The staff rota documentation for Sylfaen Ward reviewed for that day and the previous 2 weeks, documented that the gender of the vast majority of staff was female which would be preferred for undertaking enhanced observations of patients on that ward.

Identified improvement

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 which documents and captures the descriptive detail and context around time of restraints and level of injuries sustained from the restraints.

What we found on follow-up

The registered provider had undertaken further analysis of incidents at the hospital covering the period highlighted during our previous inspection. This provided further details around the number of restraints and injuries that were recorded on the registered provider's incident reporting information system (IRIS). Copies of the latest Hospital Clinical Governance meeting agenda and minutes evidenced that restraint data was reported on and discussed.

However, this information and analysis is only as reliable as the quality of information entered in to the system by staff at the hospital. Since our inspection in April we identified that incidents had occurred that had not been recorded on to IRIS and therefore would not have been included in IRIS reporting information being considered by the Clinical Governance Committee.

Also, whilst the registered provider's improvement plan responding to the Non Compliance Notice stated that incidents would be reviewed each day during the morning meeting, this had subsequently been removed from the morning meeting to a specific incident review meeting. However, without the morning meeting review of incidents the registered provider failed to identify that the incident had not been recorded on to IRIS.

Therefore we are not assured that the registered provider has yet established systems to record, monitor and take actions and learnings from incidents at the hospital.

Overall Therapeutic Management of Violence and Aggression compliance for regular and bank staff was at 78% with future sessions arranged to increase compliance.

Identified improvement

The registered provider must provide assurances that robust systems and processes are in place for dealing with safeguarding matters and referrals.

What we found on follow-up

The registered provider had revised their Safeguarding procedures. However, due to the short timescales between their revision and our inspection we were unable to test these processes to gain assurance.

Identified improvement

The registered provider must ensure Care and Treatment Plans are available in line with Mental Health (Wales) Measure 2010.

What we found on follow-up

We reviewed four sets of patient care plans across two wards; Sylfaen ward and Dderwen Ward.

Each patient has a care plan following the domains of measure and had positive behaviour support plans that were person centred. Patient records evidenced that standardised assessments were completed which included physical health needs.

Care plans had aims and objectives started, however these were not always SMART focused.

Further improvement needed

The registered provider must ensure that care plans are written with SMART objectives.

Identified improvement

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.

What we found on follow-up

There were no overarching Care Plans in place on the wards at the time of the inspection. However, the registered provider had started to develop these, known as ‘flash cards’, and provided a copy for one that had been developed shortly after this inspection. This demonstrated a positive start in addressing this improvement and progress needs to be sustained at pace to ensure these key documents are in place for all patients.

Identified improvement

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.

What we found on follow-up

It was evident that efforts were ongoing to stabilising workforce by progressing with recruitment to vacant positions. In the meantime experienced staff from other Elysium services were on short term placements at Cefn Carnau to support the required improvements at the hospital and fulfil some of the shortfalls in staffing rotas that would be required to be filled by less familiar agency staff.

The registered provider had developed a handover record for each ward that aimed to provide staff on the incoming shift with key information. However, these had not yet been embedded in to practice at the hospital and therefore at the time of our inspection we were unable to conclude whether this process would address this recommendation.

Quality of management and leadership

Identified improvement

The registered provider must make sure that a robust system of monitoring is in place to ensure that staff appraisals and supervision is regularly taking place for staff.

What we found on follow-up

The registered provider had recently developed a database to record supervision and appraisal. A supervision tree had also been developed to cascade supervision through the hospital staffing structure.

Copies of supervision records were maintained and kept confidentially within staff members' human resource files.

At the time of the inspection the supervision process had only recently commenced and therefore we were unable to review this process to gain assurance of this being embedded in to practice.

Identified improvement

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

What we found on follow-up

The registered provider had developed revised hospital governance arrangements and were able to describe these to the inspection team. However, these new arrangements were only just starting to be implemented and therefore we were not able to review them in order to form a conclusion with regards to their effectiveness or whether the new arrangements had been embedded into practice. This issue will continue to be followed up outside of the inspection process and will form a key component when we next inspect the hospital.

4. What next?

As described in the What We Did section of this report, the purpose of this inspection was to get some immediate assurance that actions were being undertaken to address significant areas of non-compliance that were identified in an inspection in April 2021. Many of the issues posed a real risk to patient safety and we need to be sure that effective action was takin place.

We have not identified many new recommendations for improvement during this inspection. Any issues we identified and were resolved during the inspection are listed in Appendix A. New recommendations arising from this inspection are shown in Appendix B of this report where we require the service to complete and improvement plan telling us about the actions they will take to address the issues we have identified.

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.

Whilst this report does indicate that progress is being made against the issues identified during the April 2021 inspection there is still much to do before we can be assured that all regulatory breaches have been resolved. Therefore, Cefn Carnau Hospital remains 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.

5. How we conduct follow-up inspections

Follow-up inspections can be announced or 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. In some circumstances, we will decide to undertake an announced inspection, meaning that the service will be given up to 12 weeks' notice of the inspection.

The purpose of our follow-up inspections is to see what improvements the service has made since our last inspection.

Our follow-up inspections will focus on the specific areas for improvement we identified at the last inspection. This means we will only focus on the National Minimum Standards for Independent Health Care Services in Wales relevant to these areas.

During our follow-up inspections we will consider relevant aspects of:

- Quality of patient experience
- Delivery of safe and effective care
- Management and leadership

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. We will also highlight any outstanding areas of improvement that need to be made.

Further detail about how HIW inspects 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
Not applicable	Not applicable	Not applicable	Not applicable

Appendix B – Improvement plan

Service: Cefn Carnau

Date of inspection: 6 & 7 May 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				
No further improvements identified	Not applicable	Not applicable	Not applicable	Not applicable
Delivery of safe and effective care				
Mental Health (Wales) Measure 2010	Mental Health (Wales) Measure 2010			
Quality of management and leadership				
No further improvements identified	Not applicable	Not applicable	Not applicable	Not applicable

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):

Job role:

Date: