NHS Mental Health Service Inspection (Unannounced)

Ty Llidiard

Cwm Taf Morgannwg University Health Board

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care
Promote improvement:	Encourage improvement through reporting and sharing of good practice
Influence policy and standards:	Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced mental health inspection of Ty Llidiard within Cwm Taf Morgannwg University Health Board on 08 – 11 November 2021.

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

Ty Llidiard consists of two wards, the Enfys Ward and Seren Ward. Care is predominately provided to patients on the larger Enfys Ward, and the smaller Seren Ward is used to provide short periods of acute care to patients who may require it. This inspection focused solely on the Enfys Ward.

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

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

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

2. Summary of our inspection

We observed staff interacting with patients respectfully throughout the inspection.

Safe and therapeutic methods of de-escalation were being used to help protect the safety and well-being of patients.

However, we found evidence that the health board was not fully compliant with all Health and Care Standards in all areas. In particular, improvements are needed to ensure care plans meet best practice guidelines for care and treatment planning.

This is what we found the service did well:

- Staff demonstrated a good level of understanding of the patients they cared for
- Patients received physical healthcare assessments that were regularly monitored
- Patients had access to a good range of therapies and activities
- Suitable protocols were in place to manage risk, health and safety and infection control
- Staff described appropriate strategies for managing challenging behaviour to promote the safety and well-being of patients
- The statutory documentation we saw verified that patients who were detained were done so correctly.

This is what we recommend the service could improve:

- Make more information readily available to patients, such as how to make a complaint
- Care plans must focus on the strengths of patients to aid their recovery and independence, and evidence unmet needs
- The dates of multi-disciplinary team meetings must remain consistent to ensure patients receive sufficient and timely care

- Medication Administration Records, Section 17 leave forms and care plans should be maintained to best practice guidelines
- Medical equipment, such as weighing scales, must be checked to ensure it remains fit for purpose and provides accurate readings
- Staff must have access to the most recent version of policies.

3. What we found

Background of the service

The Welsh Health Specialised Services Committee (WHSSC) is responsible for commissioning inpatient provision for NHS Child and Adolescent Mental Health Services (CAMHS) on behalf of the seven local health boards in Wales. Cwm Taf Morgannwg University Health Board is commissioned by WHSSC to provide this service across south Wales at Ty Llidiard, which is located on the site of the Princess of Wales Hospital in Bridgend.

Ty Llidiard has 15 mixed gender beds. At the time of the inspection, the unit was at full capacity, but six patients were on approved leave.

The service employs a staff team which includes a senior nurse, ward manager and a team of registered nurses and healthcare support workers. The multidisciplinary team includes professionals from psychiatry, psychology, and occupational therapy. The unit is supported by the health board's clinical and administrative structures.

Quality of patient experience

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

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

Patients had access to a wide range of group and individualised activities to help support and maintain their health and well-being.

Patients were supported to maintain their education, either via the on-site school or through attendance at their usual school.

Improvements were needed to make more information readily available to patients throughout the unit.

Staying healthy

During the inspection we reviewed the records and care plans of four patients at the unit. We saw evidence of comprehensive physical assessments being undertaken on patients upon admission and throughout their stay.

We saw posters displayed throughout the ward promoting a healthy lifestyle, and highlighting good mental health techniques, such as coping strategies and how to increase self-esteem.

A school is located on the second floor of the building which provides patients with educational input during their time at the unit. Daily transportation is also available to allow some patients to continue their education at their usual school. Patients are able to participate in a range of therapeutic and leisure activities out of school hours. We saw an activity timetable was displayed in the lounge which included activities such as quizzes and bingo. An art therapy room and sports hall with gym equipment was available for patients to use under supervision. A games room was also available which included a pool table, football table and piano.

The unit had designated garden areas which provided pleasant outdoor spaces. Patients are offered and encouraged to take a walk every day after school.

Dignified care

Throughout the inspection we observed staff treating patients appropriately and with dignity and respect. The staff we spoke with demonstrated a good level of understanding of the patients they were caring for. We spoke with a parent of a patient at the unit, who provided positive feedback on the care being provided to their child. Staff told us that they respect the privacy of patients by knocking the door before entering their bedrooms.

Each patient had their own bedroom and bathroom, which included a toilet and shower, and provided patients with privacy and dignity. Communal single sex toilets were also available throughout the ward. We noted that the communal toilet for girls was painted pink, and that the communal toilet for boys was painted blue. The health board may wish to consider painting the communal toilets in neutral colours to be more inclusive to any non-binary patients that may be admitted.

Patients were able to personalise their rooms with pictures, posters and their possessions, if deemed appropriate following individual risk assessments. Each bedroom offered adequate storage space. The living areas looked clean, and bedroom furniture appeared to have been well maintained, but we felt some rooms could do with a new coat of paint.

Each bedroom door had an observation panel so staff could undertake visual observations with minimal impact upon patients. Patients could lock their bedroom from inside, but staff could over-ride the locks if necessary. We were told that the bedrooms are locked during the daytime to encourage patients to attend school, interact with each other, and to make use of the other facilities at the unit.

We saw that items that may be considered a risk to patients were stored in a separate store room which patients could request access to. We noted that the store room was cluttered and appeared disorganised, which could potentially lead to personal items being lost or misplaced.

Improvement needed

The health board must organise the store room to ensure it is tidy and keeps the personal possessions of each patient secure.

The health board must ensure patient bedrooms are decorated and painted regularly.

Patient information

We were told that patients and their family members are provided with a range of information about what to expect during their stay at Ty Llidiard on admission. We saw information about advocacy services and visiting times displayed in the lounge on the ward. However, no information was available on the wards for patients on the role of HIW, and how patients could contact the organisation. This is a requirement of the Mental Health Act 1983 Code of Practice for Wales[1].

There was a patient status at a glance board[2] in the main office displaying confidential information regarding each patient being cared for on the ward. The board was designed in such a way that confidential information could be covered when the board was not in use. This meant that the staff team were making every effort to protect patient confidentiality.

Improvement needed

The health board must ensure that patients are informed about the role of HIW, their right to meet visitors appointed by HIW in private, and that they may make a complaint to HIW.

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff ensured they communicated appropriately and effectively with patients. We saw staff taking their time to talk and explain things to patients using words and language suitable to the individual patient. The patients we spoke to felt that staff listened to what they had to say.

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[1] The Mental Health Act 1983 Code of Practice for Wales supports professionals to promote and protect the rights of patients: https://gov.wales/sites/default/files/publications/2019-03/mental-health-act-1983-code-of-practice-mental-health-act-1983-for-wales-review-revised-2016.pdf

[2] A board that provides staff with a quick reference to essential information about the individual patients being cared for on the ward.

A daily community meeting is held on the ward between staff and patients. The meeting allows staff to inform patients of upcoming activities and other relevant information, such as tribunals and medical appointments. One patient told us that they were unaware of when an advocate was going to be attending the unit until they turned up on-site. The health board may wish to consider ensuring all patients are informed in advance of planned advocate visits during the community meetings.

Individual care

Planning care to promote independence

The care plans we reviewed did not focus on patient strengths, or their recovery and independence. In addition, we noted that the unmet needs of patients were not recorded. It is important that unmet needs are documented so that they can be reviewed by the multi-disciplinary team (MDT) to consider options for meeting those needs.

There was evidence of MDT involvement in the development of care plans and their reviews. During the inspection, the weekly MDT meeting was brought forward from Wednesday to Tuesday at short notice. This meant that some relevant members of the MDT and other professionals were not present, and that patients and their families/carers were unable to attend. Although we were informed that this was an isolated occurrence, the dates of MDT meetings should remain consistent whenever possible to ensure full involvement of other MDT professionals and patients and their families/carers.

Improvement needed

The health board must ensure that patient care plans:

- focus on the strengths of patients to aid their recovery and independence
- evidence unmet needs.

People's rights

During the inspection we reviewed the legal records of three patients that had been detained at the unit under the Mental Health Act. We found that relevant documentation had been completed correctly when patients had been detained at the unit. Further information on our findings on the legal documentation is detailed in the Mental Health Act Monitoring section of this report.

The number of visitors allowed to see patients at the unit has varied during the COVID-19 pandemic in line with restrictions put in place by the Welsh Government. A maximum of two visitors are currently allowed to visit patients, and separate rooms are available to allow meetings to take place in private. In addition, a visitors flat is available for overnight stays for family members that may live far away from Ty Llidiard.

A phone was available for patients to use to maintain contact with families and friends. Patients had limited access to their mobile phones and could only use them at designated times, such as outside of school hours. We saw a poster displayed in the lounge informing patients about the rules on using mobile phones while at the unit.

Listening and learning from feedback

Patients could use the daily community meetings as a way to provide feedback on the care that they receive at the unit and discuss any concerns. Patients and carers could also provide feedback using an online survey tool. The results of the survey were reviewed and discussed by senior staff at the unit to consider improvements to the service.

We were told that the ward manager would try and informally resolve any complaints received in the first instance, by speaking with patients about the issues they had.

However, during the inspection we did not see information displayed around the ward to inform patients and their families about how they could make a formal complaint, for example, through the NHS Wales Putting Things Right[3] process.

Improvement needed

The health board must ensure that patients are informed about how to make a complaint through the NHS Wales Putting Things Right process.

[3] Putting Things Right is the process for managing concerns about services provided by the NHS in Wales. http://www.wales.nhs.uk/ourservices/publicaccountability/puttingthingsright

Delivery of safe and effective care

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

There were established processes in place to suitably manage potential risks, health and safety and infection control.

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

Appropriate strategies were in place to manage challenging behaviour to promote the safety and well-being of patients.

Improvements were needed to patient care plans to ensure they are maintained in line with best practice guidelines.

Safe care

Managing risk and promoting health and safety

The Ty Llidiard building is located separately from the main Princess of Wales Hospital, and has its own car park directly outside the building. Visitors are required to enter the unit via a reception area and intercom system which helps to deter unauthorised persons from entering the building. Access throughout the unit was restricted to maintain the safety of patients, staff and visitors, which included the controlled egress from each ward.

The facilities are split over two floors, with both wards located on the ground floor, and offices and the school situated on the first floor. A lift was available to assist people with mobility difficulties.

The unit and wards provided a clean and comfortable environment for patients, and furniture and fixings were appropriate for the patient group. We saw evidence that a daily environmental checklist was being completed to check for issues across the building. Annual environmental audits have also been undertaken which are reviewed by the health board to monitor compliance.

We were provided with a copy of the health board's Health and Safety policy, which set out arrangements to create a safe environment at all locations across

the health board. However, we noted the policy was beyond its next review date of February 2021.

Improvement needed

The health board must review their Health and Safety policy.

Infection prevention and control

Throughout our visit we observed the environment to be visibly clean and tidy. We were told that shared equipment and reusable medical devices are decontaminated after each use. We saw that cleaning equipment was stored and organised appropriately.

Staff told us of the work undertaken at the start of the pandemic to help control the risk of transmitting COVID-19 throughout the unit. Carpets were removed from the patient bedrooms, and fittings were replaced with wipeable furniture. The frequency of cleaning increased, and we saw that cleaning schedules had been signed when tasks had been completed.

Patients are currently tested for COVID-19 every five days, or upon their return from leave. Any patients that are suspected, or confirmed, as positive, are isolated in their bedrooms. Visitors are required to complete a COVID-19 screening checklist and wear Personal Protective Equipment (PPE) before being admitted inside the unit. We observed staff wearing face masks on the wards and saw that an adequate amount of PPE was available for staff to use.

We saw evidence that relevant policies were in place that detailed the various infection control measures in place at the unit. Regular audits had been completed to check the cleanliness of the wards and compliance with PPE requirements. We were told that the central infection prevention and control (IPC) team at the health board also visit the unit to help identify any areas for improvement.

We looked at the training records for staff working at the unit, and saw that compliance with IPC training among nursing staff was relatively low at 61 per cent.

Improvement needed

The health board must ensure all staff are up to date with their IPC mandatory training.

Nutrition and hydration

The care plans we reviewed showed that patients' dietary needs had been assessed using an appropriate evidence based tool. Ongoing monitoring measurements, such as fluid and food intake, and weight gain/loss, had also been recorded.

Patients were able to choose their meals for the day each morning. We were told that patients with special diets were catered for, and any specific patient requests could be accommodated. Patients could access the kitchen on the ward which had facilities such as a microwave, toastie machine and a slush puppy machine. This allowed patients to make snacks and drinks throughout the day with assistance from staff.

Some patients were receiving the nutrients and fluids they required through a nasogastric (NG) tube[4]. We were provided with a copy of the health board's policy which detailed the procedures to follow to provide the safe management of NG tube feeding. However, the policy was beyond its next review date of February 2021. During our review of patient records, we also noted that care plans for patients requiring NG tubes did not document the individual approach that would best lead to successful feeding, such as describing when, how and where patients wish to be fed.

We saw that the dining room was tidy and had suitable furniture and facilities. Each patient had a set seat with their name on it to provide stability and a routine for their meal times.

[4] A nasogastric (NG) tube is a flexible tube that can be inserted through the nose and into the stomach. It is commonly used for delivery of feed, medications, fluids, or for drainage of gastric contents.

Improvement needed

The health board must review their Nasogastric Insertion and Positional Confirmation for Adults, Children and Infants policy, or ensure staff at Ty Llidiard have access to the latest version if it has subsequently been reviewed since the inspection.

The health board must ensure care plans for patients requiring NG tubes outline the individual wishes of the patient to help best achieve successful feeding.

Medicines management

We reviewed Ty Llidiard's clinic arrangements and found that on the whole, the management of medicines was safe, but that some improvements were needed.

During our inspection we saw medicines being managed safely and effectively. Medication was stored securely within cupboards, and medication fridges were locked. We saw that daily temperature checks of the medication fridge were being completed to ensure that medication was stored at the manufacturer's advised temperature. Relevant policies, such as medicines management and rapid tranquillisation, were in date and available to staff.

We reviewed four Medication Administration Record[5] (MAR) charts and noted positively that no rapid tranquilisation or PRN prescriptions[6] had been used recently, and that low amounts of medication were being used in general. However, we identified the following issues during our review:

- The height and weight measurements, and allergy information, of patients were not always completed

[5] 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.

[6] PRN prescription stands for 'pro re nata,' which means that the administration of medication is not scheduled. Instead, the prescription is taken as needed.

- The three month rule[7] date to highlight when treatment can no longer be provided without authorisation from a second opinion approved doctor (SOAD) was not entered on two occasions

- Assessment forms to determine whether patients had the capacity to consent to treatment were not being kept together with the patient's MAR chart

- We noted that some patients at Ty Llidiard had the same first names, but the MAR charts did not contain a photo of each patient. This increased the potential risk of confusing one patient's medication with another.

We looked at the arrangements in place at the unit for the storage and safe use of controlled drugs and drugs liable to misuse. Records we viewed evidenced that weekly stock checks were being conducted with the appropriate nursing signatures certifying that the checks had been carried out.

Improvement needed

The health board must ensure that MAR charts are completed accurately and in full.

Safeguarding children and adults at risk

We found processes in place to help ensure that staff at the unit safeguarded patients, and saw evidence that referrals were being made to external agencies as and when required.

We were told that there has been open and regular communication between staff at Ty Llidiard and the Cwm Taf Morgannwg Multi-Agency Safeguarding Hubs (MASH)[8], who have provided guidance and advice when required.

[7] When a patient is detained under a section of the Mental Health Act, treatment necessary for a mental disorder may be given for a period of three months without the patient's consent; after three months, such treatment needs to be authorised by a SOAD.

[8] Multi Agency Safeguarding Hubs are the single point of contact for all professionals to report safeguarding concerns across the Cwm Taf Morgannwg area.

We saw that 82 per cent of nursing staff, and 100 per cent of therapies staff, had completed their Safeguarding Children mandatory training. However, only 66 per cent of medical staff had completed their training.

Improvement needed

The health board must ensure all staff are up to date with their Safeguarding Children mandatory training.

Medical devices, equipment and diagnostic systems

We saw that regular checks of resuscitation equipment were being undertaken to ensure that the equipment was present and in date, and we saw that staff had documented when these checks had occurred.

During our checks of the medical equipment available at the unit, we noted that the weighing scales had last been checked and calibrated[9] in January 2020. This meant we were unsure whether the scales were providing accurate measurements.

It was evident through discussions with staff that they were aware of the location of ligature cutters in case of an emergency.

Improvement needed

The health board must ensure that all medical equipment throughout the unit is maintained appropriately so it remains fit for purpose and provides accurate readings.

[9] If you calibrate an instrument or tool, you mark or adjust it so that you can use it to measure something accurately.

Effective care

Safe and clinically effective care

We found safe and therapeutic responses were in place to manage challenging behaviour and promote the safety and well-being of patients. Patients had ward management plans that outlined individual therapeutic interventions and who had responsibility for their delivery.

Principles of positive behavioural support were being used as a primary method of de-escalation. Where necessary, staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the safe physical restraint of patients was only used as a last resort. Staff wore personal alarms for their own safety which they could use to call for assistance if required. We saw up to date policies in place to provide the framework for managing such interventions.

We saw that any use of restraint was documented in an electronic incident log, and such incidents were discussed at governance meetings to identify any learning.

We saw that up-to-date ligature point risk assessments were being maintained. These identified potential ligature points throughout the building, including the wards, and what action had been taken to remove or manage these.

Record keeping

Patient records were paper files that were being stored and maintained within locked offices. We observed staff storing the records appropriately during our inspection.

Patient files were however, disorganised, and it was therefore difficult to easily locate the required information held within the files. This was also our finding from our previous on-site inspection of Ty Llidiard in May 2019. We spoke with senior managers about the limitations of maintaining paper records appropriately, and the health board should consider moving to an electronic patient record system as soon as possible.

Further information on our findings in relation to patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Improvement needed

The health board must ensure that patient records are maintained in accordance with legislation and clinical standards guidance.

Mental Health Act Monitoring

We reviewed records containing the statutory detention documents for three patients at the unit. Copies of the legal paperwork were stored securely in the nursing office, and original documents kept off-site in the Mental Health Act administrator's office. The records we viewed were well organised, easy to navigate and contained detailed and relevant information. The current statutory documentation verified that the patients were legally detained. It was evident that detentions had been applied within the requirements of the Act and the Mental Health Act 1983 Code of Practice for Wales.

The Mental Health Act administrator was experienced, well organised and knowledgeable about their role. They described suitable and robust systems of audit in place for the management and auditing of the statutory documentation. The administrator was a member of the All Wales Mental Health Act Administrators Forum which helped them to keep up to date with any changes in legislation, and discuss common themes, issues and experiences.

During our discussions with staff we were informed that the legal status of patients is discussed at multi-disciplinary team (MDT) meetings, and that quarterly operational meetings are held between senior managers and other multi-disciplinary agencies to discuss and address any issues. It was also confirmed that staff have continued to undertake training on the Mental Health Act remotely throughout the pandemic.

We saw that Section 17 leave[10] was suitably risk assessed for each patient. However, we noted that the leave forms did not:

- Describe the intended outcome or purpose of the leave, or review how it went upon the patient's return

[10] Section 17 leave allows the detained patient leave from Ty Llidiard.

- Contain a section for the patient to sign to indicate their involvement and agreement to their leave
- Contain a photograph or description of the patient to enable safe return if the patient fails to return from their leave.

Improvement needed

The health board must ensure that Section 17 leave forms are completed accurately and in full, and address the issues we identified in this report.

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

We reviewed the care plans of a total of four patients at the unit. We saw that completed Wales Applied Risk Research Network (WARRN) assessments[11] provided good summaries of personal and historical factors associated with the individual risks of patients. We also saw evidence that all observations undertaken on patients had been completed and documented appropriately within their care plans. However, we found that the care plans we reviewed:

- Appeared to be developed from a generic and standardised template; the patient's views and contribution to their own care plans was not evident, and therefore the patient's voice was not visible
- in one care plan, the name of the patient was not mentioned throughout, and in another, the name of a different patient was incorrectly included in one section
- Were not written using child friendly language that reflected the voice of the patient
- Did not have consideration of the eight areas of a person's life as set out in the Mental Health (Wales) Measure 2010

[11] Wales Applied Risk Research Network is a formulation-based technique for the assessment and management of serious risk for patients, which has been adopted across most Child and Adolescent Mental Health Services (CAMHS) across Wales.

- Were not signed by the patient to evidence that they had agreed to it and received a copy
- Did not contain evidence to show whether patients had been assessed for capacity for a range of needs during their stay at the unit, for example, use of their mobile phone or handling their finances.

Furthermore, the care plans did not show evidence that inpatient core assessment tools had been used to comprehensively assess patients on their admission. In some instances, it appeared pre-existing assessments undertaken for patients when they were in the community were continuing to be followed after admission, with no evidence that these had been reviewed and agreed by the MDT. During the inspection we spoke with the Consultant Psychiatrist about whether the assessment in place for one patient was still appropriate as there was no evidence it had been fully reviewed on, or since, admission. Changes to the outcome of the assessment were subsequently made in relation to this patient, actions which could potentially have been made sooner if comprehensive assessments had been undertaken when the patient was admitted to the unit.

Improvement needed

The health board must ensure that the issues we identified in this report in relation to care plans are rectified going forward to meet the best practice guidelines for care and treatment planning as set out in the Mental Health (Wales) Measure 2010.

Quality of management and leadership

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

Staff had a good understanding of the needs of the patients at the unit, and were committed to providing high standards of patient care.

Established governance arrangements were in place to provide a focus on maintaining and improving standards.

Arrangements were in place to ensure compliance with mandatory training and annual appraisals.

We found senior management were committed to implementing a programme of change to transform the service in response to previous concerns raised.

Governance, leadership and accountability

Ty Llidiard, and the wider Child and Adolescent Mental Health Services (CAMHS) for Cwm Taf Morgannwg University Health Board, have been under scrutiny over the last two years, both internally and externally, from stakeholders such as the National Collaborative Commissioner's Unit (NCCU) and the Welsh Health Specialised Services Committee (WHSSC). This has led to concerns being raised about Ty Llidiard, and the wider CAMHS service, in relation to culture, leadership and performance.

On the back of these pressures, it was positive that staff at the unit, and senior managers of the health board, engaged openly with us during the inspection. Senior managers discussed the actions that had been taken to start addressing the concerns identified. This included the recent appointment of a new Head of Nursing at Ty Llidiard, who was responsible for overseeing the improvements required. We were provided with weekly highlight reports, which showed the key actions that had been implemented, and upcoming actions to be taken, to progress towards service improvement.

During our discussions with staff throughout the inspection, it was evident that the issues at the unit over the past two years in relation to culture, leadership and performance, was having a detrimental impact on the morale and well-being of staff. However, staff told us that the new Head of Nursing appointment has already begun to have a positive influence on staff morale. Changes had also recently been made to senior positions within the organisational structure, which should help to provide clearer lines of management and accountability, and give staff a greater level of autonomy to take back control of their substantive responsibilities.

We found established governance arrangements in place at the unit to provide oversight of clinical and operational issues. Audit activities and monitoring systems and processes were in place, and we saw reports that showed staff were monitoring and analysing incidents that had occurred at the unit to identify any themes. Agendas for senior management team, governance, and nursing meetings showed a wide range of standing items, which helped ensure a focus on continuously maintaining standards.

As mentioned throughout this report, we found a number of policies had passed their review date. We were not assured that staff were obtaining, or being provided with, the most up to date guidance to direct their professional practice.

Improvement needed

The health board must ensure all policies are reviewed and updated, and implement an audit of policies to ensure that ward staff have access to, and are referring to, the most recent version.

Staff and resources

Workforce

During our time at the unit we found a friendly, professional staff team who demonstrated a commitment to providing high quality care to patients. Staff were able to describe their roles and appeared knowledgeable about the care needs of most patients they were responsible for. It was positive that the staff at the unit were receptive to our views, findings and recommendations throughout the inspection.

The staffing levels appeared appropriate to meet the assessed needs of the patients within the unit at the time of our inspection. We were told that staff rotas are currently produced by senior managers, but that it will become the

responsibility of the ward manager at the unit. This will provide the ward manager with more control and greater clarity on their responsibilities.

Senior staff confirmed that there was ongoing recruitment to fill a range of nursing, therapy and medical vacancies. We were told that a staffing establishment review would also be taking place soon to further stabilise the workforce. It was clear from discussions with staff that there were concerns around the recent reduction in the capacity of the therapies team, particularly in key roles such as the family therapist. This was also compounded by their lack of onsite input during the pandemic. This has had an impact on nursing staff by increasing their workload, and impacted on the development of relationships between patients and their families, which is key to enabling a quicker discharge. Positively, senior managers confirmed that the capacity and establishment of the therapies team will form part of the staffing establishment review.

We reviewed the mandatory training and annual appraisal statistics for staff at the unit and found that completion rates were generally high, and that plans were in place to complete anything outstanding. The electronic system provided the senior managers with details of the course completion rates and individual staff compliance details.

4. What next?

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

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

The improvement plans should:

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

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

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

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

5. How we inspect NHS mental health services

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

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

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.	Not applicable.	Not applicable.	Not applicable.

Appendix B – Immediate improvement plan

Service: Ty Llidiard

Ward: Enfys

Date of inspection: 08-10 November 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.

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

Appendix C – Improvement plan

Service: Ty Llidiard

Ward: Enfys

Date of inspection: 08-10 November 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	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must organise the store room to ensure it is tidy and keeps the personal possessions of each patient secure.	4.1 Dignified Care	The nursing staff have tidied and organised the personal possessions in the store room. All staff have been briefed to ensure all the patient's personal possessions are organised and stored securely. The store room is checked daily as part of the environmental audit	Ward Manager	Completed
The health board must ensure patient bedrooms are decorated and painted	4.1 Dignified Care	There is a rolling programme established with the estates department to ensure regular	Estates Manager and Ty	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
regularly.		decoration of the patient bedrooms. Senior Nurse and Ward Manager to identify environmental concerns requiring immediate escalation. The daily environmental audit includes a review of all patient bedrooms. If there are any areas that require attention ahead of the decoration programme, the Locality Manager would be notified by staff to raise a request with the estates department to address.	Llidiard Locality manager	
The health board must ensure that patients are informed about the role of HIW, their right to meet visitors appointed by HIW in private, and that they may make a complaint to HIW.	4.2 Patient Information	Posters with information about HIW have been put up in a number of patient and relative areas of Ty Llidiard. The Locality Manager and Ward Manager will ensure the information on HIW remains up to date and visible in all patient areas	Locality Manager	Completed
The health board must ensure that patient care plans: • focus on the strengths of patients to aid their recovery and independence	6.1 Planning Care to promote independence	Information has been shared with all staff on the importance and approach to developing and co-producing goal orientated care plans with patients. The Head of Nursing; Ward Manager and Nurse Audit Lead will undertake an	Head of Nursing and Nurse Audit Lead	Completed May 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
• evidence unmet needs.		assessment of training needs for staff in relation to care plans and if required put in place specific training to support staff with care plans. The quality of patient care plans will be reviewed by the Nurse Audit Lead via a monthly audit and the outcomes and any learning shared with Ward Manger / Clinical Service Group Triumvirate and all clinical staff. The Head of Nursing is developing a business case for the Health Board to consider investing in a specific nursing role to support the training of staff to help improve the quality of care and treatment planning.		Implementation of rolling documentation audit programme complete May 2022
The health board must ensure that patients are informed about how to make a complaint through the NHS Wales Putting Things Right process.	6.3 Listening and Learning from feedback	Posters with information about how to make a complaint and NHS Wales Putting Things Right process have been put up in a number of patient and relative areas of Ty Llidiard. Information around the complaint process is also given to patients when they are initially admitted to the unit. The Locality Manager and Ward Manager will	Locality Manager and Ward Manager	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		ensure the information on HIW remains up to date and visible in all patient areas		
Delivery of safe and effective care				
The health board must review their Health and Safety policy.	2.1 Managing risk and promoting health and safety	Although expired the Health Boards Health and Safety Policy is available to all staff via Sharepoint. A formal extension of the policy will be requested and considered at the next HB Health and Safety Committee whilst a full and formal review of the policy is commissioned and progressed	Head of Health Safety & Fire	September 22
The health board must ensure all staff are up to date with their IPC mandatory training.	2.4 Infection Prevention and Control (IPC) and Decontamination	The Health Board has a rolling programme of training for staff to access mandatory training. All staff have been reminded of the importance and their responsibility for being up to date with IPC mandatory training and details of how to access training via ESR on line learning with an expectation that 85% compliance will be achieved by end of June 22. The lead manager for each professional group monitors the compliance of staff with all	Ward Manager and Senior Nurse; Therapies manager and Clinical Lead	Implementation of ongoing monthly review complete – aim to achieve 85% IPC and Safeguarding Level 2 by end of June 22

Improvement needed	Standard	Service action	Responsible officer	Timescale
		mandatory training on a monthly basis and identify any required actions in order to improve compliance to at least 85%. There is a requirement for all staff to complete the mandatory training as part of their performance appraisal and development review (PADR). Reports on the compliance with mandatory training are reported and discussed in the service group's monthly performance review.		
The health board must review their Nasogastric Insertion and Positional Confirmation for Adults, Children and Infants policy, or ensure staff at Ty Llidiard have access to the latest version if it has subsequently been reviewed since the inspection.	2.5 Nutrition and Hydration	There is a clinical policy group in place across the health board to oversee the policies programme of work. The Medical Director chairs the group. The process for ratification and membership of the group is under review. A full and formal review of the policy requirement is to be discussed commissioned and progressed at the next Clinical Policy Group meeting. All staff in Ty Llidiard have access to the most up to date policies and clinical guidelines that are shared and stored on the CTM UHB sharepoint. Any updates or changes to	Medical Director / Nasogastric Feeding Lead/ Clinical Lead Radiology	October 22

Improvement needed	Standard	Service action	Responsible officer	Timescale
		policies are also shared with the local management team leads via the monthly CAMHS Quality, Safety and Patient Experience meeting and are then communicated where relevant with all clinical staff.		
The health board must ensure care plans for patients requiring NG tubes outline the individual wishes of the patient to help best achieve successful feeding.	2.5 Nutrition and Hydration	Information has been shared with all staff on the importance and approach to developing and co-producing goal orientated care plans with patients. The Head of Nursing; Ward Manager and Nurse Audit Lead together with advice and support from the Eating Disorder Outreach Service will undertake an assessment of training needs for staff in relation to patients requiring NG tubes and if required put in place specific training to support staff with care plans and approach to successful feeding. The quality of patient care plans will be reviewed by the Nurse Audit Lead via an annual audit and the outcomes and any learning shared with all clinical staff.	Head of Nursing; Ward Manager and Nurse Audit Lead	30/09/2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		The Head of Nursing is developing a business case for the Health Board to consider investing in a specific nursing role to support the training of staff to help improve the quality of care and treatment planning.		
The health board must ensure that MAR charts are completed accurately and in full.	2.6 Medicines Management	The Clinical Lead and the Pharmacy lead have reminded staff of the importance of ensuring the MAR charts are completed accurately and in full. The MARS charts will be reviewed on a weekly basis and any issues identified addressed immediately	Clinical Lead	Completed
The health board must ensure all staff are up to date with their Safeguarding Children mandatory training.	2.7 Safeguarding children and adults at risk	The Health Board has a rolling programme of training for staff to access mandatory training. All staff have been reminded of the importance and their responsibility for being up to date with Safeguarding Children mandatory training and details of how to access training. Level 2 on line safeguarding training to be 85% compliant by end of June 2022. Level 3 face to face classroom based training	Ward Manager and Senior Nurse; Therapies manager and Clinical Lead	Implementation of ongoing monthly review complete - aim to achieve 85% by end of June - 22 for Safeguarding Level 2 85% compliance to be attained

Improvement needed	Standard	Service action	Responsible officer	Timescale
		to be 85% compliant by end of September subject to class size and impacts of covid restrictions/ pandemic waves on availability. The lead manager for each professional group monitors the compliance of staff with all mandatory training on a monthly basis and identify any required actions to improve compliance to at least 85%. There is a requirement for all staff to complete the mandatory training as part of their performance appraisal and development review (PADR). Reports on the compliance with mandatory training are reported and discussed in the service group's monthly performance review.		for Level 3 Safeguarding by Sept 22
The health board must ensure that all medical equipment throughout the unit is maintained appropriately so it remains fit for purpose and provides accurate readings.	2.9 Medical devices, equipment and diagnostic systems	The Locality Manager has established a medical equipment register and will ensure all medical devices are regularly checked and serviced in accordance with a maintenance schedule. This will ensure the equipment used is fit for purpose and provides accurate readings	Locality Manager	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that patient records are maintained in accordance with legislation and clinical standards guidance.	3.5 Record keeping	The ward clerks conduct regular daily reviews of patient records. They will ensure that the records are in a good state or repair if required and the documentation and notes are filed appropriately in chronical order and in the relevant sections. Annually there is an audit of record keeping and the outcome and learning is shared with all clinical staff	Locality Manager	Implementation of ongoing review complete
The health board must ensure that Section 17 leave forms are completed accurately and in full, and address the issues we identified in this report.	Application of the Mental Health Act	All section 17 documents are checked for completion and accuracy by the Mental Health Act Department. The Mental Health Act Department will report any issues with any paperwork submitted to the ward manager and clinical lead. The Clinical Lead has ensured that medical staff involved are aware of the requirement to complete Section 17 leave forms accurately and to include the purpose of the leave and expected outcomes, and where appropriate these forms need to be signed by the young person.	Clinical Lead	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that the issues we identified in this report in relation to care plans are rectified going forward to meet the best practice guidelines for care and treatment planning as set out in the Mental Health (Wales) Measure 2010.	Monitoring the Mental Health Measure	Information has been shared with all staff on the importance and approach to developing and co-producing goal orientated care plans with patients. This has included ensuring the care plans are written in child friendly language and consider the 8 areas as outlined via the Mental Health measure. The Head of Nursing; Ward Manager and Nurse Audit Lead will undertake an assessment of training needs for staff in relation to care plans and if required put in place specific training to support staff with care plans. The quality of patient care plans will be reviewed by the Nurse Audit Lead via an annual audit and the outcomes and any learning shared with all clinical staff. The Head of Nursing is developing a business case for the Health Board to consider investing in a specific nursing role to support the training of staff to help improve the quality of care and treatment planning.	Head of Nursing, Ward Manager and Nurse Audit Lead	30/09/2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The health board must ensure all policies are reviewed and updated, and implement an audit of policies to ensure that ward staff have access to, and are referring to, the most recent version.	Governance, Leadership and Accountability	Existing processes to ensure that policies are reviewed and updated appropriately and in accordance with changes to statutory and professional guidance are in place. Further work is to be undertaken to explore the possibility of linking this work programme to other organisational databases and tracking systems to ensure compliance is monitored and policies regularly reviewed All staff in Ty Llidiard have access to the most up to date policies and clinical guidelines that are shared and stored on the CTM UHB sharepoint. Any updates or changes to policies are also shared with the local management team leads via the monthly CAMHS Quality, Safety and Patient Experience meeting and are then communicated where relevant with all clinical staff.	Director of Corporate Governance. Head of Clinical Audit and Effectiveness Ward Manager	Complete October 2022 Complete

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): **Lloyd Griffiths**

Job role: **Head of Nursing for CAMHS at Ty Llidiard**

Date: **16 February 2022**