Independent Mental Health Service Inspection (Unannounced)

Priory Healthcare

Ty Cwm Rhondda

Cillad and Clydwch

Inspection date: 10 & 11 January 2022

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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 inspection of Ty Cwm Rhondda independent mental health hospital on the evening of 10 January 2022 and following day of 11 January. The following sites and wards were visited during this inspection:

- Cilliad - Low Secure
- Clydwch - Low Secure

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

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

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

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

2. Summary of our inspection

We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed that staff interacted with patients respectfully throughout the inspection. However, we heard different staff on a number of occasions using language that was not professional.

The hospital provided patients with rehabilitative, focused care that was supported by a good range of hospital facilities and access to the local community.

Governance arrangements for the hospital fed through to Priory Group governance arrangements which facilitated a two way process of monitoring, learning and service development.

This is what we found the service did well:

- Staff interacted and engaged with patients respectfully
- Provided a range of suitable facilities in a well maintained environment of care
- Rehabilitative focused care to aid recovery and supported patients to maintain and develop skills
- Medicines management was safe and effective
- Established governance arrangements that provided safe and clinically effective care.
- Monitoring the use of the Mental Health Act

This is what we recommend the service could improve:

- The use of appropriate and professional language by staff
- Mealtime options for patients

There were no areas of non compliance identified at this inspection requiring immediate remedial action.

3. What we found

Background of the service

Ty Cwm Rhondda is registered to provide an independent low secure mental health hospital for males at Tyntyla Avenue, Ystrad, Tonypandy, Pentre CF41 7SU. The hospital comprises of two 10 bed wards: Cilliad and Clydwch. The service was first registered in October 2007.

The service employs a staff team which includes a Hospital Director, a team of registered mental health nurses and healthcare support workers, a practice nurse, occupational therapist and occupational therapy assistants, psychologist, social worker and a psychiatrist.

The operation of the hospital is supported by a team of administration staff, catering staff, domestic staff and a maintenance person.

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

Quality of patient experience

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

We observed that staff throughout the hospital interacted and engaged with patients appropriately and treated patients with dignity and respect.

Whilst there were positive therapeutic relationships between staff and patients, it was noted that some staff were not always using appropriate and professional language.

The hospital provided patients with health promotion, protection and improvement opportunities that were supported by a good range of hospital facilities and access to the local community.

Health promotion, protection and improvement

There was a range of health promotion, protection and improvement information and initiatives available to the patients at Ty Cwm Rhondda which assisted in maintaining and improving patients' wellbeing.

There was a practice nurse role at Ty Cwm Rhondda which was undertaken by a staff member who was a registered general nurse. Patients were registered with a GP practice in the local community. Patients were also able to access dental services and other physical health professionals as required. Patients' records evidenced detailed and appropriate physical assessments and monitoring.

The hospital had a full time occupational therapist and two occupational therapy assistants. Patients had individualised activity timetables that included various therapeutic activities with access to the community facilities.

There was a range of well-maintained facilities to support the provision of therapies and activities; this included a social area known as the Piazza with a pool table and patient shop, along with a computer room, art room, an occupational therapy kitchen and a multi-faith room which was also used a sensory room with suitable equipment to enable this.

There was also a hospital gym which was equipped with a range of exercise equipment. The gym had been refurbished since our previous inspection and the flooring replaced which was highlighted in our previous inspection report.

The patients and staff we spoke with were positive about the activity and therapy arrangements and felt that the hospital was able to facilitate a wide range of activities for the patients.

We were informed, understandably, that accessing facilities in the community had become more difficult during COVID-19 pandemic. However, where possible efforts have been made to continue community access for patients. The hospital should ensure that links with local facilities and services are re-established to ensure that patients are able to utilise the community, in line with government restrictions, to enable them to develop skills as part of rehabilitative focused care in preparation for discharge to a less secure environment.

Dignity and respect

Throughout the hospital, all the staff we observed interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients. On the whole the patients we spoke to were complimentary about the staff at the hospital.

We observed staff being respectful toward patients and speaking with patients in calm tones throughout our inspection. There was evidence of friendly interactions between staff and patients and some patients referred to banter with staff and they felt that this was positive in their relationship with staff. However, when speaking with staff on a number of occasions we heard different staff using language that was not professional. This included referring to increase of aggressive behaviours as “kicking off” and the patients as “boys”. We discussed this with a number of senior staff members at the hospital and were advised that they would follow up on our concerns to ensure that staff maintain professional boundaries and use appropriate language.

Each patient had their own bedroom. Patients were able to lock their bedroom doors which staff could override if required. Patients' bedrooms had en-suite facilities consisting of a toilet, sink and a shower. We observed a number of bedrooms and it was evident that patients were able to personalise their rooms. Patients had sufficient storage for their possessions within their rooms. Any items that were considered a risk to patient safety, such as razors, aerosols, etc. were stored securely and orderly on each of the wards and patients could request access to them when needed.

Bedroom doors had viewing panels so that staff could undertake observation without opening the door and potentially disturbing the patient. It was positive to note that viewing panels were in the closed position and opened to undertake observations and then returned to the closed position. This helped maintain patients' privacy and dignity. In response to an improvement identified during the previous inspection, the outsides of observation windows was covered by a small curtain that prevented the corridor lights shining in to the bedrooms which disturbed some patients' sleep. During our previous inspection some patients had placed towels over the doors to block out the light, however, this could impede the ability of staff to undertake patient observations. The curtains that were now in place could be lifted by staff to enable them to undertake observations in to the bedrooms.

There were suitable arrangements for telephone access on each of the wards so that patients were able to make and receive calls in private. Depending on individual risk assessment, patients were able to have access to their mobile phones. Patients signed a mobile phone contract with the registered provider to agree to terms of use to confirm that the mobile phone would not be misused and allow staff to monitor mobile phone use and content.

The registered provider's Statement of Purpose also described how hospital staff would support patients in ways which would maintain their privacy and dignity.

Improvement needed

The registered provider must ensure that staff continue to have positive therapeutic relationships with patients whilst maintaining professional boundaries and ensuring the use of appropriate language.

Communicating effectively

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

Both wards had planning meetings every morning to arrange activities, within the hospital and the community, alongside other activities and meetings, such as care planning meetings, tribunals, medical appointments, etc.

Each ward had community meetings every two months, helping patients to provide their views on the ward and hospital and informing them of any matters related to the service. It was evident that these community meetings fed in to hospital and organisational governance meetings, enabling patients' views to be considered by senior managers in the hospital and wider Priory organisation.

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

Care planning and provision

Our conversations with patients and staff helped us to establish that there was a focus on rehabilitation with individualised patient care that was supported by reducing restrictive practices.

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

Citizen engagement and feedback

There were regular patient meetings to allow patients to provide feedback on the provision of care at the hospital.

There was a complaints policy and procedure in place at the hospital. The policy provides a structure for dealing with all patient complaints for services within Ty Cwm Rhondda. We reviewed a sample of complaints which evidenced that these were dealt with in line with the registered provider's policy.

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 and infection control. This enabled staff to continue to provide safe and clinically effective care.

Overall, Mental Health Act documentation evidenced compliance with the Act, an improvement since our previous inspection.

Managing risk and health and safety

Ty Cwm Rhondda had processes in place to manage and review risks and maintain health and safety at the hospital.

The hospital had a list of prohibited items and there were secure lockers available to store any items that cannot be taken further than the hospital reception, i.e. mobile phones, lighters, flammable liquids, etc.

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

Overall, the hospital was well maintained which upheld the safety of patients, staff and visitors. Staff were able to report environmental issues to the dedicated hospital maintenance person who maintained a log of issues, work required and date of work completion.

Furniture throughout appeared to be fit for purpose, appropriate to the patient group and in a good state of repair. However, the airlock between reception and the main hospital areas had a faulty key fob sensor for staff exiting the building. To exit, staff had to either be let through by reception staff or exit through the ground floor meeting room. This could have impact if a meeting was being held or family visit was taking place in this room.

Within the front stairwell of the hospital there was some items of machinery on the floor at the bottom of the stairwell. These were a tip hazard and also could be an obstruction in an emergency situation.

There were up-to-date ligature point risk assessments in place. These identified potential ligature points and what action had been taken to remove or manage them.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system including the names of the patient(s) and staff involved, a description, location, time and length of the incident. Any use of restraint was documented, including who was involved and the body positions of each person involved in the restraint.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner by a member of the clinical team involved in the individual patient's care and an employee responsible for hospital health and safety.

Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed. Additional reports could be produced to look at specific areas as required. The incident reporting system and reporting schedules ensured that incidents were recorded, reviewed and monitored to assist in the provision of safe care at Ty Cwm Rhondda.

Improvement needed

The registered provider must ensure that the airlock exit key fob sensor is repaired.

The registered provider must ensure that stairwells and routes of exit are kept clear of obstructions.

Infection prevention and control (IPC) and decontamination

Dedicated housekeeping staff were employed at the service. On the whole communal areas of the hospital were visibly clean, tidy and clutter free.

We saw evidence to confirm that Ty Cwm Rhondda conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands of the COVID-19 pandemic. Staff we spoke to were aware of infection control obligations. The registered provider had COVID-19

documentation to support staff and ensure that staff remained compliant with policies and procedures.

The training statistics provided by the registered provider evidenced that all staff were up to date with their infection control training

On arrival at hospital, visitors were required to show proof of a recent negative Lateral Flow Test (LFT) or complete one on arrival. Hand hygiene products were available in reception and in relevant areas of the hospital.

There was access to hand washing and drying facilities throughout the hospital. During our discussions no issues were highlighted in relation to access to Personal Protection Equipment (PPE). PPE, including masks and gloves, were available at the ward entrance with bins were provided for the disposal of equipment. Staff were wearing masks in communal areas and throughout the wards.

Cleaning schedules were in place to promote regular and effective cleaning of the wards and staff were aware of their responsibilities around infection prevention and control. We observed staff wiping telephones and computers with cleaning products between and after use to reduce the risk of cross contamination.

However, some doors, in particular for the medication room on Clydwch, were worn underneath the locks and bare wood exposed which cannot be effectively cleaned and was therefore an infection control concern.

Improvement needed

The registered provider must ensure that surfaces, such as doors, do not have bare wood that prevents effective cleaning.

Nutrition

Patients were able to access drinks and snacks on the wards, and each patient had their own cupboard to store their food items. Patients were provided with a choice of options for breakfast, lunch, dinner and super. We were informed that the menus varied seasonally through the year. However, patients told us during discussions that there was limited choice and the meal options were repetitive. We reviewed the current menus and it was evident that this was the case. Often the choice on offer was whether to have the vegetarian or non-vegetarian version of a meal, for those patients who were vegetarian this leaves no choice.

Improvement needed

The registered provider must ensure that there menu options are expanded to provide a variety of choices for each mealtime.

Medicines management

Overall, medicines management on the wards was safe and effective. Medication was stored securely with cupboards with medication fridges locked and medication trolleys secured. There was regular pharmacy input and audit undertaken that assisted the management, prescribing and administration of medication at the hospital.

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

There were appropriate arrangements for the storage and use of Controlled Drugs and Drugs Liable to Misuse; these were accurately accounted for and checked daily.

Each of the Medical Administration Records (MAR charts) reviewed contained the patient's name and their Mental Health Act legal status. MAR charts were consistently signed and dated when medication was prescribed and administered.

It was positive to note that some MAR Charts included a photograph of the individual patient which aided staff in identifying and ensuring that they are administering medication to the correct patient. Where MAR charts did not include a photograph there was not always a record to state that this was because the patient had not given consent. The registered provider should ensure that photographs are in place in MAR charts unless the patient declines to give consent.

Copies of Consent to Treatment Certificates to authorise medication prescribed (for mental disorder) under the Mental Health Act were kept with the corresponding MAR chart.

Medical devices, equipment and diagnostic systems

There were regular audits at the hospital and staff had documented when these had occurred to ensure that the equipment was present and in date.

There were ligature cutters located throughout the hospital in case of an emergency. As an improvement from our previous inspection, ligature cutters were easily accessible within the nursing office on each ward.

Safe and clinically effective care

Overall, we found governance arrangements in place that helped ensure that staff provided safe and clinically effective care for patients.

Clinical governance arrangements for the hospital fed through to The Priory Group governance arrangements which facilitated a two way process of monitoring and learning.

Records management

Patient records were a combination of paper files that were stored and maintained within the locked offices, and electronic information, which was password protected. We observed staff storing the records appropriately during our inspection.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients across both wards and spoke with the mental health act administrator to discuss the monitoring and audit arrangements in place.

The organisation and availability of the statutory documentation and associated records was vastly improved since our previous inspection. This enabled us to gain assurance that detentions were compliant with the Act and overall followed the guidance of the Mental Health Act Code of Practice for Wales, 2016 (the Code).

It was evident that detentions had been applied and renewed within the requirements of the Act and copies of legal detention papers were available to ward staff at the hospital. There were clear records of patients being informed of their statutory rights regularly throughout their detention.

The renewal of detention was correctly applied on statutory forms and clearly documented within patient records. It was also evident that those patients'

detentions were reviewed by the Mental Health Review Tribunal and at Hospital Manager Hearings [1], when applicable or required.

Medication was provided to patients in line with Section 58 of the Act, Consent to Treatment. Consent to treatment certificates were kept with the corresponding electronic medication record. This meant staff administering medication could refer to the certificate to ensure that medication was prescribed under the consent to treatment provisions of Section 58 of the Act. For two patients whose consent to treatment certificate was authorised by a Second Opinion Appointed Doctor[2] (SOAD), whilst there was a record of the discussion written by the SOAD between the SOAD and each of the two statutory consultees[3], there was no entry by the statutory consultees to record their views on the authorised medical treatment.

All leave had been authorised by the responsible clinician on Section 17 Leave authorisation forms, these were up-to-date and well recorded.

There was a range of information available for patients explaining their rights under the Act. During the inspection we noted that some of the information was out of date; this was rectified during the inspection.

[1] The organisation (or individuals) responsible for the operation of the Act in a particular hospital. Hospital managers have various functions under the Act, which include the power to discharge a patient.

[2] The second opinion appointed doctor (SOAD) service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient.

[3] A SOAD must consult with two people 'statutory consultees' who before issuing certificates approving treatment. These are normally a qualified nurse who has been professionally concerned with the patient's care and another qualified person (not a nurse or doctor) who has direct knowledge of the patient in their professional capacity (e.g. Social Worker, Occupational Therapist, Physiotherapist, Pharmacist, Psychologist, Dietician, Art Therapist). The 'statutory consultees' must document their consultation with the Second Opinion Appointed Doctor.

Improvement needed

The registered provider must ensure that an entry is made in the patient's record by each of the two statutory consultees to document their views on the medical treatment authorised by the second opinion appointed doctor.

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

The hospital used the Priory's electronic record system that was organised and easy to navigate. We looked at one patient's care plan documentation in detail.

The patient's electronic record had a range of care plans to direct staff in providing the care to the patient and supporting the patient to meet their needs whilst at the hospital.

Care plans were developed by staff using a range of standardised patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them. However, there were no review dates specified on each of the care plans to ensure that these were regularly monitored and updated as required.

The hospital developed Positive Behavioural Support (PBS) plans for each of the patients at the hospital. However, we were informed that there was not a consistent approach for saving these on the electronic patient record; some staff save the PBS plan under care plan tab and others put it in the risk tab. This is a similar finding to our previous inspection when it was not clear where to find PBS plans within each patient's records. For the patient we reviewed we could not locate the PBS plan, therefore it was unclear if it was saved in the incorrect part of the electronic record or whether it was yet to be finalised. PBS plans are essential for supporting patients in an individualised manner, and these must be easily accessible to staff by being saved in a consistent location on the electronic patient record.

Improvement needed

The registered provider must ensure that care plans have specific review dates documented.

The registered provider must ensure that Positive Behavioural Support (PBS) plans are consistently location on the electronic patient record.

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.

There were defined systems and processes in place to support the effective operation of the hospital within wider governance arrangements associated with the Priory Group.

We observed a committed staff team who had a good understanding of the needs of the patients at the hospital. Training statistics evidenced many mandatory training compliance rates to be 100%.

Governance and accountability framework

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

However, on our arrival on the first evening we were not assured that staff on the nightshift were fully aware of the number of staff and patients at the hospital. The responses to some of our questions lacked certainty and reliance on speaking to staff members on the other ward to gain clarification. Whilst there was a process in place for the nurse in charge of the night shift to be informed of the hospital occupancy and staffing, it was evident that this had not occurred to a sufficient standard that evening. It is essential that staff, in particular registered nurses, know how many staff and patients are present on each ward within the hospital to ensure the safety of all.

There was clear leadership displayed by senior members of staff including multi-disciplinary team members. We found that staff were committed to providing patient care to high standards when we were present on the wards. It was positive that, throughout the inspection, the staff at the hospital were receptive to our views, findings and recommendations.

Improvement needed

The registered provider must ensure that established processes are followed to ensure that staff know how many staff and patients are present on each ward within the hospital to ensure the safety of all.

Dealing with concerns and managing incidents

There was a complaints policy and procedure in place at the hospital. The policy provides a structure for dealing with all patients' complaints for services within the hospital. There were established processes in place to ensure that the hospital safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

There was an electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system including the name of patient(s) and staff involved, a description, location, time and length of the incident. This provided staff with appropriate data to identify trends and patterns of behaviour. A sample of complaint records were looked at during the inspection to ensure completeness and compliance with the complaints policy.

There was a hierarchy for incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation.

Workforce planning, training and organisational development

We reviewed the mandatory training and annual appraisal statistics for staff at the hospital and found that completion rates were high. The electronic records provided the senior managers with details of the course completion rates and individual staff compliance details.

We reviewed the staffing establishment at Ty Cwm Rhondda; there were two registered nurses vacancies and two healthcare support worker vacancies which the registered provider was recruiting to. On staff rotas evidenced that regular staff were used to fulfil any shortfalls in the rota; this means there was little requirement for unfamiliar staff from bank or agency, which ensures a consistency of care for patients and support to fellow staff members. However,

some staff had picked up a large number of additional shifts over recent weeks, and whilst there were processes in place to monitor this, the registered provider must ensure that a staff member's professional competence and patient care is not affected due to fatigue.

Workforce recruitment and employment practices

Staff explained the recruitment processes that were in place at Ty Cwm Rhondda. It was evident that there were systems in place to ensure that recruitment followed an open and fair process. Prior to employment, staff references were received, Disclosure and Barring Service (DBS) checks were undertaken and professional qualifications checked. All staff received an induction prior to commencing work on the wards at the hospital.

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 – Improvement plan

Service: Ty Cwm Rhondda

Date of inspection: 10 & 11 January 2022

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The registered provider must ensure that staff continue to have positive therapeutic relationships with patients whilst maintaining professional boundaries and ensuring the use of appropriate language.	10. Dignity and respect	Choice of language used was addressed on the day by ward manager Kayleigh Jones and a reflective practice was undertaken with the team. Has been discussed in weekly supervision and shared as parts of lessons learnt through clinical governance with no further arising issues.	Rhiannon Ham Kayleigh Jones	Complete 11.02.2022
Delivery of safe and effective care				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that the airlock exit key fob sensor is repaired.	22. Managing risk and health and safety 12. Environment 4. Emergency Planning Arrangements	Estates call out had been placed 10.01.22 for repair to air lock sensor. Sensor fully replaced and functioning	Rhiannon Ham Mandy Ferguson	Complete 11.01.2022
The registered provider must ensure that stairwells and routes of exit are kept clear of obstructions.	22. Managing risk and health and safety 12. Environment 4. Emergency Planning Arrangements	Trolley had been placed in front of out of commission door. Discussed with maintenance and housekeeping. Trolley is now stored appropriately away from any air lock doors. Addressed on the day of feedback being provided. Door has been fully replaced by estates	Rhiannon Ham Mandy Ferguson	Completed 11.02.2022 Door Replaced 09.02.2022
The registered provider must ensure that surfaces, such as doors, do not have bare wood that prevents effective cleaning.	13. Infection prevention and control (IPC) and decontaminati on	Maintenance officer and site service manager to complete a full site review of doors and frames for painting or replacing. Aluminium plating to be placed around locks and areas of high wear and tear to prevent reoccurrence.	Mandy Ferguson Ian Hickman	18.02.2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Painting and plating to be completed w/c 21.02.22.		
The registered provider must ensure that there menu options are expanded to provide a variety of choices for each mealtime	14. Nutrition	Following consultation with the patient group menus have been devised on a 4 week rotational basis. These will incorporate seasonal changes and menu changes based on meal feedback. Patient group requested healthier options and a change of meal times to support a healthier lifestyle. New menus implemented from 07.02.22 Recipe cards and allergens have been identified and shared with the wards to support the patient group with healthier choices. Additional choices have been varied for each meal time Vegetarian/Vegan/Diabetic options have been reviewed for each meal time and are clearly indicated on the menus. Meal satisfaction is reviewed weekly during patients' morning meeting and	Rhiannon Ham	07.02.2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		menus are reviewed based on the feedback.		
The registered provider must ensure that an entry is made in the patient's record by each of the two statutory consultees to document their views on the medical treatment authorised by the second opinion appointed doctor.	20. Records management Mental Health Act Monitoring	Addressed at the point of feedback and conveyed to the team. MHAA has added to monthly audit to ensure compliance and to prompt a reminder for to any clinicians to submit necessary documentation to record consultation.	Lisa Lawrence Rhiannon Ham	11.01.2022 07.02.2022
The registered provider must ensure that care plans have specific review dates documented.	20. Records management	Addressed at the point of feedback and conveyed to the team. Charge nurses now complete weekly documentation/care plan audits and feedback on SMART/TIME Measured objectives to request review if required.	Rhiannon Ham	12.01.2022
The registered provider must ensure that Positive Behavioural Support (PBS) plans are consistently location on the electronic patient record.	20. Records management	MDT and Nursing Team advised of where PBS plan was to be reflected on care notes for consistency. Under assessment tab.	Rhiannon Ham	12.01.22
Quality of management and leadership				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that established processes are followed to ensure that staff know how many staff and patients are present on each ward within the hospital to ensure the safety of all.	1 Governance and accountability framework	Addressed with the nurse in charge of shift – appointed nurse duties and expectations cascaded by Ward Manager Handover document updated to reflect key information for appointed nurses for alternate wards to ensure key issues are communicated between the wards. Quarterly nurses meetings have been arranged with Nursing SMT	Kayleigh Jones Rhiannon Ham	12.01.2022

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): Rhiannon Ham

Job role: Hospital Director

Date: 18.02.2022