Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Tŷ Grosvenor

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Tŷ Grosvenor on 25, 26 and 27 April 2022.

The following hospital wards were reviewed during this inspection:

- Alwen Ward - 15 single gender beds providing locked rehabilitation services
- Brenig Ward – 15 single gender beds providing locked rehabilitation services.

Our team for the inspection comprised of two HIW Inspectors, four clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
All patients who completed a questionnaire rated the care and service provided by the hospital as either very good or good. Staff interacted and engaged with patients appropriately and treated patients with dignity and respect. Patients had access to a range of suitable activities and therapies. Patients could engage and provide feedback to staff on the provision of care at the hospital in a number of ways. Patients had access to a mental health advocate who provided information and support with any issues they may have regarding their care.

This is what we recommend the service can improve

- Work must be undertaken to improve the appearance of the garden for patients on the Brenig ward
- The oven in the occupational therapy kitchen on the Alwen ward must be repaired or replaced.

This is what the service did well:

- The appointment of patient representatives was a positive initiative that helped promote patient engagement and ensure the voice of patients is heard.

Safe and Effective Care

Overall summary:
Staff appeared committed to providing safe and effective care. Patient care and treatment plans were being maintained to a good standard and were easy to navigate. Safe and therapeutic responses were in place to manage challenging behaviour and promote the safety and wellbeing of patients. The statutory documentation we saw verified that the patients were appropriately legally detained. Suitable protocols were in place to manage risk, health and safety and infection control. However, we found that some audits were not effective at identifying errors or areas for improvement.

This is what we recommend the service can improve

- Medication Administration Record charts must be completed to a higher standard and audited more effectively

- Guidance must be developed that sets out the requirements for the safe use of the Extra Care Areas on each ward
- Staff must be reminded of the importance of wearing their personal alarm at all times.

This is what the service did well:

- There was a strong additional focus on the physical healthcare of patients being led by the physical health nurse at the hospital.

Quality of Management and Leadership

Overall summary:
We found improvements had been made in a number of areas since our previous inspections at the hospital. There appeared to be better oversight of clinical and operational issues by senior management. The majority of staff who completed questionnaires provided positive feedback about working at the hospital. Recruitment was being undertaken in an open and fair process with appropriate employment checks being carried out prior to employment.

This is what we recommend the service can improve

- Efforts to recruit permanent staff must be continued to reduce the number of agency staff being used to fill rotas and provide stability and consistency in care being provided to patients.

3. What we found

Quality of Patient Experience

Patient Feedback

We handed out HIW questionnaires to patients during the inspection to obtain their views on the service provided at the hospital. In total, we received nine completed questionnaires. All the completed questionnaires were from patients who had been a patient at the hospital for more than one month. All patients who completed a questionnaire rated the care and service provided by the hospital as either very good or good. Some of the questionnaire results appear throughout the report.

Health promotion, protection and improvement
We looked at a sample of patient records and saw evidence that patients received appropriate physical assessments upon their admission in addition to their mental healthcare. Patients also received ongoing physical health checks during their stay such as weight management and monitoring. Measurements were recorded on National Early Warning Score charts and within physical health and wellbeing care plans. A part-time physical health nurse was employed by the hospital to undertake these tasks. The nurse was also responsible for ensuring all patients are registered with the local GP practice and have access to other key health services when required.

Each ward provided a range of facilities to help patients maintain their health and wellbeing. Communal areas were spacious and DVDs and books were available to patients. Art materials were available for craft activities and occupational therapy kitchens allowed patients to take part in activities of daily living. However, we noted the oven in the occupational therapy kitchen on the Alwen ward was rusty and we recommend that it is either repaired or replaced.

Gym equipment was available on both wards and patients were taking part in a keep fit class on Brenig ward during the inspection. The occupational therapy team arranged group and individualised activities for patients internally at the hospital and externally within the local community. All patients who completed questionnaires felt that there were sufficient and appropriate recreational and social activities for them to do.

Both wards had outside gardens and we observed patients using these spaces regularly during the day times. All patients who completed questionnaires said that they were able to go outside for exercise and wellbeing purposes. However, we

noted that the garden for the Alwen ward appeared better maintained than the garden for the Brenig ward, which had a notable amount of weeds present and some broken furniture. We recommend that work is undertaken to improve the appearance of the garden for the Brenig ward.

Tŷ Grosvenor is a non-smoking hospital and patients told us that they had been given help and advice by staff to stop smoking before the smoking ban came into force.

Dignity and respect

We observed staff treating patients appropriately and with dignity and respect. Staff seemed to have developed good relationships with patients and took time to understand their needs or any concerns patients raised. All patients who completed questionnaires felt that staff were polite to them and treated them with dignity and respect.

En-suite bedrooms for patients provided a good standard of privacy and dignity. Patients could lock their rooms, but staff could override the locks if required. We observed staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering. Each bedroom door had a vision panel which enabled staff to undertake observations from the corridor without disturbing patients. During our tour of the hospital we positively noted that the vision panels were closed by default to protect the privacy of patients.

Patients were able to personalise their rooms and store their own possessions. Personal items were risk assessed on an individual basis for the safety of each patient. This included the use of personal mobile phones. A telephone was available at the hospital for patients to use to contact friends and family if required.

Patient information and consent

A patient information guide was available to patients and their relatives / carers. The registered provider's statement of purpose described the aims and objectives of the service. We saw that both documents were up to date and contained all the relevant information required by the regulations. Registration certificates from HIW were on display in the entrance area of the main building.

We saw that relevant information for patients was on display throughout the wards. This included details about how patients could contact, and access, advocacy services and about how patients could raise a complaint. Information about the role of HIW was also available and informed patients that they could contact the organisation should they wish.

We noted that patient information was predominantly only available in English. We were told that information was available in other languages to patients on request. We spoke with Welsh speaking patients at the hospital who confirmed they were aware that information would be made available in Welsh if requested. They also told us that they had been informed of which staff members could converse through the medium of Welsh.

Patient status at a glance boards were located in the nursing offices on each ward. The boards were out of sight of patients which helped protect patient confidentiality.

Communicating effectively

Staff communicated appropriately and effectively with patients, and patients were confident in approaching staff to engage in discussions. The patients we talked to during the inspection spoke positively about their interactions with staff during their time at the hospital. Suitable rooms were available for patients to meet staff and other healthcare professionals in private.

Daily morning meetings were being held to tell patients about upcoming activities within the hospital and the community, and other relevant information, such as tribunals and medical appointments.

Patient representatives had been appointed to act as a point of contact for other patients to talk to about any issues they may have. We were told that the patient representative chaired monthly community meetings where staff and patients discuss any suggestions, concerns or patient feedback. The patient representative also attended weekly clinical governance meetings. We noted this as a positive way of encouraging patients to participate in these meetings.

Care planning and provision

During the inspection we reviewed the care and treatment plans of five patients. It was positive to note that the quality of care and treatment plans had improved since our last couple of inspections at Tŷ Grosvenor. Our findings on the care and treatment plans are detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

A handover meeting was being held every weekday morning for nursing staff to update the multi-disciplinary team (MDT) on any concerns, issues or incidents that had taken place the day before. We attended a handover meeting during the inspection and saw that staff demonstrated a good level of understanding of the patients they were caring for and that discussions focused on what was best for the individual patient.

Equality, diversity and human rights

During the inspection we looked at the patient records of four individuals that had been detained at the hospital under the Mental Health Act (the Act). We found that legal documentation we reviewed was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code).

The hospital had policies in place to help ensure that patients' equality and diversity were respected. The hospital mainly provided an accessible environment for people who may have mobility difficulties. A lift was available to assist people with mobility difficulties to access Brenig ward, which was located on the first floor. However, we noted that access to the garden for Brenig ward was only via stairs. Consideration should be given to ensuring safe access to the garden for Brenig ward for patients that require extra assistance.

We were told that all patients have access to a mental health advocate who can provide information and support to patients with any issues they may have regarding their care. All but one of the patients who completed questionnaires confirmed that they had been offered the support of an advocate during their time at the hospital.

Citizen engagement and feedback

We found strong evidence that patients could engage and provide feedback to staff about their care at the hospital in a number of ways. The daily morning and monthly community meetings provided opportunities for patients to discuss issues regarding their care. We saw that any requests from patients are displayed on the walls of each ward along with a response from staff to show what actions had been taken. ‘You said, we did’ boards were also displayed on each ward to inform patients of changes made as a result of their feedback. However, we noted that the ‘you said, we did’ board on Brenig ward needed to be updated more regularly as it had not been updated since January 2021.

We were told that surveys are issued to patients following their admission and following discharge from the hospital to help identify any improvements necessary with either process. The social worker at the hospital also undertakes family and carer surveys.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
Overall, we were assured that Tŷ Grosvenor had processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors at the hospital. The entrance to the hospital was secured at all times throughout the inspection. A range of up-to-date health and safety policies were available for staff. Ward managers were undertaking weekly checks of the environment on each ward. Monthly health and safety audits were being completed and submitted to the central health and safety team at Elysium Healthcare for them to monitor compliance.

Ligature point risk assessments had been undertaken that detailed the actions taken to mitigate potential ligature points throughout the hospital. A review of the ligature risk assessments by the quality assurance regional manager was scheduled to take place on the same day of the inspection. This was postponed due to our arrival at the hospital, but we were assured that the review would take place at the next earliest opportunity. During the inspection we spoke with the hospital manager about whether the bathroom doors inside patient bedrooms were potential ligature points. The hospital manager assured us that potential risks of the bathroom doors would be added to the ligature risk assessment when reviewed by the quality assurance regional manager.

Personal alarms were available for staff to wear which they could use to call for assistance if required. We did note that a small number of staff were not wearing their personal alarm during the inspection. We recommend that staff are reminded of the importance of wearing their personal alarm at all times to help protect the safety of both staff and patients. Nurse call points were available within patient bedrooms so that patients could summon assistance if required.

Infection prevention and control (IPC) and decontamination
We found suitable IPC arrangements in place at the hospital. A range of up-to-date policies were available that detailed the various infection control procedures to keep staff and patients safe. Regular audits had been completed to check the cleanliness of the environment and monitor compliance with hospital procedures.

We were told that two separate IPC leads had been appointed, one from housekeeping staff, and one from clinical staff. This appeared to be working well as we observed housekeeping, nursing and support staff working well together and staff seemed clear about their individual responsibilities in relation to infection

control measures at the hospital. Cleaning schedules documented the cleaning being undertaken at the hospital.

The environment of both wards and the wider hospital was clean and uncluttered. Furniture and fixings were appropriate for the patient group and in a good state of repair apart from the chairs in the communal lounge of the Alwen ward. The material on the arms of the chairs had worn away and must be replaced as they are unable to be cleaned effectively.

We found appropriate procedures were in place to help control the risk of transmitting COVID-19 throughout the hospital. Multiple hand gel dispensers were available for both staff and patients to use. Staff wore face masks on the wards, and staff did not highlight any issues relating to access to other PPE during our discussions. We observed staff encouraging patients to practice good hand hygiene such as washing hands before mealtimes.

We saw a high compliance rate among permanent members of clinical staff for mandatory training in infection prevention and control level one (98 per cent) and level two (94 per cent).

Nutrition

We saw that the dietary needs of patients had been assessed on admission and that patients received ongoing weight management checks during their stay. Measurements were recorded on National Early Warning Score charts and within physical health and wellbeing care plans.

Patients are provided with a variety of meals throughout the day by the hospital. We saw the menu choices for each week displayed on each ward. Facilities were available for patients to have hot and cold drinks. All patients who completed questionnaires agreed that they were able to access a drink when they needed to.

During our tour of the Alwen ward we found sandwiches in the kitchen fridge that only had the name of the patient on it and no other information. The date of when packaged items are made and their use by date must be labelled to protect the health of patients.

We were told that patients are able to feedback their suggestions and opinions to staff about the food at the hospital during their monthly community meetings. We saw evidence of the hospital listening to patients by taking action to implement suggestions, such as agreeing to make more vegetable choices available. Feedback about the food from patients who completed questionnaires was variable; half of the patients agreed, while half of the patients disagreed, that the food at the hospital was good and that it met their dietary requirements.

Medicines management
Relevant policies, such as medicines management and rapid tranquillisation, were in date and available to staff electronically on the computer in the clinic rooms.

There was good evidence of staff ensuring that patients had individualised medication management plans. We found clinical staff, the physical health nurse and the local GP had worked together to ensure decisions about medication were person centred and regularly reviewed to check they continued to be appropriate. It was clear that patients had been involved in these discussions which we noted as good practice. A range of easy read medication information leaflets were available for patients to access.

We found the clinic rooms to be clean and tidy with individual patient medications and stock medications stored appropriately. Medication fridges were locked when not in use. However, we saw some gaps in the recording of daily temperature checks of the medication fridges and clinic rooms on both wards.

Controlled drugs were stored securely and we saw evidence that stock checks were being undertaken twice a day. We found that on the whole, controlled drugs were administered to patients in line with best practice guidance. However, we saw two instances where controlled drugs had not been counter signed and two instances where entries had been omitted in the logbook.

The majority of Medication Administration Record charts we looked at had been completed as required. All the charts had the relevant personal details documented such as name, allergy status and legal status. However, we did find some omissions where medication administered to patients had not been signed for or noted as refused by the patient on the charts.

We were told that weekly audits of the MAR charts are undertaken internally by clinical staff and externally by an independent pharmacist. Some of the omissions on the charts we found had not been identified during either of the audits. In one instance, the external audit had found an issue with an incomplete chart but it had not been effectively escalated in order for the issue to be investigated further internally. This meant we were not assured that the systems in place to monitor the quality of the completion of MAR charts and identify errors were effective. We recommend that a review is undertaken by the service to identify improvements with the audit processes and the procedures for internal escalation when the independent pharmacist externally identifies issues.

Safeguarding children and safeguarding vulnerable adults
We found processes in place to help ensure that staff at the hospital safeguarded patients appropriately. We saw that incidents had been subject to internal investigations and had also been referred to external safeguarding agencies.

We saw evidence that safeguarding is included at monthly clinical governance meetings as a standing agenda item to help identify any themes and lessons learned. We noted in the minutes of the February 2022 clinical governance meeting that compliance among staff with safeguarding training was 100 per cent.

Some patients who completed a questionnaire told us that they did not feel safe from other patients while at the hospital. We recommend the service reflects on this finding and identifies ways of making all patients feel safe during their stay at the hospital.

Medical devices, equipment and diagnostic systems
We saw evidence of weekly checks being undertaken on resuscitation and emergency equipment held on each ward. Staff had documented when these had occurred to ensure that the equipment was present and in date.

Safe and clinically effective care
The hospital had policies in place to help protect the safety and wellbeing of patients and staff. The safe and therapeutic management of violence and aggression policy described approaches for staff to follow to safely manage challenging behaviour. We noted that the policy reflected the Safewards model and we saw the 10 interventions displayed on each of the wards. Care and treatment plans for patients included positive behavioural strategies.

We were told that staff would observe patients more frequently in line with the observations and engagement (safe and supportive) policy if their behaviour became a cause for concern. Observation levels for individual patients were discussed among the MDT in the daily handover meetings.

Patients are encouraged to discuss any restrictive practices implemented by the hospital at their weekly community meetings. Any feedback is discussed by staff in monthly least restrictive practice meetings to review whether any restrictive practices can be removed.

Staff had undertaken training in Therapeutic Management of Violence and Aggression (TMVA). We saw that the use of restraint was documented in patient records and recorded on the corporate electronic incident, reporting and information system (IRIS). We were told that all incidents of restraint are discussed

by the MDT at the daily handover meetings and that debriefs, and reflective practice take place with staff and patients following any incidents.

Each ward had a separate Extra Care Area (ECA) that provided a low stimulus environment for patients that required it. The conditions of using the ECA for individual patients was documented within their care and treatment plans. We were told that the ECA is never used to seclude a patient. However, no corporate policy was in place that set out the guidance and requirements to ensure the safe use of the ECAs at the hospital, for example to document that the ECAs should never be used for seclusion purposes.

Records management
Patient records were being maintained electronically. The electronic system was password protected to prevent unauthorised access and breaches in confidentiality. We used the system throughout the inspection and found patient records to be comprehensive and well organised, which made it easy to navigate through the sections.

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

Mental Health Act Monitoring
We reviewed the statutory detention documents of four patients currently residing at the hospital. All records were found to be compliant with the Mental Health Act and Code of Practice. Clear reasons were being documented to evidence why detention under the Act was the most appropriate way of providing care for patients.

Original documents were being stored securely in the administration office and staff at the hospital maintained electronic versions. The documents we viewed were well organised and contained detailed and relevant information. Patients were being made aware of their rights in relation to their detention at the hospital and that this was revisited regularly to ensure patients continued to have an understanding.

All relevant consent to treatment certificates were stored alongside the MAR charts as required. We saw that Second Opinion Appointed Doctor (SOAD) assessments had been sought when patients had refused to provide consent.

Good arrangements were in place to document Section 17 leave appropriately. We saw that leave was being suitably risk assessed and that the forms determined the

conditions and outcomes of the leave for each patient. Patients had signed their leave form to indicate their agreement to the terms.

There was good support available for patients from the local Independent Mental Health Advocacy service. An advocate attends MDT and care and treatment meetings when patients require help and support.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
Care and treatment plans were contemporaneous, easy to navigate and well maintained. Each patient had their own programme of care that reflected their individual needs and risks. The domains of the Welsh Measure were being reflected and objectives focussed on recovery and rehabilitation. However, we felt the care and treatment plans could benefit from a measurable approach by documenting the frequency and duration of the interventions listed.

Appropriate pre-admission and upon admission assessments were being undertaken and clearly documented. There was evidence of multidisciplinary involvement in the development and ongoing review of the care and treatment plans we saw. It was also clear that patients had been involved in the care and treatment process, with the patient voice being well reflected within the documentation. All patients who completed questionnaires said that they had felt involved in the development of their care and treatment plan.

A notable area of good practice was the additional focus on physical healthcare led by the physical health nurse. We found comprehensive physical assessments and corresponding care and treatment plans for both preventative health screening and management of longer-term conditions.

There was evidence of discharge and aftercare planning and we noted that patients and care co-ordinators had been involved in the process.

Quality of Management and Leadership

Staff Feedback

We handed out HIW questionnaires to staff during the inspection to obtain their views on the service provided at the hospital. In total, we received 18 completed questionnaires. Staff responses were positive across all areas, with all respondents (who gave an opinion) recommending their mental health setting as a place to work and agreeing that they would be happy with the standard of care provided for their friends or family. Some of the questionnaire results appear throughout the report.

Governance and accountability framework

It was positive that throughout the inspection staff were receptive to our views, findings and recommendations. Staff we spoke with were passionate about their roles and we saw staff working as a team during our time at the hospital.

All staff who completed a questionnaire told us that the hospital encourages teamwork and that they are supported to identify and solve problems. The majority of staff who completed a questionnaire also agreed that communication between senior management and staff is effective and that senior managers try to involve staff in important decisions.

We found improvements had been made in a number of areas since our previous inspections at the hospital. Established arrangements were in place at the hospital level which helped provide management with better oversight of clinical and operational issues. Audit activities and monitoring systems and processes ensured the hospital had a focus on continuously maintaining standards. However, as previously mentioned in the report, the service must ensure that audits are completed appropriately by staff to ensure they are effective and identify areas for improvement.

Information in relation to safety and performance of the hospital was collated by staff at the hospital and submitted to the central team at Elysium Healthcare to be monitored corporately. Agendas for clinical governance meetings showed a wide range of standing items to help ensure that the hospital focussed on all aspects of the service.

Dealing with concerns and managing incidents

Patients we spoke with during the inspection informed us that they knew how to make a complaint should they wish to do so. Any complaints received by the hospital are categorised as informal or formal. Staff aim to resolve informal

complaints as soon as possible. Formal complaints are captured in a log book and then uploaded to IRIS.

We were told complaints, incidents and safeguarding issues at the hospital are discussed at clinical governance meetings and are also reviewed at a corporate level to help identify trends and patterns of behaviour.

Workforce planning, training and organisational development
At the time of our inspection there appeared to be sufficient numbers of appropriately trained staff to meet the assessed needs of the patients at the hospital. However, from discussions with staff it was evident that the service has experienced difficulties in relation to staff retention and a high number of vacancies, both in terms of nursing staff and in the MDT. The hospital director told us about initiatives taking place to recruit permanent members of staff. A high proportion of agency staff have been used at the hospital to cover any staffing shortfalls. We were told that wherever possible the same agency staff members are used who are familiar with the hospital to provide consistency for patients. However, one staff member commented:

> *"Agency staff appears to have become a way of life and this is very frustrating to management and staff."*

The service must continue to be mindful when employing agency staff to ensure the proportion of agency staff working at the hospital does not impact on the safety of the care being provided to patients.

All staff who completed a questionnaire agreed that they are able to meet the conflicting demands on their time at work and have enough time to give patients the care they need. All staff who completed a questionnaire also agreed that they would recommend the hospital as a place to work and that if a friend or relative needed support they would be happy with the standard of care provided by the hospital.

We reviewed the mandatory training statistics for staff at the hospital and found that completion rates were high at 97 per cent. Staff who completed a questionnaire told us that they had also been supported by the hospital to undertake other training relevant to their role. As of April 2022, 91 per cent of staff had also received their annual appraisal. We also saw that staff had been receiving monthly clinical supervision sessions with senior members of staff.

Workforce recruitment and employment practices
A recruitment policy was in place that set out the arrangements to ensure recruitment followed an open and fair process. Prior to employment, potential

staff are required to provide two references and evidence of professional qualifications. Disclosure and Baring Service (DBS) checks are also carried out, and then renewed every three years, to ensure staff are fit to work at the hospital.

Newly appointed permanent staff receive a period of induction to learn about the hospital, read company policies and complete mandatory training. Staff are assessed by senior managers after three months to ensure they have demonstrated their competence to do the job in practice. Agency staff receive a welcome pack before their first shift at the hospital to provide relevant information about each ward. Agency staff are required to sign the pack to confirm they have understood before undertaking any duties. We were told that all staff have contracts of employment and up-to-date role profiles.

A freedom to speak up / whistleblowing policy was in place should staff wish to raise any concerns directly with the hospital director, registered provider or an alternative appropriate body if required. All staff who completed a questionnaire said that they would know how to report any concerns about unsafe practice and that they would feel secure raising concerns about patient care or other issues at the hospital.

4. Next steps

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

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

The improvement plans should:

- Clearly state how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

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.			

Appendix B - Immediate improvement plan

Service: Tŷ Grosvenor

Date of inspection: 25-27 April 2022

The table below includes any immediate non-compliance 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.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate non-compliance concerns were identified on this inspection.				

Appendix C - Improvement plan

Service: Tŷ Grosvenor

Date of inspection: 25-27 April 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	Standard/ Regulation	Service action	Responsible officer	Timescale
The oven in the occupational therapy kitchen on the Alwen ward must be repaired or replaced.	Quality of patient experience	Maintenance operative inspected ovens on both wards, oven on Brenig ward found needed repairing. Part sourced and repaired.	Maintenance	Completed
Work must be undertaken to improve the appearance of the garden for the Brenig ward.	Quality of patient experience	The garden on Brenig ward at the time of inspection was left to grow due to a competition called 'lets dig it'. The service users had requested to do before and after pictures of the garden to enter the competition, furthermore the service users had requested to let the garden grow to encourage wildlife, namely bees. The gardenwork is currently underway through paid real work opportunities for service	Maintenance/ Gardener	Completed

		users and a gardener attends to assist weekly. New outdoor furniture has been ordered with expected delivery of 1 month.		
The 'you said, we did' board on Brenig ward needs to be kept updated regularly.	Quality of patient experience	The OT department has been allocated to update the 'you said, we did' boards. Ward managers will check monthly as it will be incorporated into the monthly environmental checklist.	OT	Completed
Staff must be reminded of the importance of wearing their personal alarm at all times.	Safe and effective care	A meeting took place to look at all security issues with the security leads, email communication has been sent out to reiterate the importance of wearing an alarm and addressed in both ward staff meetings. Ward managers will check randomly to ensure alarms are being worn.	Security Leads / Ward Managers	Completed
The armchairs in the communal lounge on Alwen ward must be replaced.	Quality of patient experience	The armchairs are awaiting collection to be reupholstered. Estimated time scale for return is mid August	Hospital Director	15/08/22
The date of when packaged food is made by	Safe and effective care	The head chef will ensure that all food is labelled with use by date prior to coming onto the wards.	Head Chef/ Ward Managers	Completed

the hospital and its use by date must be labelled.		The process has been relooked at and incorporated onto a daily and night checklist to ensure food is labelled with 'use by date' and disposed of accordingly. The paperwork will be monitored and audited by ward mangers weekly, they will bring the paperwork on a Thursday to the quality assurance morning meeting to be reviewed by the senior management team.		
Medication Administration Record charts must be completed to a better standard.	Safe and effective care	All nurses attended safer administration of medication training in May 2022 delivered by Ashtons pharmacy. Check the checker for each shift has been implemented to ensure no missing signatures. The internal medication audit will be signed off weekly by ward managers and has also been incorporated into the quality assurance meeting on a Thursday to highlight any issues to the senior management team.	Lead Nurse/ Ward Managers	Completed
The service must engage with patients to identify ways of making all patients feel safe during their stay at the hospital.	Safe and effective care	On both wards there is a suggestion/concerns box which service users can use. Weekly community meetings take place that encourage all service users to address any concerns or dynamics of the ward. Nurses have been asked to incorporate	Ward Managers/ OT	20/07/2022

		the topic of 'feeling safe' in 1:1 sessions. OT have been asked to formulate a patient led audit focussing on 'feeling safe'.		
A policy must be developed to set out the requirements for the safe use of the Extra Care Areas on each ward.	Safe and effective care	The use of the extra care areas was discussed in clinical governance and have been de-commissioned and will no longer be utilised for patient care. The extra care areas will be reconfigured and there are ongoing discussions for this.	Hospital Director	Completed
The frequency and duration of therapeutic interventions must be documented in care and treatment plans.	Safe and effective care	Ward mangers are completing care plan audits for all service users. Lead nurse will be delivering care plan training to all registered staff.	Occupational Therapist/ Lead Nurse	14/07/22
Audit activities must be reviewed to ensure they are being completed appropriately and are effective in identifying errors and areas for improvement.	Safe and effective care	This has been addressed in local clinical governance. Audits have been added to the quality assurance meeting weekly on a Thursday to ensure audits are audited. The senior management team can act on anything identified. Check the checker has been implemented each shift to help improve identifying errors.	Senior Management Team	Completed

Efforts to recruit more permanent staff must be continued to reduce the proportion of agency staff working at the hospital.	Quality of management and leadership	An advert is on a local electronic billboard. An advertising board has been placed outside the hospital to encourage people to apply for positions. Head office continue to advertise all vacancies nationally on jobsites and relevant journals with incentives to join the company. The publication of the new HIW report may encourage applications. Agency staff are block booked for 3 months to ensure consistency and continuity of care; they are regularly encouraged to join the company.	Hospital Director	Ongoing

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): Louise Burrows

Job role: Hospital Director

Date: 24 June 2022