Independent Mental Health Service Inspection (Unannounced)

Cefn Carnau - Bryntirion Ward, Derwen Ward and Sylfaen Ward

Elysium Health Care Ltd

Inspection date: 6 – 8 December 2021

Publication date: 9 March 2022

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@gov.wales**
Website: **www.hiw.org.uk**

Digital ISBN 978-1-80391-805-1

Contents

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 6 December 2021 and the days of 7 and 8 December 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 the 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

Overall we found that the hospital had improved considerably since the last full inspection in April 2021.

We found evidence that showed that a number of initiatives were in place or being introduced to ensure the delivery of safe and clinically effective care for the patients.

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

This is what we found the service did well:

- 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
- There were a range of suitable facilities in a well maintained environment of care
- Established governance arrangements that provided safe and clinically effective care
- Medicines management was safe and effective
- Monitoring the use of the Mental Health Act.

This is what we recommend the service could improve:

- Ensuring there is a qualified second signatory for the controlled drugs register
- Systems around the risks and control measures following restraints
- Completion of all mandatory training for all staff.

There were no areas of non-compliance identified at this inspection that required immediate corrective action.

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. Cefn Carnau is part of the Elysium Healthcare Group.

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 eight female adults over the age of 18 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 and Derwen Wards

A low secure service only for a maximum eight and six male adults respectively over the age of 18 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 13 patients at the hospital, four female and nine male patients.

The service employs a staff team which includes a 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 support workers. The team could also access other disciplines such as a dietician, speech and language therapy and physiotherapy.

There had been two previous inspections at the hospital during 2021 these were:

- A routine inspection on 13-15 April 2021, report published on 16 July 2021, the link to the report is Cefn Carnau 13 -15 April 2021

This inspection identified a number of significant issues affecting patient care at the hospital. As a result a condition was imposed on the hospital's registration preventing the admission of any new persons to the hospital until Healthcare Inspectorate Wales (HIW) has served notice confirming it is satisfied that persons would not be exposed to the risk of harm.

- A follow up to the above inspection on 6-7 May 2021, report published on 23 August 2021, the link to the report is Cefn Carnau 6-7 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.

Improvement was noted at this second inspection however there was still areas requiring further action. Therefore the purpose of this inspection was to consider whether all issues previously identified had been addressed and that the improvement had been sustained.

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.

There were a range of suitable activities and therapies available at the hospital and within the community, to aid patients' rehabilitation.

The hospital had a number of arrangements for patients to input their views on their care and the operation of the wards and hospital

Health promotion, protection and improvement

There was information available for patients about how they could improve their health. These included user friendly posters dotted around the wards and reception area. The health promotion activities noted for the month of December were in the form of a physical activities advent calendar.

There were televisions in the communal lounges and individuals had access to controlled laptop facilities. We also noted that the therapy centre had a varied selection of DVDs, games and books that patients could use. There was also a gym available in the therapy centre for patients to use with risk assessed equipment. Outdoor exercise was also promoted in the large secure grounds and garden.

The hospital had an occupational therapy centre with a kitchen that patients could access to prepare meals, under supervision. The therapy centre also offered activities such as art therapy, singing, small multi-gym and a sensory room. There was evidence of the occupational therapists (OTs) working together with the multi-disciplinary team (MDT) to encourage individualised tailored programmes of activities.

The hospital 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. There were also community activities that involved exercise when on authorised leave such as dog walking and sheep walking.

Smoking was not permitted within the hospital buildings. If any patient wishes to stop smoking, the hospital would ensure that they are fully supported through a “smoking cessation” programme. Nicotine replacement therapy would also be requested via the General Practitioner (GP).

Patients at the hospital had hospital passports. These assisted people with learning disabilities to provide staff in general hospitals with important information about the person and their physical health when they were admitted.

The menu plans that were displayed on each ward notice board, were patient friendly and included healthy options and a variety of choices.

Dignity and respect

We noted that all hospital staff interacted and engaged with patients appropriately and treated patients with dignity and respect. During the first day of our visit staff introduced us to the patients, explaining the reasons for us being there. Staff also made sure that the patients understood and provided reassurance to them.

Patients had their own bedrooms that provided an adequate standard of privacy. However, patients shared showering and bathing facilities. Patients were allowed to personalise their bedrooms. This personalisation was assessed as part of the patients’ risk management plan to ensure any items did not pose a risk of harm to the patients or others. When patients were in the general areas they were able to lock their bedroom doors to prevent other patients entering; staff could override the lock if there was an identified need.

Staff providing direct support to individuals in their bedrooms were sitting in the doorways. We were told that this direct support was usually limited to one to two hours per member of staff and then responsibility was handed over to another member of staff. On the first night of the inspection we saw a handover to a male member of staff observing a female patient in their bed. We were told that this was not ideal but a female would always be available to respond via the radio. The registered provider’s statement of purpose[1] described how hospital staff would support patients in ways which would maintain their privacy and dignity.

[1] The statement of purpose is the information required in accordance with Schedule 1 to the Independent Healthcare Regulations (Wales) 2011.

There were communal areas on each ward which provided some space for patients to spend away from their rooms. We noted that one ward had been refurbished to provide a better standard of furnishings in this area and also the ability to make hot drinks and prepare food in a microwave. We were told that the intention was to upgrade all the communal areas to the same standard.

Information boards with confidential information about patients was kept in a patient safety at a glance board in the nurses' station. The boards were out of sight of patients and were closed to prevent any information being seen when passing.

During one day of our visit we noted that there were six staff on duty in the female ward but only two of the staff were female. The registered provider must ensure staffing gender requirements are complied with.

Improvement needed

The registered provider must ensure that further work is carried out on the rotas to ensure that there are sufficient female staff to adequately cover the female ward and provide dignified care to patients.

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. The patients' guide included some pictures to make understanding easier and was written in simple English. However, we noted that the statement of purpose included information relating to out of date legislation, specifically the Private and Voluntary Health Care Regulations 2001 and the Data Protection Act 1998. In addition the statement of purpose was not dated or version controlled. The registered provider is to ensure that the statement of purpose is completed correctly and kept up to date with regard to all sections of the document.

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.

Improvement needed

The registered provider must ensure that the statement of purpose is updated and kept up to date as changes occur. In addition, the statement of purpose

must be dated and version controlled. Amended statements must be sent to HIW once completed.

Communicating effectively

We noted that advocacy services were very well embedded in the service. We saw a poster for National Youth Advocacy Service (NYAS)[2], we also saw information about the availability of an independent mental health advocate. A designated advocate spends one day every week on site meeting patients and supporting them with any issues that arise. The advocate also attended multi-disciplinary team, and the Mental Health Review Tribunal for Wales[3], meetings, at the request of patients.

We were told that written and verbal information was given to patients about HIW on admission and each time their rights were presented. The nearest relatives were also given information about HIW. We also saw that leaflets and posters were available in the communal areas and in reception. This information was available in easy-read and visual representations. We noted that a system known as Widgit Symbols[4] were used to help patients who had difficulty with text. There was a large range of information provided in accessible formats across the site. This information included information about medications and about how care would be planned. The information and format included:

- Cefn Carnau physical training achievement activity chart with pictures
- Easy read feedback forms

[2] The NYAS offers independent and confidential information, advice, advocacy and support to children and young people who want their wishes and feelings heard when decisions are being made about their lives.

[3] The Mental Health Review Tribunal for Wales (MHRT for Wales) safeguards patients who have had their liberty restricted under the Mental Health Act. We review the cases of patients who are detained in a hospital or living in the community subject to a conditional discharge, community treatment or guardianship order.

[4] Widgit Symbols can help users of all ages, abilities and backgrounds who have difficulties with text or communication in settings ranging from nursery schools to dementia care homes.

- Menu choices with pictures
- Occupational therapy chart with pictures
- Wearing surgical masks in an easy read format
- Washing your hands, described using widget symbols.

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.

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

We were told that the hospital had access to a translation service. However, there was little Welsh signage and we were told that the hospital were not aware of any patients who spoke Welsh. The hospital should consider introducing more Welsh signage and notices, as the opportunities arise.

Care planning and provision

The patients' care plans were stored on an electronic system. We found the system and the documentation easy to navigate and current with evidence of assessments, including full physical health assessments.

Patients preferred activities were listed in their positive behavioural support (PBS)[5] plans. These plans included my best day, likes and dislikes and preferred activities. There was a flexible approach that was discussed at the various huddle meetings held daily on each ward, attended by ward staff and therapy staff, to accommodate activities. The emphasis was on the therapeutic value and in understanding patient behaviours.

[5] Positive Behaviour Support is a person-centred approach to people with a learning disability who may be at risk of displaying challenging behaviours.

Throughout the inspection we observed patients participating in 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.

Patients had access to a telephone, depending on their care plans and risk assessment. There were two distinct areas, away from the ward areas where patients could meet with visitors. The arrangements for contact between patients and their relatives, friends or representatives were set out in the hospital's statement of purpose. It stated that the hospital was supportive of patients who maintain contact with relatives and friends outside the hospital, providing that this did not compromise care and treatment. During our visit, we also noted that arrangements had been made for a family Christmas lunch for one patient with their relatives to be held in the therapy centre kitchen.

Citizen engagement and feedback

We were told that patients could provide feedback to the service or make a complaint, patients would be supported to make these complaints. The complaint form was written in terms the patient could understand. Patients could also talk to staff about the service they received. There were informal and formal routes for complainants to raise things that patients were not happy with.

Information was displayed around the hospital about how patients and families were able to provide feedback about their care. Suggestion boxes with easy read photos on how to use, were noted on all wards and in the reception. We were told that patients and families were also given information about routes for giving feedback about the service they received.

We noted a "You say – We did" board on display in reception that identified issues and suggestions raised by patients and identified actions and responses. We also noted that the patients' community meetings were held and these were also discussed in the hospital's clinical governance meetings under the heading of patient carer experience.

Delivery of safe and effective care

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

The hospital environment was equipped with suitable furniture, fixtures and fittings for the patient group.

There were established processes and audits in place to manage risk, health and safety, medicine management and infection control. This enabled staff to continue to provide safe and clinically effective care. However, areas of improvement were identified in regards to ensuring there is a qualified second signatory available when recording the administration of the controlled drugs in the controlled drugs register.

Legal documentation to detain patients under the Mental Health Act or restrict patients leaving the hospital were compliant with the relevant legislation.

Managing risk and health and safety

Access to the hospital grounds, from the outside, was via a secured gate, controlled via an intercom to the reception. All hospital buildings were also secured via key fob access. There was also an alarm that sounded should a member of staff try to remove keys from the hospital.

The ward areas were all quiet when we arrived, with a calm ambience in each area. All wards showed signs of recent decoration and there were large poster boards with scenic views making large wall spaces look much more homely. There were no unpleasant odours noted during the initial walk around. All toilet and shower areas were uncluttered and relatively clean. In the reception area a door used as an exit to external areas was found to be unlockable - this was identified on the first evening visit and was repaired the following day.

It was clear that since our last full visit in April 2021, significant changes had been made to the environment. It was freshly decorated and felt more homely, clean and uncluttered. There had been creative robust storage solutions used.

Staff told us about some of the changes, which had taken place or were planned, to the external areas of the hospital. These included updating the security system

for access control, installing floodlighting on the perimeter and relaying the drive. They also said that a considerable amount of money and time had been spent to bring the hospital up to standard and to freshen up the hospital. Derwen ward had been fully refurbished, the anti-ligature curtains had been changed and there were new anti-ligature doors in many areas. A new fire escape gate, to prevent patient access, had been added to one fire escape and a similar approach was being carried out on another fire escape. We were told that the hospital were changing all the doors into anti-ligature doors. There were additional patient safe display cabinets and clocks on order. Further refurbishments of the wards were also starting in the early part of 2022.

There was a pleasant odour throughout the areas we visited. It was relaxed and quiet with low level activity, which was conducive to evening winding-down time. Some staff were chatting with patients, some patients were relaxing in their bedrooms and other staff were carrying out direct observations.

We noted that old doors had been replaced, flooring was renewed in areas that required it and the general ambience was positive. The furniture we saw was in good repair and functional.

However, we did observe four potential hazards to patient safety on Bryntirion Ward:

- There was a red fire alarm situated on the right hand wall of the corridor, which was at arms-length height. This was a potential ligature hazard
- There was a long length of fixed glass running along the top of the right-hand corridor wall, which was covering recessed lighting cable. This could be smashed or broken and used to self-harm or be used as a weapon to harm others
- The brass plates directly underneath the bedroom door hinge was raised and the edges sharp enough to cause harm to patients
- One door hinge was broken and as a result could be used as a ligature or as a weapon.

Whilst the ground floor wards were accessible for anyone with mobility difficulties, there were not any lifts available should they be needed. There were two wards on the first floor, currently the patients on the ward can use the stairs. There were ramps available to access the reception and therapy centre. There was a visitors' room on the ground floor with ramp access.

The hospital appeared to be well maintained, the living arrangements were clean and the appliances and furniture well maintained and in good working order. There were clearly improvements to the overall cleanliness, organisation and orderly running of the hospital. Appliances and furniture were in good working order and functional. We were provided with environmental risk assessments in addition to ligature risk assessments. The internal and external environments were greatly improved since the last inspection.

We were told that there were proposals in place to reduce the number of wards at the hospital. This would be done by moving all the male patients into the downstairs Bryntirion ward and moving all the female patients into the upstairs Derwen ward. Sylfaen ward would then be closed. We were also told of the plans to build a new purpose built hospital on the outside grounds.

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. Staff also had walkie-talkie radios for staff to communicate with each other.

During the inspection we were provided with data regarding the number of restraints that took place across all wards from 1 November to 7 December 2021. From the copies of the handover sheets from one shift to another, we noted that the incidents including restraints were captured in these sheets. Additionally, we saw evidence that the incidents were discussed in the daily morning meetings. We were provided with copies of the clinical governance minutes for the three months August to October 2021. We noted that restraints and incidents were discussed in the meetings to establish any patterns and to discuss any further actions.

The clinical services manager showed us documents for a proposal to introduce a reason for restrictive intervention review which would be completed for restraint incidents that were prolonged for more than 10 minutes or where there are more than 3 incidents in one month. This would capture information regarding the incident, including staff and patient feedback, debriefs and safeguarding. This would then be used to inform PBS plan reviews and proposed support.

Copies of the last three monthly security committee minutes were provided. These showed the various areas that were discussed regularly such as security breaches, key security, restrictive items and procedures. There were also actions to be carried out as a result of the discussions that were updated at the start of the next meeting.

We were also provided with copies of the following relevant policies, including:

- Managing Incidents and Untoward Occurrences, this outlined the approaches that may be used to safely manage challenging, aggressive and violent behaviour
- Observations and Engagement Policy, that aimed to minimise the risk of vulnerable patients harming themselves or others and emphasised the clinical and therapeutic benefit of positive engagement
- Seclusion and Segregation and Intensive Mental Healthcare, to ensure that patients requiring seclusion, long term or therapeutic segregation or intensive mental healthcare were cared and treated according to the requirements of the Mental Health Act Code of Practice Wales (reviewed 2016)
- Management of Violence and Aggression, this recognised the need to ensure that appropriate review takes place following an incident or untoward event involving patients in the hospitals' care.

Improvement needed

The registered provider must ensure that the potential hazards identified are risk assessed and action taken to ensure that the items are repaired or the risks reduced.

Infection prevention and control (IPC) and decontamination

On arrival at hospital visitors we were required to show proof of a recent negative lateral flow test (LFT) or complete a test on arrival. There was hand gel available in the reception area for visitors and there were also supplies of personal protective Equipment (PPE) available if required by visitors in the entrance porch.

We were provided with a copy of the IPC management policy which was part of the wider organisation's IPC manual. This described how IPC was managed within the organisation in accordance with the legislation and expert guidance as above. However, the document was one of the wider Elysium Healthcare set of documents. It referred to the English healthcare providers and inspectorate such as the Care and Quality Commission and Public Health England (now the UK Health Security Agency).

We were also provided with the two latest IPC audits, an assurance checklist dated 15 November 2021 and an ad hoc unannounced check dated 1 December 2021. They both confirmed that the necessary actions were being carried out by staff (such as wearing PPE) and relating to the environment (for example posters on wearing PPE). Where there was non-compliance, there was evidence of

further detail and action taken. Issues were also discussed in the clinical governance meetings held monthly.

The compliance figures with the training provided, showed over 90 percent compliance with IPC training at level one for support staff, but only 62 percent at level two for clinical permanent and bank staff groups. Regarding sepsis training, we were also told that the electronic learning completed by staff for health and wellbeing includes sepsis indicators and considerations.

Hospital laundry facilities were available so that patients could undertake their own laundry with the appropriate level of support from staff based on individual needs. The laundry equipment appeared to be working correctly. We also noticed a domestic washing machine in one of the wards.

We noted that there were ample stocks of PPE available when entering the various buildings at donning and doffing PPE stations. During our discussions with staff, no issues were highlighted in relation to access to PPE.

Staff we spoke with explained the cleaning arrangements, with an employed cleaner in the mornings and throughout the day staff would address any items that needed cleaning. There was also a night cleaning checklist on the ward and the nurse in charge would report any issues. We were also told of the 12 hour IPC audit checklists that included checking that all staff wear PPE and that the donning and doffing stations had sufficient of PPE. These were collected by the business support manager and any issues were fed back at the daily meetings.

Nutrition

We saw that menu planners were posted on notice boards in each ward and patients were supported to make appropriate choices. The choices included soups, salads and jacket potatoes as well as cooked meals. Meals were prepared on site and transported to the wards. Patients were encouraged to eat together with staff at dining tables. The food prepared looked appetising and warm.

Patients were also able to participate in meal and snack preparation with staff support. Drinks were available as required and patients also had their own allocated cupboards where they could store purchases of drinks and snacks. Patients with leave could also access the community to purchase food items and ingredients. The facilities for hot and cold drinks were in good working order. There were kitchen facilities on all wards that appeared to be in good working order with a fridge, kettle and microwave in place. Individuals could access the kitchens to make drinks or snacks as allowed by their individual risk assessments and support needs.

There was an occupational therapy kitchen within the therapy centre which enabled patients to prepare and cook their own meals and develop their skills. We were told that the breakfast club was popular and we saw patients being supported to make their own breakfast, such as hot pastries.

The importance of nutrition and nutritionally balanced meals were discussed in the clinical governance meetings and included feedback from the patient council meetings. The hospital also had access to a dietician.

Medicines management

The All Wales drug charts were completed correctly with appropriate codes being consistently used for the non-administration of drugs. We noted that patient names and identity were checked, before the administration of medication and there were also photos of the patient on the charts. Medicine administration was recorded consistently and contemporaneously on all charts reviewed with signatures recorded and there were no gaps. There was also individualised medicines information for each patient.

A weekly ordering process was undertaken by registered staff and stock was ordered, received, entered on the stock control records and stored appropriately. The clinical room was clean and clutter free. There were weekly ward based audits and also weekly audits by the community pharmacists.

As required medication usage was monitored as part of the physical health monitoring by the clinical lead nurse and the general practitioner. The hospital was using the standardised stopping over medication of people (STOMP)[6] monitoring tool.

[6] STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines. It is a national project involving many different organisations which are helping to stop the over use of these medicines. STOMP is about helping people to stay well and have a good quality of life. Psychotropic medicines affect how the brain works and include medicines for psychosis, depression, anxiety, sleep problems and epilepsy. Sometimes they are also given to people because their behaviour is seen as challenging. People with a learning disability, autism or both are more likely to be given these medicines than other people.

We noted that all medications were stored securely in medication rooms that were clean and uncluttered. Controlled drugs (CDs) were appropriately stored in a locked cabinet within the large drug cupboard. Injectables and liquids were also appropriately stored in a locked fridge. The medications were not taken round the hospital and patients would visit the medication room where the medications were kept. The room had a stable door enabling patients to come and collect their medication from outside the medication room when called.

Fridges were used and temperatures were appropriately monitored, this included the fridge daily minimum and maximum temperature as well as the room temperature. We noted that there had been several consecutive days where the maximum fridge temperature was above nine degrees (most medication stored in fridges needed to be kept below nine degrees Celsius). Staff provided evidence of the report to maintenance to show that action had been taken. However, fridge temperatures must be maintained within the required specified temperatures to ensure medication remains effective.

CDs were recorded and signed for correctly by the first signatory, the second signature was not always achieved due to the non-availability of a qualified second member of staff. As mentioned in the April report, compliance with standards could be improved by increasing the availability of staff adequately trained to provide the second signature for controlled drug administration and stock checks. The registered provider must review its policy and if senior healthcare support workers (HCSW) are being used for secondary signatures then they must receive the appropriate training.

The rapid tranquilisation policy was noted as being overdue for review on the one ward checked. The medicine management policy, which staff were able to access, was also noted as being overdue for review on the one ward checked.

Improvement needed

The registered provider must ensure that:

- Policies are reviewed and updated regularly in a timely manner
- Qualified or nominated staff are available to ensure that the daily controlled drug checks are carried out correctly, including the necessary signatures
- The fridge temperatures are kept within the correct ranges.

Safeguarding children and safeguarding vulnerable adults

We were provided with a copy of the safeguarding policy that aimed to prevent, identify and report abuse in a timely manner. We also saw a copy of the safeguarding and notification log that showed the incidents sent to HIW and the actions taken as a result of the incidents.

Staff we spoke with were aware of the safeguarding policies and the need to ensure safeguarding actions were undertaken promptly.

There was information displayed on a safeguarding information board in reception that included a safeguarding flow chart and the safeguarding process for reporting and recording. The board showed that the hospital director was the safeguarding lead. We were told that the hospital had good links with the local safeguarding team.

We saw evidence that part of the review of restraint incidents included any safeguarding issues and that senior managers would review and raise any relevant safeguarding referrals as required.

Safe and clinically effective care

Staff we spoke with said they believed that they had enough time to provide safe and effective care. One member of staff we spoke with also said that they had been given autonomy and support to look at the issues of providing safe and effective care.

We were told that the hospital were actively recruiting for various positions both qualified and unqualified. The hospital were also placing reliance on moving from three to two wards to reduce the number of agency staff and to ensure that permanent staff could staff the remaining two wards.

We were told about the benefits of the various meetings held at the hospital to assist with the governance of the setting. This included the daily huddle which was a daily approach to risk assessment and MDT decision making as well as providing timely feedback to patients. The terms of reference for the huddle stated that all available staff on the ward could participate and that there had to be at least three disciplines present. The daily huddle allowed staff to share information with all members of the team. The main aim of the meeting was to coordinate patient care. Any unclear information could be highlighted and clarified, allowing time to think about and hopefully manage crisis before it happened. All staff, clinical and non-clinical, were encouraged to speak up to share their perspective. These huddles were improvement focused and non-punitive.

Overall, and when compared to the inspection in April 2021, we found that there were governance arrangements in place that helped ensure that staff at the hospital provided safe and clinically effective care for patients. There was evidence of appreciation of staff doing a good job and staff demonstrated a good insight of the patients and their needs which prompted wider consideration and support of needs and risk.

We were also told about the review of the model of the care in the unit, including positive behaviour support and trauma informed care. There was clear organisational management of the hospital that allowed for patients to receive appropriate care and treatment that was based on multi-disciplinary decisions and policies

We noted a number of new systems in place or in process of being put in place to establish best practice regarding the use of restrictive practice. There is a need to embed a system that ensures that the required risk control measures have been completed. This should link to health and safety monitoring to ensure that all corrective actions have been completed. In particular that debriefs following restraints are routinely completed to inform any further actions or corrective actions. For example, for the evaluation of identified interventions or support strategies, PBS review, change in patient support needs and staff training needs. This will ensure a dynamic risk assessment approach is maintained. The proposed review of restrictive practice may achieve this but at the time debriefs could not be confirmed as routinely occurring. There is a need to quality assure that plans are implemented consistently for continuity of care and support and an awareness of actions taken to address inconsistencies or maintain safety and wellbeing of patients.

There is a need for reactive strategies to have more detail regarding specific responses and physical interventions employed.

Whilst primary and secondary interventions were person centred, they need more detail and focus in the “important for” section regarding health and safety requirements needed to keep the person safe from harm.

Improvement needed

The registered provider must ensure that:

- The hospital embed a system that ensures that the required risk control measures have been completed following a restraint. This should link to health and safety monitoring to ensure that all corrective actions have been completed

- Ensuring that the plans are quality assured and implemented consistently for continuity of care and support and an awareness of actions taken to address inconsistencies or maintain safety and wellbeing of patients
- Reactive strategies have more detail regarding specific responses and physical interventions employed
- The primary and secondary interventions have more detail and focus in the “important for” section regarding health and safety requirements needed to keep the person safe from harm.

Participating in quality improvement activities

There were a number of good practices, initiatives and development plans that senior staff told us about. There was a shortened version of patients’ positive behavioural support plans available in the nurses’ station. This was a one page description that included, name and some personal details, their goals, what to talk about, therapies and activities, triggers, risks and early warning signs.

There had been a more in-depth induction for healthcare support workers to enable them to carry out more effective observations. Calm cards (how to calm a patient) were being used to replace ‘pro re nata’ (PRN)[7] medications where possible.

A visual training video was being produced for new staff including reference to room searches and tap downs.

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 were

[7] The use of ‘pro re nata’ (PRN) or ‘as required’ medicines are used in inpatient mental health services, often as a first-line intervention when patients are experiencing challenging or strong emotions, despite recommendations that non-pharmacological interventions should be attempted first.

able to find the care notes and medical records we required. There were good physical health assessments and monitoring recorded in patient notes.

The electronic Mental Health Act records were only accessible by authorised personnel and were password protected. The legal paperwork was securely stored in a locked cupboard in the Mental Health Act administrator's office, which was locked and situated on the upper floor of the administration building.

In the case notes reviewed we saw comprehensive notes of all aspects of the patients' life". The entries were noted to be clear, contemporaneous, complete and understandable.

Mental Health Act Monitoring

We reviewed the statutory detention documents of four patients. 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)[8]. 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 medication was prescribed under the consent to treatment provisions of the Mental Health Act.

All staff had access to Mental Health Act training as part of the induction programme and specific Mental Health training is part of staff mandatory training modules.

[8] 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.

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

We reviewed the care plans of a total of two patients. The patients' care plans were easy to navigate and were current with evidence of assessment. Electronic notes were organised under tabs, the headings including core information, legal, physical health / MDT meetings and leave. Relevant sections were easily located but users of the system had to be familiar with the software in order to obtain information from numerous entries.

The short term assessment of risks and treatability (START)[9] assessment document was used to provide an overview assessment of individual needs. These were indicated as being reviewed monthly but they were often rolled over month to month and content often remained the same. There was evidence that the complete assessment was reviewed and up-dated within the year. Additionally, multiple assessments from the MDT were also current on the electronic patient record.

There was evidence of a full physical health assessment for both patients. Recognised standardised assessment tools were detailed on physical health tabs including a venous thromboembolism (VTE)[10] assessment and PBS plans that were developed using standardised assessments and formulation processes. Such PBS plans represent best practice in managing behaviours that challenge.

[9] The Short-Term Assessment of Risk and Treatability (START) is a concise clinical guide for the dynamic assessment of short-term (i.e., weeks to months) risk for violence (to self and others) and treatability.

[10] Venous thromboembolism (VTE) is a disorder that includes deep vein thrombosis and pulmonary embolism. A deep vein thrombosis (DVT) occurs when a blood clot forms in a deep vein, usually in the lower leg, thigh, or pelvis. A pulmonary embolism (PE) occurs when a clot breaks loose and travels through the bloodstream to the lungs. Venous thromboembolism (VTE) is an important safety issue in the inpatient mental health care of older people.

The care and treatment planning (CTP)[11] clearly stated the treatment plan, objectives and outcomes to be achieved and planned review dates. There were professional groups identified with responsibility for delivery. Interventions were linked to the needs for one patient and for the other patient interventions were detailed and were relevant to their identified needs. There was a particular focus on recovery for one patient checked as they were due to be discharged and their views on their goals were included. For the other patient there was a focus on rehabilitation and a stepped down approach. No unmet needs were identified in the care plans.

Risk assessments were noted, which clearly set out the risks identified and a specific plan to mitigate and manage risk. There was evidence that patients were involved in the care and treatment plan with quotes from the patients that assisted the CTP in being more person centred. The names and contact details of the nearest relative, carers were clearly identified in the notes.

The care plan addressed the dimensions of life as set out in the mental health measure, all domains were identified in the online care plan. Whilst there was not a hospital based care co-ordinator for one patient record we checked there was a care co-ordinator identified from the patient's commissioning authority. The management of obesity and diabetes was addressed via monitoring by the lead nurse for physical health care. There was evidence of weight management and monitoring.

Advocacy service visited once per week and could attend MDT and could be contacted by patients. There was evidence in the CTP of a request for advocacy involvement in meetings.

There was no evidence of direct involvement of family for some patients due to a difficulty in contact between the family and the patient. However, there was evidence of their family being kept up-to-date and queries regarding the patient's care were answered by staff.

[11] The Care and Treatment Plan is one of a number of rights delivered by the Mental Health (Wales) Measure to secondary mental health service users. It gives you the opportunity to set goals in all areas of your life and, in the process, to take more control of your recovery.

Evidence was seen that the CTP had been reviewed regularly and in a timely way. It was observed on the daily huddles where the multi-disciplinary team used a standardised approach to assess risk collectively and make decisions collaboratively. Patients were informed in a timely manner of the discussions held so this directly affected the sense of calm on the ward environment. Where reviews took place with the MDT, they were documented in the relevant patient's care record.

There was evidence of discharge planning with the community mental health team actively involved in the discharge and aftercare process, including new placement staff team involvement.

Medication was reviewed by the consultant psychiatrist and was also covered in the review by the lead nurse for physical health care using a standardised approach to the prescription and monitoring of anti-psychotics. In the one ward checked there was accessible information available about the major anti-psychotics[12], anti-depressants[13] and anxiolytics[14] so that patients could read easy read versions of information about the medication prescribed for them.

[12] Antipsychotic medicines are mainly used to treat mental health conditions such as schizophrenia and other psychoses, agitation, severe anxiety, mania and violent or dangerously impulsive behaviour.

[13] Antidepressants are medications used to treat major depressive disorder, some anxiety disorders, some chronic pain conditions, and to help manage some addictions.

[14] An anxiolytic is a medication or other intervention that reduces anxiety. This effect is in contrast to anxiogenic agents which increase anxiety. Anxiolytic medications are used for the treatment of anxiety disorder and its related psychological and physical symptoms.

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 the hospital were receptive to our views, findings and recommendations.

There were established governance and accountability processes in place.

We observed a committed staff team who had a good understanding of the needs of the patients at the hospital. Whilst there were ward staff vacancies we saw reasonable actions to mitigate the impact of this on patient care with the use of regular agency staff where possible.

Mandatory training completion rates were low for a number of modules, the hospital provided details of how this will be addressed.

Governance and accountability framework

Since our previous inspection in April 2021 a new hospital director had been employed who was currently completing the process to be the new registered manager at the hospital. Additionally, other changes had been made to the senior management team. Through our discussions it was clear that these changes had improved the management at the hospital and staff morale appeared to be better. It was also clear that a number of changes had been made to the environment at the hospital, which had addressed a number of issues from the previous inspection and subsequent follow-up.

Discussions held with senior staff, including the new hospital director, the clinical services manager and the support services manager, showed that they were keen to ensure the restriction on the registrations were changed. There had been a number of apparent changes that had taken place to improve the standard of the environment; and the treatment and support being provided to patients.

We noted collaboration between the MDT and the ward staff. The ward staff we spoke with said they felt involved with the patients' care and treatment decisions.

We were told that there had been a recent staff survey and the results were being reviewed by the clinical governance committee.

The current governance and reporting arrangements included the daily huddle, as described above and then the daily meetings with the entire senior management team. Monthly senior management team meetings had also recently started. In addition, there were monthly clinical governance meetings and security committee meetings. There were also monthly multi-disciplinary team meetings for each patient.

We saw evidence of the visit and report undertaken on behalf of the registered provider in accordance with regulation 28 of the Independent Healthcare Regulations (Wales) 2011[15], on 16 November 2021. We were also told there had been a remote assessment carried out by the same team in March 2021.

Dealing with concerns and managing incidents

We were told that all incidents were recorded on the organisation incident reporting system. Incidents would be investigated, initially during the next day huddle. Here there would be discussions on the last 24 hours, patients would be included and there would be an initial debrief for staff and patients as well as a discussion on risks. If there was evidence of frequent incidents involving the same staff, they would be referred to the psychologist for reflective practice and to talk about any difficulties staff had. Patients would be informed of the results of any investigations and feedback given to staff.

Senior management would be involved if the incidents were considered as serious. If the incident occurred overnight, the on call manager would be informed and safeguarding information would be completed as necessary. Both HIW would be informed, as well as Commissioning Care Assurance and Performance System (CCAPS). Other agencies would be informed as necessary.

Senior management told us that as staffing issues, such as the number of agency staff employed, were reducing, and that there had been a reduction in the number

[15] https://www.legislation.gov.uk/wsi/2011/734/made

of incidents. This was also related to the increased community leave, due to more permanent staff being available.

Workforce planning, training and organisational development

Staff we spoke with told us about the recent changes that had been put into place on support and management arrangements. The ward managers met with their staff at the huddle and also reported back to staff about the outcomes of the daily meetings and they reported into the senior management teams. Additionally, there were monthly ward meetings. Information was passed onto staff through these meetings and also through emails and face to face individual meetings. The clinical services manager was also available to speak to clinical staff with any issues and operated an open door policy.

We were also told about the arrangements in place to address the lack of clinical supervision previously, with a practice support lead being appointed to lead this supervision. Non-clinical staff were supported by the support business manager who held monthly check-ins with all their staff.

Staff we spoke with said that the wider organisation offered a good training programme and specifically referenced the Therapeutic Management of Violence & Aggression (TMVA) that included restart and reflect. In addition, staff had attended clinical supervision training, national vocational qualifications and qualifications and credit framework approved courses. Staff stated that there was a significant number of online courses available through the Elysium website (called My Elysium Learning (MEL)) in addition to mandatory training courses. Staff were sent a list of all courses available quarterly.

Training figures indicated that the training compliance rates were low in some areas and we recognise that face to face training had been difficult due to the pandemic. The compliance with mandatory training was tracked through the company dashboard which showed 64 percent compliance (both permanent and bank staff compliance). The compliance with the individual training varied for permanent staff from 44 percent for immediate life support to 90 percent for infection control level 1 for support staff. Staff we spoke with also stated that there was a requirement to complete the Mental Health Act, the Mental Capacity Act code of practice and Deprivation of Liberty Safeguards training. There were also workshops on these throughout the year. The registered provider must ensure that mandatory staff training compliance is increased and that a process is put in place to ensure all staff are in date with their training compliance.

We were told that the clinical services manager was collating details of the training that needed to be completed to inform staff of the requirements during supervision.

The art psychotherapist also provided training during staff induction on learning disabilities and autism; borderline personality disorders; and emotions in relation to patients. They also gave clinical supervision to staff individually and in groups as well as weekly reflective practice to support staff and to support patients.

Senior staff stated that they encouraged staff during the appraisal process to complete additional training. Where staff found a course that would support professional development, they would be supported by the organisation.

Improvement needed

The registered provider must ensure that:

- Mandatory staff training compliance is increased
- A process is put in place to ensure all staff are in date with their training compliance.

Workforce recruitment and employment practices

Staff explained the recruitment processes that were in place at the hospital. It was evident that there were systems in place to ensure that recruitment followed an open and fair process. Prior to employment staff references were received, disclosure and barring service checks were undertaken and professional qualifications checked. Newly appointed staff undertook a period of induction under the supervision of the heads of care.

Staff we spoke with said that they thought that the staffing levels were currently appropriate regarding the staff to patient levels. Staffing levels were considered to be good during weekdays but not as good on the weekend when more agency staff were employed. Staff said there was not a problem in increasing staffing numbers when this was required by the acuity of patients.

The new hospital director told us that one of the aims of the hospital was the stability of the site. One person was accountable for the staffing list, including gender balance and skill mix. Additionally, there was now a qualified nurse night co-ordinator employed.

Three charge nurses had been appointed from within the hospital and they had recruited senior healthcare support workers (HCSW) and were also trying to recruit additional HCSWs. This along with the possibility of reducing the number of wards from three to two would increase the number of permanent staff available to work at the premises.

There were a number of agency staff working on the wards during our visit (on one day 14 of the 21 staff on duty were agency or bank staff). We were told that the hospital aimed to block book the same staff to ensure continuity. Management said there was an ongoing programme of recruitment at the hospital to ensure sufficient staffing levels were in place to provide a safe environment and consistent care for patients.

Staff we spoke with said that referrals to occupational health support were available to all staff. A wellbeing lead has been nominated and had been completing wellbeing packages for staff. There was also an organisational wellbeing service available by telephone with counselling and a 24 hour helpline. Support staff were also having weekly team meetings to raise any emerging issues.

We noted instances of racist abuse of staff from patients. We were told that the police had been involved and that the consequences of the actions had been explained to the patients. The staff member had been advised to report the matter but the staff involved had been reluctant to pursue the matter further with the police. The clinical services manager was available to support the staff involved. The matters were reported to the clinical governance meetings. In an attempt to address this issue patients had been involved in craft work relating to 'Black Lives Matter' that was on display in the therapy centre and in having presentations from different staff on different cultures.

The clinical services manager was also looking to introduce a mutual expectation policy that included reference to access to items and explaining why patients were on a certain type of observation. The challenging and difficult behaviours that patients sometimes exhibited were partly due to uncertainty about how they were expected to behave. The policy is a way to promote effective and mutually respectful partnership between staff and patients. Other wellbeing initiatives that had been introduced included raffles and being nominated to the Elysium staff star nominations for going above and beyond in their role.

We were told that the majority of staff had completed an appraisal within the last 12 months and the information supplied by the hospital supported this. Clinical and non-clinical supervision was being introduced at the hospital, including weekly reflective practice. The art psychotherapist had written a policy on clinical supervision. The clinical services manager had provided managerial supervision and nursing leadership to senior nurses. They had also set up a clinical support working group where staff could choose who would provide the clinical supervision. The ward managers told us that they meet monthly for a group supervision and once a month individually as agreed with staff.

4. What next?

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

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

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

The improvement plans should:

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

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

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

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

5. How we inspect independent mental health services

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

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

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

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

We also consider other professional standards and guidance as applicable.

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

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

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B – Immediate Improvement plan

Service: Cefn Carnau Elysium Healthcare

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

Date of inspection: 6 – 8 December 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				

Appendix C – Improvement plan

Service: Cefn Carnau -Elysium Healthcare

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

Date of inspection: 6 – 8 December 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 registered provider must ensure that further work is carried out on the rotas to ensure that there are sufficient female staff to adequately cover the female ward and provide dignified care to patients.	Dignified Care	The hospital routinely, at each morning meeting, check staffing levels and skill/gender mix across the service. Whilst the pandemic has caused difficulty in this area we continually strive to ensure an appropriate gender balance. The Senior Nurses who operate as day and night shift coordinators are fully aware of the gender balance requirements and will work collaboratively to move staff members to different wards if required.	Dean Harries	01/02/2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		At times enhanced observations may need to be undertaken by somebody of a different gender, on these occasions a staff member of the same gender will be available to support toilet access, bathroom access or other tasks where patient dignity must be maintained.		
The registered provider must ensure that the statement of purpose is updated and kept up to date as changes occur. In addition, the statement of purpose must be dated and version controlled. Amended statements must be sent to HIW once completed.	Patient Information	This is complete. The Hospital Director will keep version controlled copies and send to HIW at each update once agreed by the RI.	Dean Harries	10/02/2022
Delivery of safe and effective care				
The registered provider must ensure that the potential hazards identified are risk assessed and action taken to ensure that the items are repaired or the risks reduced.	Managing risk and promoting health and safety	The hospital undertake a monthly environmental assessment which focuses on the quality of the environment. This is supplemented by a weekly walkaround document which observes a range of domains, environment being a key part of this.	Dean Harries	10/01/2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Each environmental improvement is raised to the Support Services Manager and the maintenance department for action.		
The registered provider must ensure that: • Policies are reviewed and updated regularly in a timely manner • Qualified or nominated staff are available to ensure that the daily controlled drug checks are carried out correctly, including the necessary signatures • The fridge temperatures are kept within the correct ranges.	Medicines Management	The out of date policies observed on the day have been reviewed and are now available. At the time of the inspection the hospital did not have Controlled drugs however did manage Drugs Liable to Misuse. The DLM books will form part of ward manager weekly report to ensure regular review. Refrigerator temperatures will be added to the night coordinator checks to ensure oversight of temperatures and remedy when the temperatures fall out of the compliant range.	Dean Harries	14/02/2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that: • The hospital embed a system that ensures that the required risk control measures have been completed following a restraint. This should link to health and safety monitoring to ensure that all corrective actions have been completed • Ensuring that the plans are quality assured and implemented consistently for continuity of care and support and an awareness of actions taken to address inconsistencies or maintain safety and wellbeing of patients • Reactive strategies have more detail regarding specific responses and physical interventions employed	Safe and clinically effective Care	The Incident debrief form has been launched within the hospital which enables the review of the full incident from which includes pre-incident information. This system ensures such information is monitored and recorded or where is it not recorded it can be addressed. This system was in place during the inspection but requires time to embed into the service. Debrief compliance will be reported at each local governance meeting and form part of the governance action plan. All PBS plans have been reviewed to ensure all information contained within is evidence based and accurate. MDT teams are forming part of the process to ensure these changes can be embedded.	Dean Harries	01/03/2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
• The primary and secondary interventions have more detail and focus in the “important for” section regarding health and safety requirements needed to keep the person safe from harm.		As above. PBS plans have been fully reviewed and the ethos of these plans has been that they are directed by the patient and supported by the full MDT. These changes need to be embedded into the systems of the service.		
Quality of management and leadership				
The registered provider must ensure that: • Mandatory staff training compliance is increased • A process is put in place to ensure all staff are in date with their training compliance.	Workforce	The service has developed specific face to face training sessions with bookings in advance to ensure staff members have access to appropriate training. Training compliance is reviewed in local governance on a monthly basis. Ward manager reporting has been introduced to ensure regular oversight and action where required.	Dean Harries	01/04/2022

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): Dean Harries

Job role:	**Registered Manager. Hospital Director**
Date:	**07/02/2022**