Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection (Unannounced)

Ty Gwyn Hall

Elysium Healthcare

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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**

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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 independent mental health inspection of Ty Gwyn Hall, Llantilio Pertholey, Abergavenny, NP7 6NY on the evening of 27 January and following days of 28, and 29 January 2020. The hospital is owned by Elysium Healthcare.

The following sites and wards were visited during this inspection:

- Ty Gwyn Hall
- Skirrid View
- Pentwyn House

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 lay 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 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 staff interacting with patients respectfully throughout the inspection.

Staff were positive about the support and leadership they received.

Patients had good access to education, psychology, occupational therapy and community activities.

Improvements are required in relation to medicines management and there were areas of the hospital where redecoration and refurbishment was required.

This is what we found the service did well:

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Patients were provided with a good range of therapies and activities
- Care and Treatment plans were completed in line with the Welsh Measure
- Established governance arrangements that provided safe and clinically effective care.

This is what we recommend the service could improve:

- Safe and effective medicines management
- Cleanliness and redecoration of some areas in the hospital.

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

3. What we found

Background of the service

Ty Gwyn Hall is registered to provide an independent mental health service at Ty Gwyn Hall, Llantilio Pertholey, Abergavenny, NP7 6NY.

Ty Gwyn Hall provides the following, as outlined in their conditions of registration:

- Ty Gwyn Hall (17 bed mixed gender rehabilitation unit)
- Skirrid View (15 bed mixed gender assessment unit)
- Pentwyn House (4 bed mixed gender step down unit)

At the time of inspection, there were 30 patients.

The service employs a staff team which includes a Hospital Manager, Clinical Service Manager, along with ward based multi-disciplinary teams (MDT) including a ward managers, charge nurses, occupational therapists and therapy support workers. The ward teams also had support from the hospital's responsible clinicians, psychologists, social workers, and activities coordinator.

The hospital employs a service support manager and a team of maintenance workers, catering staff and domestic staff. There is also a team of support services, housekeeping and administrative staff. The hospital is supported by the management and organisational structures of Elysium Healthcare.

There is a clear focus on physical healthcare at Ty Gwyn Hall, a physical health nurse had been appointed since our last visit who works closely with the MDT in managing the physical health and wellbeing of patients. Ty Gwyn Hall is also engaged with local community services which includes General Practice (GP) surgeries, dentists and opticians.

The service was first registered in January 2005.

Quality of patient experience

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

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

Patients we spoke to told us they were happy and receiving good care at the hospital.

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

Health promotion, protection and improvement

There was a range of health promotion, protection and improvement information and initiatives available to the patients at Ty Gwyn Hall which assisted in maintaining and improving patients' wellbeing. The lounge areas provided patients with a number of useful resources, such as board games, arts and crafts, and a vast selection of DVD's and books.

Patients in Skirrid View also had access to a beauty and pampering area in the lounge area. Patients in Skirrid View and Ty Gwyn Hall had access to gym equipment, however we saw an office cupboard located in the gym room in Ty Gwyn Hall, which seemed out of place. An alternative storage area for this cupboard should be found.

An activities co-ordinator also provided an outdoor fitness club, where patients participated in football, rounders and outdoor fitness sessions. At the time of our inspection the activities co-ordinator was off work. Some patients who spoke to us mentioned that activities during the day were limited. The registered provider should make sure that staff levels are flexible to deal with demands of changing circumstances in order to ensure activities are still available for patients during the day.

The occupational therapy staff who spoke with us were very enthusiastic about their roles and were keen to tell us about the activities they had planned in

conjunction with patients both within the hospital and in the local community. During our inspection we saw many examples of patients accessing the community to go shopping, swimming, visit the library and attend college courses.

At the time of our inspection the occupational therapists had no office space to work from, however plans were in place for long term service development at Ty Gwyn Hall which included a new occupational therapy building. The registered provider is requested to keep HIW informed of the developments to ensure that all ward environments will continue to reflect appropriate standards of in-patient provision.

Patients were able to access GP, dental services and other health professionals as required. Patients' records also provided evidence of detailed and appropriate physical assessments and monitoring. Staff had access to four designated hospital vehicles which enabled staff to facilitate patients' activities and medical appointments in the community.

Smoking was not allowed within the hospital buildings, however patients did have access to designated smoking areas located in the garden area.

Improvement needed

The registered provider must ensure the cupboard in the gym room of Ty Gwyn Hall is removed.

The registered provider should make sure that staff levels are flexible to deal with demands of changing circumstances in order to ensure activities are still available for patients during the day.

Dignity and respect

We noted that all employees; ward staff, senior management and administration staff, 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. We observed staff taking time to speak with patients and address any needs or concerns the patients raised, this demonstrated that staff had responsive and caring attitudes towards the patients.

It was also positive to note that staff had documented and understood individual patient preferences for interventions to manage their challenging behaviours. Through our conversations with patients and staff we were informed that, where

possible, these advanced preferences were followed which helped maintain patients' dignity and wellbeing.

Across the hospital there was clear evidence of staff practices and policies following the Least Restrictive Practices of Care. This contributed to maintaining patients' dignity and enhancing individualised care at Ty Gwyn Hall.

Each patient had their own bedroom. Patients were able to lock their bedroom doors which staff could override if required. The bedrooms provided patients with a high standard of privacy and dignity. The bedrooms offered adequate storage and patients were able to personalise their room with pictures and posters. Patients told us that staff respected their privacy and dignity. During the course of our inspection we saw many examples of staff knocking on patients doors before entering 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 phone. 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 or distract patients from participating in planned activities.

Patient information and consent

The hospital had a written statement of purpose and a patient information guide which was made available to patients and their relatives/carers.

On the wards, we saw advocacy posters which provided contact details about how to access the service. Advocacy information and registration certificates from Healthcare Inspectorate Wales were also on display along with information on the complaints process and how to raise a complaint. However there were also no bilingual posters or information displayed in Welsh within the hospital. Given that the service operates in Wales, arrangements should be made to provide information in Welsh.

Facilities were available for patients to spend time with family and friends; a visitor room was available, however there was limited information available for families and visitors in this room.

Improvement needed

The registered provider must ensure information on the hospital is available in the visitor's room for families and visitors.

The registered provider must ensure that information displayed in the hospital is also available in Welsh.

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff made sure they communicated appropriately and effectively with patients. Staff took time to undertake discussions using words and language suitable to each 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.

We frequently observed patients approaching a variety of staff from the multidisciplinary team, and it was praiseworthy to see staff take time out to speak to the patients irrespective of other commitments staff may have been dealing with at the time. The hospital manager was also observed talking to patients who responded well to him, evidencing that the hospital manager has spent time getting to know the patients on an individual basis, it was clear to see that the hospital manager was a familiar and friendly face to the patients.

We attended staff meetings and staff demonstrated a good level of understanding of the patients they were caring for. All patients spoken to, stated that they felt safe and able to speak with a staff member should they need to. There was clear mutual respect and strong relationship security between staff and patients.

There were a number of meetings that involved patients and staff, this included formal individual care planning meetings and group community meetings. We saw a variety of meeting records during our inspection which demonstrated that regular staff meetings were taking place and information was being shared amongst the teams.

Staff and patients told us about the patients' community meetings, this is a positive initiative to provide service users with a platform to discuss any issues or improvements they wanted to make at the hospital. We saw evidence of regular patient meetings and it was pleasing to hear staff and patients speaking about the patients' community meetings in a positive way. In addition a patient

representative was present in governance meetings. This demonstrated that the hospital governance structure was an inclusive process.

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

There was a clear focus on rehabilitation with individualised patient care that was supported by least restrictive practices, both in care planning and hospital practices.

We found that there was clear evidence of multidisciplinary involvement in patient care plans which helped support the hospital in being able to deliver comprehensive care to the patients.

Care plans were well structured, comprehensive, and detailed. Progress reports were also dated and signed by the patients. We also saw that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals

Each patient had their own individual weekly activity planner, this included individual and group sessions, based within the hospital and the community.

Equality, diversity and human rights

Staff practices aligned to established hospital policies and systems ensured that patients' equality, diversity and rights were maintained. 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 about their rights and entitlements whilst at the hospital.

Citizen engagement and feedback

There were regular patient meetings and surveys to allow for patients to provide feedback on the provision of care at the hospital. Information was also available to inform relatives and carers on how to provide feedback. We saw evidence of recent patient surveys and action plans demonstrating how the hospital was implementing improvements and changes based on the outcome of the patient survey.

There was a complaints policy and procedure in place. The policy provided a structure for dealing with all complaints within the hospital.

Complaints were categorised as informal and formal complaints. Informal complaints were logged on each ward within a paper document with formal complaints recorded on a computerised complaints log for the whole hospital.

A sample of informal and formal complaints established that an independent person was assigned to investigate the complaint and actions were taken in line with the organisation's complaints policy to ensure that complaints were dealt with appropriately at the hospital.

Complaints were also recorded in individual patient records along with the outcome of the complaint. The complaints process and associated actions were overseen by the hospital manager. Patients we spoke with also had knowledge and understanding of the complaints process.

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; however some areas were in need of redecoration and refurbishment.

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.

However, some improvements were required in relation to the management of medicines.

Managing risk and health and safety

Ty Gwyn Hall had processes in place to manage and review risks and maintain health and safety at the hospital. The hospital provided individualised patient care that was supported by least restrictive practices, both in care planning and hospital or ward practices.

Staff used radio communications which they could use to call for assistance if required. There were also nurse call points around the units and within patient bedrooms so that patients could summon assistance if required. We noted that staff did not have access to personal alarms and staff we spoke with told us that they would benefit from having access to personal alarms. The registered provider must review security provisions for staff at the hospital and consideration must be given for staff to have access to personal alarms.

The furniture, fixtures and fittings at the hospital were appropriate for the patient group. 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 these. There were weekly audits of resuscitation equipment, staff had documented when these had occurred to ensure that the equipment was present and in date.

Staff were able to report environmental issues to the hospital estates team who maintained a log of issues and work required and completed. We were informed that hospital estates team were responsive and made referrals to

contractors quickly when required. Throughout the inspection, we saw the estates team responding and undertaking maintenance work to rectify environmental issues.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system that included 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. Incident reports were automatically linked to the individual patient's electronic care notes which ensured that these were up-to-date.

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 Gwyn Hall.

The hospital had a business continuity plan in place that included the service's responses to such things as adverse weather, utility failures and outbreak of infectious disease.

On the first night of the inspection we noted that the toilet area near the reception on Ty Gwyn Hall was soiled and dirty. The laminate flooring in the corridor leading to the toilet also had a strong smell of urine. The remaining bathroom areas on Ty Gwyn Hall had some water stains and were in need of refurbishment. A number of refurbishments are due to commence at the hospital and we were told by the hospital manager that this included the toilet areas in Ty Gwyn Hall and the bathroom area in Skirrid View. However in the interim period the registered provider must ensure that the toilet areas in Ty Gwyn Hall is clean and do not smell of urine.

Improvement needed

The registered provider must review security provisions for staff at the hospital and consideration must be given for staff to have access to personal alarm.

The registered provider must ensure the toilet area in Ty Gwyn Hall is cleaned

and the area leading to the toilet does not smell of urine.

Infection prevention and control (IPC) and decontamination

Dedicated housekeeping staff were employed at the service. All communal areas of the hospital were visibly clean, tidy and clutter free. There was access to hand washing and drying facilities throughout the hospital. Staff had access to Personal Protection Equipment (PPE) when required.

A comprehensive system of regular audit in respect of infection control was in place. Daily audits were completed and filed accordingly. Staff confirmed that cleaning schedules were in place to promote regular and effective cleaning of the hospital and they were aware of their responsibilities around infection prevention and control.

Cleaning equipment was stored and organised appropriately. There were hospital laundry facilities available so that patients could undertake their own laundry with appropriate level of support from staff based on individual needs. The laundry facilities were very small and due to the limited space could not comfortably accommodate two people. This meant that it was extremely difficult for patients, who needed support, to use the facilities to do their own laundry. There was also no storage or shelving to store patient laundry items.

The registered provider must ensure there is sufficient storage space for patients clothing in laundry room.

There were suitable arrangements in place for the disposal of clinical waste. Appropriate bins were available to dispose of medical sharp items, these were not over filled. We did note that the medication bin in Skirrid View was full at the time of our inspection. The registered provider must ensure that the medication bin is emptied on a regular basis.

Improvement needed

The registered provider must ensure there is sufficient storage available to store patients' clean laundry.

The registered provider should consider a more suitable area for laundry facilities that provides sufficient room for patients to be supported in developing this important life skill as part of their rehabilitation programme.

The registered provider must ensure that the medication bin is emptied on a regular basis and not overfilled.

Nutrition

We found that patients were provided with a choice of meals. On Skirrid View a blackboard is updated on a daily basis with the day's lunch and tea choices. Patients are provided with breakfast, lunch, tea and supper every day. Patients said they choose what they want at the time and don't have to make their choice in advance. We were also told that patients with specific dietary needs are accommodated. Kitchen staff will regularly meet with patients to discuss their dietary needs and wishes and make every effort to meet their requirements. Patients told us of examples where they have requested alternatives and these had been provided.

In the dining room areas of the hospital, tea, coffee, milk and squash were freely available for patients. Patients also told us that they can buy and store drinks and snacks in their bedrooms. As well as the meals provided, patients were able to purchase food when out in the community and order take-away deliveries to the hospital.

Medicines management

Overall, we noted that medication was securely stored. All clinic rooms were locked to prevent unauthorised access, as were medication cupboards. The temperatures of medication fridges and clinic rooms were being monitored and recorded, to check that medication was stored within the appropriate temperature range. Medication trolleys were also secured to the clinic room, to prevent them being removed by an unauthorised person.

There were appropriate arrangements in place on the ward for the storage and use of Controlled Drugs and Drugs Liable to Misuse. Records viewed evidenced that twice daily checks were conducted with the appropriate nursing signatures certifying that the checks had been carried out. However, the signatures appeared to be only initials and it was not expressly clear which member of staff was actually certifying that checks had been carried out. There was no index on the front of records and there was no Doctor's registration number or nurse PIN number to assist in identifying the signature, therefore it was difficult to associate the initials with medical staff. The registered provider must make sure that all completed checks contain signatures that are easily identifiable.

During medication administration we noted that staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

The Medication Administration Records (MAR Charts)[1] reviewed were fully completed by staff. This included completing all relevant patient details on the front and subsequent pages, their Mental Health Act legal status, and all consent to treatment forms were present with the charts. During a review of some MAR Charts, we identified that some drugs had been discontinued, however it was not clearly highlighted that the drug was no longer required. The hospital must ensure that any prescribed medication that has been discontinued, is clearly crossed out, in line with safe medicines management and hospital policy

MAR Charts reviewed showed a range medication prescribed on the basis of individual needs and where medication was not administered the reason had been recorded appropriately. However we did identify two incidents where non-administration was due to the hospital awaiting delivery of the medication. The registered provider and pharmacy need to develop a more robust system for managing and ordering out of stock and emergency medication.

The pharmacist visits weekly and completes clinic room checks, audits medicines and provides a report to the hospital. This report is sent electronically and any issues are picked up. Through examination of this report we highlighted medication errors where prescription writing errors were recorded for both Skirrid View and Ty Gwyn Hall, these errors included some prescriptions not being signed or dated. The registered provider must ensure prescription writing is accurate to ensure staff and patients have access to the correct medication. The pharmacy report also evidenced and supported the medication charts inspected as detailed above where medicines were not administered due to them being out of stock. The registered provider must ensure the pharmacy activity report is reviewed and discussed at clinical governance and any issues identified are investigated accordingly. Appropriate training and management interventions should take place if any reoccurring themes or repeated errors occur.

[1] 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.

We also identified that the hospital were prescribing high dosages of anti-psychotic treatments, and were prescribing equasym[2]. We reviewed patients' records and also spoke with staff to gather evidence for their use and quantities prescribed. Following on from conversations with staff we were reassured by the reasons given for their use. We also spoke with the pharmacist who confirmed that a meeting was due to take place to discuss the issues we had raised. However the registered provider must make sure that the use and dosage of these drugs are rationalised, and the justification for usage is appropriately recorded in patient records. The registered provider must also make sure the hospital's medication policy is reviewed and updated.

Improvement needed

The registered provider must ensure that Controlled Drugs and Drugs Liable to Misuse are at all times accurately signed for and that the signature is identifiable to a staff member.

The registered provider and pharmacy need to develop a more robust system for managing and ordering out of stock and emergency medication.

The registered provider must ensure prescription writing is accurate to ensure staff and patients have access to the correct medication.

The registered provider must make sure that the use of high dosage anti-psychotic treatments and equasym are documented, justified and rationalised in patient records.

The registered provider must ensure prescription writing is accurate to ensure staff and patients have access to the correct medication.

The registered provider must ensure the pharmacy activity report is reviewed and discussed at clinical governance and any issues identified are investigated accordingly.

[2] Equasym a drug used to treat attention deficit hyperactivity disorder (ADHD)

Safeguarding children and safeguarding vulnerable adults

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. During discussions with staff they were able to demonstrate the process of making a safeguarding referral. Through conversations with the hospital manager it was evident that the hospital had built up a close working relationship with the local authority. This collaborative approach is key to effective safeguarding processes and demonstrated that the hospital placed a strong emphasis on safeguarding their patients. The hospital social worker took the lead on safeguarding processes, child contact/visiting arrangements and care planning.

Medical devices, equipment and diagnostic systems

Weekly audits of resuscitation equipment were taking place and staff documented when these had occurred to ensure that the equipment was present and in date. There is an emergency grab bag in the staff office on Pentwyn House, which is only used for the purpose of training. We did check this bag and noted that a number of items were missing from this bag. Staff are fully aware that this bag is used for training purposes only and that in an emergency staff can access an emergency bag on Skirrid View, however an emergency bag specifically for Pentwyn House, which is regularly checked and recorded, should be considered.

There were a number of ligature cutters located within all wards in case of an emergency. During staff discussions it was evident that all staff were aware of the locations of ligature cutters. There were up-to-date safety audits in place, including ligature point risk assessments. We identified that staff were carrying large bunches of keys which may impact their ability to quickly identify a key in an emergency situation. We would recommend that the hospital manager reviews this and identifies a solution where staff are not carrying large bunches of keys.

Improvement needed

The registered provider should consider a fully functioning emergency bag on Pentwyn House.

The registered provider must review the large bunch of keys carried by staff to make it easier for staff to identify keys in an emergency situation.

Safe and clinically effective care

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 Elysium Healthcare central governance arrangements, which facilitated a two way process of monitoring and learning.

Strategies were described for managing challenging behaviour to promote the safety and well-being of patients. We were told that preventative techniques were used and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the physical restraint of patients was used, but only as a last resort. We noted good evidence of the use of de-escalation techniques and recognition of triggers in the documentation we inspected. Debriefs take place following incidents and this process is used as a learning and reflective practice technique supported by psychology.

For every restraint or verbal de-escalation there is an incident form completed; the incident is then discussed at governance meetings and any lessons learnt are shared with staff.

Participating in quality improvement activities

Links with local colleges, leisure centres, and community initiatives ensured that patients had access to courses and activities, enabling patients to participate in meaningful activities during their time at the hospital. There were many examples of patients being involved in hospital walking groups and having access to outdoor activities in the hospital as well as in the community.

Information management and communications technology

The computerised patient record systems were well developed and provided high quality information on individual patient care. The system was comprehensive, and easy to navigate.

There were good electronic systems in place for incident recording, clinical and governance audits, human resources and other hospital systems, which assisted the management and running of the hospital.

Records management

Patient records were electronic and password protected to prevent unauthorised access and breaches in confidentiality.

We reviewed a sample of patient records across all wards. It was evident that staff from across the multi-disciplinary teams were writing detailed and regular entries which provided a live document on the patient and their care.

We saw that staff were completing care documentation and risk assessments in full.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients across Ty Gwyn, which included Ty Gwyn Hall, Skirrid View, and Pentwyn House.

All records were found to be compliant with the Mental Health Act (the Act) and the Mental Health Act Code of Practice for Wales (the Code). Robust systems of audit were in place for management and auditing of statutory documentation and the Act formed part of the clinical governance meetings. There were clear records of patients being informed of their statutory rights verbally and in writing, regularly throughout their detention.

Patients' detentions were reviewed within timescales at hospital managers' review panels. There was clear evidence of patients being invited to appeal through a formal processes and of being actively supported to do so through the Mental Health Act Administrators Office, advocacy services and the MDT who provided well written, comprehensive reports for these appeals.

All information for patients regarding the Act was in an easy to understand language, if necessary with visual, simple information which was relevant to the individual patient. Pictorial representation displayed on notice boards throughout the hospital in respect of the Act legislation was seen as good practice.

The Act administration was managed by an experienced Mental Health Act Administrator based at Ty Gwyn Hall, who is supported by a team of three staff on other Elysium sites in South Wales. They are also a member of the All Wales MHA Managers Forum (where issues and good practice regarding the Act is shared) that meet regularly through the year and provide an ongoing support network and body of knowledge.

Advocacy services were available and accessible to all patients.

There was clear compliance with the Second Opinion Appointed Doctor (SOAD) process, for example timescales and administration had improved significantly and this was evidenced through their audit process.

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

We reviewed the care plans of a total of six patients.

We reviewed a sample of care files and found that they were generally maintained to a good standard. Entries were comprehensive and recognised assessment tools were used to monitor mental and physical health.

There were comprehensive needs and risk assessments completed throughout the patient admission which directly linked to the plan of care and risk management strategies implemented on the wards. There was clear evidence of multidisciplinary involvement in the care plans which reflected the domains of the Mental Health (Wales) Measure.

Risk management plans were also personalised and identified potential triggers for patients, enabling staff to identify changes in behaviours. Management of patients' behaviours were reflected in their care plans and risk management profile, along with staff training to use skills to manage and diffuse difficult situations.

We saw evidence of comprehensive risk assessments on patients' records and in some cases we saw the development of positive behavioural support plans to help the patient identify their own needs and assist staff to identify and manage risk. These plans were updated as a minimum every three months but usually more regularly depending on assessment and needs which helped to identify changing behaviours and triggers.

It was really positive to see that care files clearly demonstrated patient involvement in care discussions which were patient focussed and signed by the patient. Overall, the nursing documentation viewed was very good and physical assessments were well completed.

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.

We observed a committed staff team who had a good understanding of the needs of the patients at the hospital.

Recruitment was undertaken in an open and fair process with appropriate employment checks being carried out prior to and regularly during employment.

The completion rates of training, managerial supervision and annual appraisals were very good.

There was dedicated and passionate leadership displayed by the hospital director who was supported by committed multidisciplinary teams. We found that staff were committed to providing patient care to high standards.

Governance and accountability framework

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

There was dedicated and passionate leadership displayed by the hospital director who was supported by committed multi-disciplinary teams. The team was a cohesive group of leaders and interviews with them demonstrated that they valued and cared for the staff and patients and were striving to make improvements at the hospital. It was pleasing to see that the quality assurance officer and hospital manager are introducing new ideas to make improvements to current working practices.

A number of new initiatives include the development and expansion of the hospital which includes new toilet and bathroom areas in Ty Gwyn Hall, a refurbishment of the communal bathroom in Skirrid View, and the new development which will include more accommodation and a new occupational therapy unit.

In addition at the time of our inspection Elysium Healthcare were delivering training to all staff on Safewards[3] model of care and a new staff induction programme was due to be implemented in March.

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 was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system that included 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 of 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. Staff told us that the hospital management team were approachable and visible and during interviews with staff they told us they had confidence to speak with management if they needed to raise issues or concerns. In addition, regular staff meetings were taking place which provided staff with opportunities to have discussions and share information amongst the teams.

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[3] Safewards - A new model of conflict and containment on Psychiatric ward.

Workforce planning, training and organisational development

We reviewed the mandatory training and clinical supervision statistics for staff at the hospital and found that completion rates were 85.5 %, we were assured that this area will be improved with the implementation of the new training programme. The electronic records provided the senior managers with details of the course completion rates and individual staff compliance details.

All staff had regular professional development meetings with senior management and we saw evidence of meaningful and relevant professional development discussions and plans which were documented in individual staff records.

There was a supervision structure in place and staff confirmed that they had regular supervision sessions. Staff also spoke positively about group supervision and reflective practice sessions.

Wellbeing days are held for staff and there were a number of staff initiatives introduced such as the Elysium star which provided staff and patients with an opportunity to nominate a staff member a star for recognition of good work. These staff initiatives demonstrated that the leadership team appreciated and invested in staff morale and wellbeing and valued the views and opinions of patients.

We found that staff were committed to providing patient care to high standards when we were present on the wards. Staff spoke positively about the leadership and support provided by the heads of care and hospital manager. It was clear to see through the meetings we attended that staff and patient ideas, and opinions were valued. A nominated member of health care support staff attended morning meetings and nominated patients were in attendance at governance meetings.

Staff and patients we spoke to told us that the hospital manager was approachable and had an open door policy. We saw many examples of patients and staff visiting the hospital manager's office throughout our visit. This demonstrated strong leadership and investment in staff and patients which sets standards for all staff to follow.

Staff we spoke with stated that the staffing levels were sufficient given the level of dependency at the time of the inspection. The hospital manager informed us that the staff rotas were planned in such a way to ensure that any short notice

staff absences were addressed without adversely affecting the level of service provided.

At the time of our inspection staff interviews were taking place for a newly developed senior lead nurse role, providing existing staff with opportunities to develop through the organisation. Health care workers also have a structured career path with different levels of responsibilities and pay scales.

A new care pathway had also been implemented with a step down house located in the community providing current patients with an opportunity to access recovery based community care whilst living independently. The hospital manager spoke of future plans to develop further community based housing for patients.

Workforce recruitment and employment practices

As highlighted in the information management section of this report, 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. Therefore we were assured that recruitment was undertaken in an open and fair process.

Newly appointed staff undertook a period of induction under the supervision of the heads of care. Staff showed us documentary evidence and talked us through the systems of induction in place at the hospital. We were also told of the new induction programme which will provide regional training on a four weekly basis for all new staff to attend. In addition, any current staff whose mandatory training will be due to expire will be able to attend specific modules on the induction course, meaning that staff mandatory training requirements should always be met.

The hospital had a clear policy in place for staff to raise any concerns and staff we interviewed had knowledge of the policy. Occupational health support was also available to 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.			

Appendix B – Improvement plan

Service: Ty Gwyn Hall

Date of inspection: 27 – 29 January 2020

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 the cupboard in the gym room of Ty Gwyn Hall is removed.	3. Health promotion, protection and improvement	The cupboard in the Ty Gwyn Hall gym will be removed	Hospital Director	31/03/2020
The registered provider should make sure that staff levels are flexible to deal with demands of changing circumstances in order to ensure activities are still available for patients during the day.	3. Health promotion, protection and improvement	The hospital will continue to monitor staffing levels daily through the use of Elysium Healthcare's "Safe Staffing" guidelines. Staffing will be flexed in line with day to day demands to ensure activities are available throughout the day. In addition we have appointed Activity	Ward Manager	20/03/2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Coordinating staff members by day, evening and weekends to ensure in house and community based activities are planned and facilitated.		
The registered provider must ensure information on the hospital is available in the visitor's room for families and visitors.	9. Patient information and consent	Information relating to the hospital will be placed in all visiting rooms to make accessible to Family and Friends	Hospital Director	31/03/2020
The registered provider must ensure that information displayed in the hospital is also available in welsh.	9. Patient information and consent	Where possible the hospital will ensure that information is available in both Welsh and English	Hospital Director	30/05/2020
Delivery of safe and effective care				
The registered provider must review security provisions for staff at the hospital and consideration must be given for staff to have access to personal alarm.	22. Managing risk and health and safety	Skirrid View Unit already has the provision of personal attack alarms as part of its existing Nurse Call System. We will arrange for a review of the system within Ty Gwyn Hall by an approved contractor and arrange installation of a Nurse Call System	Support Services Manager	June 30th 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure the toilet area in Ty Gwyn Hall is cleaned and the area leading to the toilet does not smell of urine.	12. Environment	that incorporates a personal alarm The cleaning schedule within Ty Gwyn Hall will be updated to increase the frequency of cleaning this area until refurbishment works can be completed.		
The registered provider must ensure there is sufficient storage available to store patients' clean laundry.	13. Infection prevention and control (IPC) and decontamination	The laundry area and system for managing patient laundry will be reviewed to allow for effective storage of clean laundry	Support Services Manager	30/04/2020
The registered provider should consider a more suitable area for laundry facilities that provides sufficient room for patients to be supported in developing this important life skill as part of their rehabilitation programme.	13. Infection prevention and control (IPC) and decontamination	The proposed new build, Occupational Therapy Unit incorporates two domestic washing machines/dryers within the Service user Kitchen area. When this is completed Service Users will be able to access this area to complete laundry as part of their rehabilitation programme.	Hospital Director	30/09/2020
The registered provider must ensure that the medication bin is emptied on a regular basis and not overfilled.	13. Infection prevention and control (IPC) and	The service contract for the medication bins will be reviewed and if necessary increased to	Support Services Manager	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	decontamination	ensure that a regular collection and disposal is completed.		
The registered provider must ensure that Controlled Drugs and Drugs Liable to Misuse are at all times accurately signed for and that the signature is identifiable to a staff member.	15. Medicines management	The NIC in charge will ensure that CD and DLM are signed accurately at the end of each shift. The Ward Managers will conduct a weekly check and report any issues to the Clinical Services Manager during weekly supervision meetings. In the case that specific nurses are failing to accurately record the use of DLM/CD medication they will be provided with supervision, training and ultimately face disciplinary action to improve performance. A copy of sample signatures and initial for all doctors and nurses will be placed on the individual MAR folders	Clinical Services Manager	31/03/2020
The registered provider and pharmacy need to develop a more robust system for managing and ordering out of stock and	15. Medicines management	All Registered Nurses will be provided with additional training via our Ashtons Pharmacy in the Ordering and storage of	Clinical Services Manager	31/03/2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
emergency medication.		medication. All Registered Nurse will be provided with additional training in the use of the ASHTONS pharmacy management folder The Clinical Services Manager will monitor any non-administration due to supply via the IRIS incident recording with a full investigation into any non-administration incidents. The Ward Manager will monitor the emergency medication within the grab bags on a weekly basis and report any discrepancies to the Clinical Services Manager to agree how this will be resolved.		31/03/2020 20/03/2020
The registered provider must ensure prescription writing is accurate to ensure staff and patients have access to the correct medication.	15. Medicines management	All prescriptions charts will be scrutinised by a second prescriber to check for accuracy when prescription charts are completed	All prescribers	31/03/2020
The registered provider must make sure	15. Medicines	The Responsible Clinician will	Responsible	31/03/20

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
that the use of high dosage anti-psychotic treatments and equasym are documented, justified and rationalised in patient records.	management	clearly document his rationale for treatment with these medications within the individuals care records.	Clinician	
The registered provider must ensure prescription writing is accurate to ensure staff and patients have access to the correct medication.	15. Medicines management	All prescriptions charts will be scrutinised by a second prescriber to check for accuracy when prescription charts are completed	All Prescribers	31/03/2020
The registered provider must ensure the pharmacy activity report is reviewed and discussed at clinical governance and any issues identified are investigated accordingly.	15. Medicines management	This is an identified item on our CG agenda, where actions plans are discussed on identified issues and followed up on to track progress	Clinical Services Manager	31/03/2020
The registered provider should consider a fully functioning emergency bag on Pentwyn House.	16. Medical devices, equipment and diagnostic systems	The hospital will procure a fully functioning Emergency Grab Bag for Pentwyn House	Hospital Director	20/04/2020
The registered provider must review the large bunch of keys carried by staff to make it easier for staff to identify keys in	16. Medical devices, equipment and diagnostic	An electronic key-safe will be purchased by the hospital that will enhance our ability to safely store essential keys within the service.	Ward Manager Senior Nurses	31/03/2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
an emergency situation.	systems	This will include a tracking device that will enable robust management of keys. In addition each of the current key bunches will be examined to identify and remove keys that are no longer required or can be held safely in another area.		

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): Shaun Cooper

Job role: Hospital Director