Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Priory and Partnerships in Care

Ty Cwm Rhondda

Cilliad and Clydwch Wards

Inspection date: 17, 18 and 19 April 2023

Publication date: 20 July 2023

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

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

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

Digital ISBN 978-1-83504-407-0

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 Ty Cwm Rhondda on 17, 18 and 19 April 2023. The following hospital wards were reviewed during this inspection.

- Cilliad Ward – 10 beds – Low Secure
- Clydwch Ward – 10 beds – Low Secure

Our team, for the inspection comprised of two HIW inspectors, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one patient experience reviewer. The inspection was led by 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:
Staff interacted and engaged with patients appropriately and treated patients with dignity and respect. We observed good therapeutic relationships between staff and patients but witnessed staff using inappropriate and unprofessional language in relation to challenging patient behaviours. Patients had their own programme of care that reflected their individual needs and risks but there were no Patient Status at a Glance Boards displayed on the wards at the time of our inspection. It was positive to find that patients, family and carers could engage and provide feedback on the provision of care at the hospital in a number of ways. However, it was unacceptable to note that the provision of Independent Mental Health Advocate (IMHA) services to the hospital was limited to weekly telephone contact from advocacy services and no on-site visits. Therefore, we were not assured that patients had access to an IMHA who can provide information and support with any issues they may have regarding their care.

This is what we recommend the service can improve:

- The hospital garden areas should be tidied and maintained for patient use
- The registered provider must reinforce the use of appropriate and professional language by staff and should consider providing values-based training for staff in respect of this
- The registered provider must ensure that Patient Status at a Glance information can be quickly and easily accessed by all staff without compromising patient privacy and confidentiality
- The registered provider must engage with advocacy services to ensure the provision of onsite Independent Mental Health Advocate visits for the patients at the hospital.

This is what the service did well:

- Patients had individualised activity timetables and the hospital provided a range of well-maintained facilities which supported patient health and wellbeing
- Patients spoke positively about their interactions with staff
- We found strong evidence that patients were regularly reminded of their legal status and rights.

Delivery of Safe and Effective Care

Overall summary:
We found that staff were committed to providing safe and effective care at the hospital. Overall, we were assured that the service had processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors. Patient Care and Treatment Plans (CTPs) were generally maintained to a good standard but improvements were required to ensure consistency in hospital record keeping processes. During the inspection it was concerning to find examples of outdated patient Positive Behaviour Support plans (PBSs) which had not been reviewed nor updated to reflect the current needs of the patients. The statutory documentation we saw verified that the patients were appropriately and legally detained. However, some improvements were required in respect of Mental Health Act governance oversight, audit processes and document completion.

This is what we recommend the service can improve:

- Measures must be undertaken to ensure that hospital emergency resuscitation equipment is regularly checked and in date
- The hospital records management systems must be reviewed to ensure that information is captured and recorded in a streamlined and consistent way to improve working practices and ensure that records can be accessed by all staff members
- The registered provider must implement a robust system of audit and governance oversight in respect of the MHA.
- The registered provider should conduct a review of patient s17 leave to ensure leave is personalised and tailored to the needs of individual patients and that patients, family and carers are involved in decision making processes
- The registered provider should conduct a review of patient CTPs and PBSs to ensure they contain all relevant information, are regularly reviewed and updated and are accessible to all staff
- Consent to treatment forms must be completed for all patients
- Mental Capacity Act assessments must be fully completed and regularly reviewed and updated.

This is what the service did well:

- Established processes and audits were in place to manage risk, health and safety and infection prevention and control
- Patient nutritional and hydration needs were assessed, recorded and addressed appropriately.

Quality of Management and Leadership

Overall summary:
The majority of staff who completed HIW questionnaires provided positive feedback about working at the hospital. Established governance arrangements were in place to provide oversight of clinical and operational issues. Most staff told us that they feel supported in their roles and satisfied with their organisational management. However, we were informed that the separate governance systems in place for clinical and hospital staff could sometimes cause communication difficulties between nursing staff, administrative staff and clinical staff. During the inspection we noted that there was no formal staff meeting process in place for staff to provide feedback on their experience at the hospital. We found that staffing levels were appropriate to maintain patient safety but there were several staff vacancies being recruited to at the time of our inspection.

This is what we recommend the service can improve:

- The registered provider should conduct further discussions with hospital staff to discuss ways to improve staff relationships, communication and working practices.
- The registered provider should provide additional training and governance oversight in relation to medications management, MHA and MCA document completion.
- The registered provider should undertake robust measures to progress the ongoing recruitment to vacant posts in the hospital
- The hospital should reintroduce a formal meeting process for staff in order to capture staff feedback and act upon any issues raised.

This is what the service did well:

- Overall staff mandatory training completion rates were high at 85.5 per cent

3. What we found

Quality of Patient Experience

We invited patients to complete HIW questionnaires to obtain their views on the service provided at the hospital. In total, we received seven completed questionnaires. Patient responses were mostly positive across all areas, with almost all patients agreeing that they felt safe in the hospital and all confirming that staff treat them with dignity and respect. Some of the questionnaire results appear throughout this 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 had physical health care plans which documented regular health screening. It was positive to find that hospital provided a weekly clinic which ensured that any ongoing health conditions were monitored by the practice nurse. Any relevant patient information discussed during the clinic was reported to the MDT for ongoing awareness. The hospital had strong supportive links with the local General Practice surgery which strengthened the quality of patient care provided by the hospital.

We found that the hospital had a full-time occupational therapist (OT) and two occupational therapy assistants to support the provision of therapies and activities. Patients had individualised activity timetables and the hospital provided a range of well-maintained facilities which supported patient health and wellbeing. This included a social "Piazza" area which had a patient shop and activities including a pool table for patient use. Patients had access to a computer room, art room and an occupational therapy kitchen. Patients could also use the hospital gym which offered a range of exercise equipment. Staff who completed our online questionnaire spoke positively of the service provided by the hospital. They told us:

"It's just a nice, well run, well organised and effective place to work and for the patients it appears to be 'a happy and comfortable and supportive placement'."

We noted that each ward had an outside garden area for patients but found that both gardens required some general maintenance to make them more pleasant and appealing. We saw a small pile of garden waste items in the Cilliad garden which should be removed. Some staff expressed that the hospital could make better use

of the outdoor facilities for patients. They were asked how the setting could improve the service it provides and told us:

"More meaningful use of the outdoor spaces could provide further opportunities for activities, such as a gardening club, or outdoor games in garden or on grounds where safe."

We recommend that the hospital garden areas should be tidied and maintained for patient use.
The registered provider should consider ways in which the outside spaces could be used to provide additional therapeutic activities for patients.

Dignity and respect
The registered provider's Statement of Purpose outlined how hospital staff supported patients to maintain their privacy and dignity. Each patient had their own en-suite bedroom which provided a good standard of privacy. We were told that patients could lock their rooms if they wished, but staff could override the locks if necessary. Staff always knocked before entering patient bedrooms which evidences their respect for patient privacy. Patients were able to store possessions and personalise their rooms as desired. Items that were considered a risk to patient safety were securely stored in individual patient lockers on each of the wards and patients could request access to them when needed.

All bedroom doors had observation panels and were covered by a small curtain which could be lifted to allow staff to undertake patient observations without opening the door. This minimised the risk of disturbing the patient and helped to maintain patient privacy and dignity. Staff also had access to a night light switch outside patient bedrooms which enabled them to safely carry out night time observations with minimal disturbance for patients.

Suitable visiting arrangements were in place at the hospital and there were designated areas which offered patients a higher level of privacy if needed. There were rooms on each of the wards where patients could make and receive calls in private. Some patients had access to mobile telephones so they could keep in touch with family and carers, depending on individual risk assessment.

Throughout the inspection we observed staff treating patients with dignity and respect. Staff took the time to speak with patients to understand their needs or any concerns the patients raised. Patients who we spoke to during the inspection and who completed our questionnaire confirmed that staff were polite, supportive, and helpful. It was positive to note that there were many long-serving permanent staff members at the hospital and it was clear that good professional relationships had been developed to support patient health and wellbeing.

However, we found that continued improvements were required in order to ensure the use of appropriate and professional language by staff members. During our previous inspection in 2022 we recommended that the registered provider must ensure that staff continued to have positive therapeutic relationships with patients and used appropriate language. During this inspection we again noted that staff showed a high level of familiarity with patients and referred to them as “mate” “pal,” or “chum.” We again heard staff referring to patient aggressive behaviours as “kicking off,” and we also heard staff describing a patient as being “clean off, day and night.” Whilst these latter comments were not made within the sight or hearing of patients, the language used was disrespectful and projected a negative image of the staff attitude to challenging patient behaviours.

The registered provider must reinforce the use of appropriate and professional language by staff and should consider providing values-based training for staff in respect of this.

Patient information and consent

During our tour of the wards it was concerning to find that there were no Patient Status at a Glance (PSAG) boards in the ward nursing offices. We were advised that the previous PSAG boards had been removed in order to protect patient confidentiality, as they could be seen from outside the office. Staff could only view patient status information by accessing the hospital computers. Regular staff members told us that they had a good overall awareness of patient status information owing to their length of service and familiarity with the patients. However, they agreed that any new, unfamiliar or agency staff members would not have ready access to this information as the hospital computers were password protected. We raised our concerns to staff regarding the importance of ensuring ease of access to patient status information for all staff.

The registered provider must ensure that patient status information can be quickly and easily accessed by all staff without compromising patient privacy and confidentiality.

The registered provider’s Statement of Purpose described the aims and objectives of the service. This document was up to date and contained all the relevant information required by the regulations. We found plentiful patient and carer information displayed on the wards in respect of health promotion, HIW, complaints processes and advocacy. We noted that the patient information was displayed predominantly in English but staff advised that the patient information could be made available in Welsh on request. During our tour of the hospital we found that some of the patient information displayed in the airlock areas of both wards was outdated.

The registered provider should ensure that patient information is kept up to date to provide clear guidance to patients and visitors.

Communicating effectively

We witnessed staff treating patients with respect and kindness throughout the inspection. Patients appeared confident in approaching staff to engage in discussions. The patients we talked to spoke positively about their interactions with staff and we saw examples of good practice which evidenced the effective communication between staff and patients in the hospital. Each ward had a nominated patient representative who acted as a point of contact and met with the ward manager to discuss any issues.

Daily handover and multidisciplinary meetings were held to discuss patient care requirements, upcoming activities within the hospital and other relevant information, such medical appointments. The service used digital technology as a tool to support effective communication by way of online meetings and electronic information sharing in order to ensure timely patient care.

We were told that one patient and one member of staff were Welsh speakers and that translation services were available when required. However, during our conversations with staff it was apparent that some staff members were unsure about how they could access the hospitals translation service processes if necessary.

The registered provider should ensure that the hospital offers language services that meet patient needs, and that all staff are aware of how they can access translation services.

Care planning and provision

During the inspection we reviewed the CTPs of five patients. The plans were person centred and each patient had a programme of care that reflected the needs and risks of the individual patients. We saw evidence that patients had been involved in the development of their care plans wherever possible. However, some improvements were required in respect of the completion and filing arrangements of patient care records to ensure consistency and staff awareness. More findings on the care plans can be found 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 an MDT 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 individuals that had been detained at the hospital under the Mental Health Act (the Act). The 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). We saw good evidence that patients were regularly reminded of their legal status and rights. Patients were provided with rights information leaflets and a staff information dashboard provided a reminder to staff about when patient rights were due.

The hospital had policies in place to help ensure that patients' equality and diversity were respected. It was positive to note that staff compliance with mandatory Diversity and Inclusion training was high at 85%. However, we noted that the hospital's Equality Diversity and inclusion Policy was out of date and had expired in 2022. It is important that policies and procedures are kept up to date and reviewed to support staff in their roles.

The registered provider must review the out-dated Equality Diversity and inclusion Policy to ensure the provision of clear and up to date guidance for staff.

Reasonable adjustments were in place so that everyone could access and use services on an equal basis. Easy Read documentation was available for patients if required. The hospital had doors, corridors and lifts could accommodate wheelchair access. Specialist equipment including hoists were kept on site for patients who would require use of them. Staff showed suitable regard for upholding patient rights and provided examples which evidenced their respect for individual patient preferences. However, during the inspection we did not find evidence of spiritual needs assessments being completed within the patient records.

The registered provider should ensure that patient spiritual needs assessments are completed in order to and promote inclusion and effective spiritual care.

During the inspection we were told that all patients had access to an Independent Mental Health Advocate who can provide information and support to patients with any issues they may have regarding their care. However, at the time of our inspection we found that the Independent Mental Health Advocate (IMHA) provision for the hospital was limited to just weekly telephone contact from advocacy services and there were no on-site advocacy visits. We discussed this matter with

staff who agreed that the hospital patients would greatly benefit from physical on-site visits by an IMHA.

The registered provider must engage with advocacy services to ensure the provision of onsite Independent Mental Health Advocate visits at the hospital.

Citizen engagement and feedback

We found strong evidence that patients, family and carers could engage and provide feedback on the provision of care at the hospital in a number of ways. A suggestion box was available to patients on both wards and the hospital held daily patient meetings where they could raise any concerns. During our discussions with staff we were told that family and carer surveys were conducted in order to gain their feedback and identify any improvements required. We saw good evidence that patient feedback was collated, recorded and discussed during Clinical Governance meetings at the hospital. A 'You said, we did' board was displayed on both wards to inform patients of changes made as a result of their feedback and we observed patients using the boards with staff during the inspection.

There was a complaints policy and procedure in place at the hospital and relevant information was displayed on the ward for patient awareness. We saw minutes of meetings which showed that staff were keeping patients informed of what actions had been taken in response to issues that had been raised. We reviewed a sample of complaints which evidenced that these were dealt with in line with the registered provider's policy.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
Overall, we were assured that the service 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 hospital entrances were accessible to everyone and were secured at all times throughout the inspection to prevent unauthorised access. The wards were split over two floors and lifts were available to assist people with mobility difficulties. Each ward provided a clean and comfortable environment for patients and the hospital environment was equipped with suitable furniture, fixtures and fittings for the patient group.

The hospital had a list of prohibited items and there were secure lockers for patient personal items on the wards. All staff carried personal alarms and radios and there were nurse call points around the wards and within patient bedrooms so that patients could summon assistance if required. Almost all patients who completed our online questionnaire told us they felt safe in the hospital. They told us:

"Staff try to keep the ward calm and safe"

A range of up-to-date health and safety policies were available for staff. There were established processes and audits in place to manage risk, health and safety and infection control. Ligature cutters were appropriately stored for use in the event of a self-harm emergency and we found up-to-date ligature point risk assessments in place at the hospital. During the inspection, we noted that the drain pipe clips within in the garden areas of the wards posed a ligature risk but were assured that patients did not use the gardens unsupervised. We further saw a gap at the top of a door frame in the communal bathroom on Cilliad which presented as a ligature risk for patients using the bathroom unsupervised. We raised this issue to staff and the door frame was repaired over the course of our inspection.

During our tour of the wards, we saw a plastic bag in the bin of the telephone room of Cilliad where patients made private calls whilst unsupervised. We recommended that the bag should be removed and the area risk assessed to prevent reoccurrence. This issue was resolved during the inspection.

We found an established electronic system in place for recording, reviewing and monitoring incidents. There was a hierarchy of incident sign-off which ensured that incident reports were reviewed and finalised in a timely manner. Incident reports

were produced and reviewed at hospital and organisation level so that appropriate lessons could be taken which encouraged shared learning. We found that incidents were appropriately recorded, reviewed and monitored to assist in the provision of safe care.

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. The training statistics provided by the registered provider evidenced a high level of staff compliance with their infection control training at 86.9 per cent.

The environment of both wards and the wider hospital was clean and uncluttered. Furniture and fixings were found to be in a good state of repair. Cleaning schedules were in place to promote regular and effective cleaning of the wards. The staff we spoke with seemed clear about their individual responsibilities in relation to infection control measures at the hospital.

Nutrition
We saw evidence that patients nutritional and hydration needs were assessed, recorded and addressed appropriately. Patients were assessed on admission using the Malnutrition Universal Screening Tool (MUST) and received weekly National Early Warning Score (NEWS) assessments. Care plans had been put in place to manage specific dietary needs where required. All patients received ongoing weight management checks and were supported to participate in a weight loss programme if necessary. Dietetic support was available to patients by GP referral if required.

Patients were able to access drinks and snacks on the wards and each patient had their own lockable cupboard to store their personal food items. We noted that the hospital had imposed a blanket restriction on caffeine for all patients but we did not see evidence of how this information was communicated to patients in the hospital. The service may wish to consider whether this practice continues to be appropriate in the long term.

We viewed the hospital's four-week rotational menu and found that patients were provided with a variety of meals in keeping with their nutritional and individual needs. We saw meals being served to patients which appeared to be hot, substantial and appealing. We were told that patients could contribute to menus and that any special requests were considered. Patients were able to feed back their suggestions and opinions to members of the catering team about the food at the hospital. We reviewed the minutes of recent patient meetings and found that

while a few patients had expressed dissatisfaction with the hospital food, most of the comments regarding the food were complimentary. Patients we spoke with during the inspection spoke positively about the food provided by the hospital.

Medicines management
Relevant policies, such as medicines management and rapid tranquillisation, were in date and were available to staff. We reviewed the hospital's clinic arrangements and found robust procedures in place for the safe management of medicines on each ward. The clinic rooms were clean, tidy and well organised. Medication fridges were locked when not in use. Daily temperature checks of the medication fridges and clinic rooms were being completed to ensure that medication was stored at the manufacturer's advised temperature. Appropriate arrangements were in place for the storage and safe use of controlled drugs and drugs liable to misuse. Drugs were stored securely and the records evidenced that stock was accounted for when administered and that stock checks were being undertaken.

We viewed a sample of Medication Administration Records (MAR charts) and found they were maintained to a good standard on both wards. There was evidence of regular medication reviews completed during ward rounds. We observed sensitive and appropriate prescribing of medication in accordance with patient needs. Some patients were supported to self-medicate, subject to the necessary risk assessments. We found that some patient medication dosages exceeded British National Formulary limits but were assured that they were prescribed in the best interests of the patient. We saw evidence that patients on high doses of medication were closely monitored and continuously reviewed with the aim of reducing the dosage in future.

During the inspection we witnessed a high use of the Mental Health Act emergency provisions for providing patient medication. We also found that the relevant forms were not well-completed when describing why these provisions had been used. We noted there were errors and omissions in a significant number of forms relating to one patient. We also saw examples of completed forms in which the medication administration route was not documented.

The registered provider should conduct a review of the hospital's use of urgent treatment under Section 62 of the Mental Health Act in order to ensure compliance with the Act and the full completion of relevant documentation.

During the inspection we generally found that Medication was provided to patients in line with Section 58 of the Act, consent to treatment. We found that completed consent to treatment certificates were well completed and stored with the corresponding electronic medication record. This meant staff administering medication could refer to the certificate to ensure that medication was prescribed

under the consent to treatment provisions within the Act. However, we found one patient record which indicated there had been a thirteen-day delay in the Responsible Clinician discussing and recording consent to the administration of medication for the patient concerned.

Discussions regarding consent to treatment must be conducted at the time of first administration of medication in accordance with the code of practice.

We further saw a patient record in which no consent to treatment form had been completed since the date of their admission on 5 April 2023, yet prescribed medication had been administered to the patient without the completed documentation in place. Whilst we were assured that the medication was administered in the best interests of the patient, we identified that this posed a risk to the patient and to any administrating staff member concerned. We raised our concerns with senior hospital staff who advised that clinical staff had mistakenly passed the responsibility for completing the form to an absent administrative staff member rather than the hospital's Mental Health Act Administrator, so the form was not completed. We also found that there was no direct governance oversight for the clinical staff team at the hospital, given that the regional clinical lead post was vacant at the time of our inspection.

In relation to this matter we advised staff that a consent to treatment form must be immediately completed for the patient concerned. We further advised that an audit must be conducted of all patient medical records to ensure there was no duplication of this error within the records of other patients. We recommended that robust additional governance oversight and preventative measures must be put in place to ensure shared learning and prevent reoccurrence of this error. Staff were receptive to our recommendations and the required actions were completed over the course of our inspection.

The registered provider must ensure that consent to treatment forms are fully completed for all patients at the hospital.

Safeguarding children and safeguarding vulnerable adults

A comprehensive safeguarding policy was in place and up to date. There were established hospital policies and processes in place to ensure that staff safeguarded vulnerable adults, with referrals to external agencies as and when required. Staff had access to the hospitals safeguarding procedures and showed awareness of the process of making a safeguarding referral. The hospital had an appointed safeguarding lead and kept a safeguarding log for continued monitoring of incidents, themes and trends. We saw evidence that safeguarding concerns were recorded and addressed appropriately in line with the registered provider's policy.

We viewed minutes of MDT and Clinical Governance meetings which evidenced that safeguarding was discussed as a standing agenda item to help identify any themes and lessons learned. Regional safeguarding meetings took place to share wider concerns across the service. Compliance among staff at the hospital with safeguarding training courses was high at over 85 per cent.

Medical devices, equipment and diagnostic systems
There were regular audits at the hospital and staff had documented when these had occurred to ensure that the equipment was present and in date. We saw evidence of weekly checks being undertaken on resuscitation and emergency equipment held on each ward. However, we noted that the test date for the defibrillator on Cilliad had expired in October 2022.

Measures must be undertaken to ensure that hospital emergency resuscitation equipment is regularly checked 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. Patient observations were conducted and recorded in line with hospital policy. We saw that risk assessments were being completed by nursing staff and reviewed by the MDT on a daily basis.

It was positive to find that the use of restrictive practices was a rare occurrence at the hospital and we were told that the last incident of patient restraint had occurred approximately nine months prior to our inspection. We saw that any use of restraint was documented in patient records and recorded on the corporate electronic system via Datix. We were told that debriefs take place with staff following incidents to reflect and identify any areas for improvement and points of learning.

Principles of positive behavioural support were being used as a primary method of de-escalation to manage challenging behaviour. During the inspection we saw examples of well-completed and person-centred Positive Behaviour Support plans (PBSs) which contained the appropriate amount of detailed information to support patient care. However, we also saw examples of PBS plans which were out of date and not regularly reviewed. On Cilliad we saw a PBS plan which was very out-dated and no longer relevant to the circumstances of the patient concerned. On Clydwch, staff were unable to locate the PBS of a patient and when it was eventually found we saw that it was dated 2021. We did not see evidence that patient PBS plans were routinely reviewed or updated. Therefore, we were not assured that the staff used PBSs as a basis to provide the most appropriate and effective care of patients. We discussed our concerns with staff who advised that they did not routinely update the PBS plans due to their high level of familiarity

with the patients. However, they agreed that new, unfamiliar or agency staff would not have awareness of the patient concerned and would not have ready access to the PBS plans.

PBS plans must be regularly reviewed, updated to reflect the current needs of patients and made accessible to all staff.

Records management
The hospital had an electronic health record system which was password protected. Information was being captured comprehensively but reviewing patient records was challenging as some of the information was recorded on electronic systems or in unofficial hospital shared drives, which appeared duplicative and confusing. During the inspection, we found that experienced staff members had difficulty in locating information from different hospital shared drives and there was a general lack of consistency in how the records were being kept in the hospital. Some regular nursing staff were not even aware of the existence of the shared drives at all. It was clear that any new or unfamiliar staff members would not be able to fully navigate the hospital records without considerable difficulty. As staff were not able to locate important hospital documentation during the inspection, we raised our concerns that this could impact on the safety of staff, patients and visitors at the hospital.

We recommend that the records management process must be reviewed to ensure that information is captured and recorded in a streamlined and consistent way, to improve working practices and ease of access for all staff. Additional training and robust supervision should be provided for staff in respect of this.

Mental Health Act Monitoring
Staff compliance with Mental Health Act (MHA) training was 78 per cent. We reviewed the statutory detention documents of four patients across both wards and spoke with staff to discuss the monitoring and audit arrangements in place. We found that patients were legally detained according to guidance and legislation. However, we were advised that there was no system of audit and governance oversight in place in respect of the MHA. During the inspection we were shown a MHA audit form which had not been completed since 2021. We also found that there were no governance processes in place which evidenced the hospital's appraisal of the competency of hospital managers in respect of the MHA.

The registered provider must implement a robust system of audit and governance oversight in respect of the MHA.

Measures must be taken to ensure the routine appraisal of hospital managers in respect of MHA administration.

Within some of the Mental Health Act records we found that historical documentation relating to the legal authority to transfer detained patients from one hospital to another under Section 19 of the MHA was missing. This meant that a full review of these particular records could not be completed during the inspection.

The service should provide robust administrative scrutiny of the detention history of patients to ensure that patient records contain all relevant historical documentation.

We saw that patient rights information was clearly documented with an assessment of patient understanding, in accordance with section 132 of the Act. Good systems were in place to support the automatic renewal of detention and we noted good practice in relation to recording the outcome of patient leave. During the inspection, we saw some evidence that Section 17 leave was used on a personalised basis. However, the leave allocation was the same for all patients at the hospital. Patients were granted Section 17 leave consisting of two one-hour leave periods, one ninety-minute leave period and one two-hour leave period per month. We saw evidence that this rigid format for leave allocation was restrictive in that it allowed patients to use leave for personalised therapeutic activities *instead of* their grounds leave, or for escorted community leave *instead of* their ninety-minute leave allocation.

Therefore, we were not assured that Section 17 leave was generally allocated to patients on an individual and personalised basis, nor that regular reviews were undertaken to increase or reduce the leave arrangements based on individual patient circumstances. In two of the patient records we saw evidence that patients had not been involved in determining the conditions and outcomes of their leave. In all four of the records there was no evidence of any family and carer involvement in this process.

The hospital should conduct a review of patient s17 leave to ensure leave is personalised and tailored to the needs of individual patients, and that patients, family and carers are involved in decision making process.

During our previous inspection of the hospital, we examined patient records and found that no entry had been made by the statutory consultees to record their views on the authorised medical treatment of patients. During this inspection we again found evidence that that no entries were made by the statutory consultees which recorded their views on the authorised medical treatment of patients.

We again recommend that the service must ensure that an entry is made in the patient records by each of the two statutory consultees which documents their views on the medical treatment authorised by the second opinion appointed doctor.

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

We reviewed five patient CTPs and found they were of good quality. On both wards the standard of care plan completion was good and the records reflected the domains of the Welsh MH measure. We found that patients received appropriate physical monitoring at regular intervals. We saw good evidence of risk assessment and management in place within the records, particularly in relation to patient leave arrangements.

However, we found that it was difficult to navigate the CTPs as the information was located within the hospital's electronic patient health record system, but also on unlinked hospital shared drives. The care plan documentation was completed to a high standard but the care notes generally did not provide a full reflection of the patient care records as they were recorded on different platforms. We further found a lack of additional and supporting information in the patient care notes platform which included the absence of pre-admission documents in some of the patient records we checked.

The registered provider must ensure that all relevant patient CTP information is transferred into patient care records so that care plans provide a full reflection of patient care and are easily accessible to all staff.

The registered provider should conduct a review of patient CTPs to ensure that all relevant information is included in accordance with guidance and legislation.

Mental Capacity Act and Deprivation of Liberty Safeguards

During the inspection we did not find any evidence of the hospital recording mental capacity assessments of patients in accordance with the Mental Capacity Act. We saw examples of patient admission forms in which the fields relating to mental capacity were left blank. We discussed this matter with staff who advised that they would conduct a full review of the hospital's ongoing assessment of patient capacity. We were advised that robust measures would be undertaken to ensure full compliance with the Mental Capacity Act.

The registered provider must ensure that mental capacity assessments are fully completed and regularly reviewed and update.

Quality of Management and Leadership

We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital. In total, we received 17 completed questionnaires. Staff responses were mostly positive across all areas, with almost all respondents recommending their mental health setting as a place to work and most 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
There were defined systems and processes in place to support the effective operation of the hospital to ensure that the hospital focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and established governance structures which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

We found staff were receptive to our views, findings and recommendations. Staff we spoke with were passionate about their roles and we saw examples of strong team working throughout our inspection. During the meetings we attended staff demonstrated that they cared for the patients and staff and valued their views and opinions on how to make improvements.

The majority of staff told us that they feel supported in their roles and satisfied with their organisational management. Staff spoke positively of the improved support available for clinical staff since the Priory Group merger had taken place. They told us:

"The service has had a challenging few years since the Priory Merger. Positively the last year has seen a number of negative and disgruntled colleagues move on. The service is now settling with staff reporting feeling more settled and less anxious.
Patients report positively about the service and their quality of life is much improved"

Most staff who we spoke to during the inspection and who completed our online questionnaire stated that senior managers were visible and that their immediate manager could be counted on to help with a difficult task at work. Most staff questionnaire respondents felt that senior managers were committed to patient care, however, a smaller number of respondents felt that the communication between senior management and staff was effective. During the inspection we

were told that there were separate governance systems in place for clinical and hospital staff and some staff identified a requirement for improved communication between nursing staff, administrative staff and clinical staff in the hospital.

The registered provider should conduct further discussions with staff to discuss ways to improve staff relationships, communication and working practices.

We noted that some staff showed a lack of awareness of clear lines of responsibility and supervisory ownership of administrative tasks, particularly in relation to the completion of consent to treatment documentation under the MHA.

The registered provider should undertake measures to strengthen its leadership and governance systems and provide additional training to ensure that staff are compliant with administrative hospital procedures.

We were further told that the current vacancy for a regional clinical lead post within the service resulted in reduced governance oversight for clinical staff in the hospital. Some staff told us they would like to formalise an aligned line management relationship with their sister hospital at Llanarth Court which they felt would improve working practices for staff.

The registered provider should conduct further discussions with staff to consider the implementation of a formal governance structure aligned with Llanarth Court Hospital.

Dealing with concerns and managing incidents
We found an effective governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care which supported improvements and shared learning from incidents and serious untoward events. There was an established electronic system in place for dealing with concerns and recording, reviewing and monitoring incidents. We were told that complaints, incidents and safeguarding issues at the hospital were discussed at clinical governance meetings and any learning was shared with all staff.

All staff who completed a questionnaire agreed that the hospital encourages staff to report errors, near misses or incidents and they would know how to report any concerns or unsafe practice.

During the inspection we noted that there was no formal meeting process in place for staff to provide feedback on their experience at the hospital. We discussed this with senior staff and were advised that their previous efforts to implement a meeting process was not well-attended so had been discontinued.

The registered provider should reintroduce a formal meeting process for staff in order to capture staff feedback and act upon any issues raised.

Workforce planning, training and organisational development
We found that staffing levels were appropriate to maintain patient safety within the hospital. Most staff we spoke to during our inspection and who completed a questionnaire agreed that there were enough staff at the hospital for them to do their job properly. All agreed that they were able to meet the conflicting demands on their time at work, but some staff told us that the use of unfamiliar agency staff put additional pressure on regular staff who were required to mentor and support the agency staff members on the wards.

At the time of our inspection, senior staff advised that there were vacancies for five registered nurses, two healthcare assistants and a full-time housekeeper at the hospital. Bank and agency staff were being used to cover any staffing shortfalls and we were advised that the hospital actively sought to block-book agency staff who were familiar with the hospital and the patient group wherever possible. We were told that the vacant posts were being recruited to but there had been some delays in respect of this.

The registered provider should undertake robust measures to progress the ongoing recruitment to vacant posts in the hospital.

During the inspection we reviewed the overall mandatory training statistics for staff at the hospital and found that completion rates were high at 85.5 per cent. All staff who responded to our questionnaire felt they had received appropriate mandatory and role-specific training to undertake their role. Staff were asked about any other training they would find useful to their role and told us:

"Sensory integration, Applied motor and Process skills assessment"
"Trainers course for RRIT and Mental Health First aider"

However, we noted that just 59.5% per cent of all staff at the hospital had received their annual appraisal.

We recommend that continued efforts must made to complete outstanding staff appraisals.

Workforce recruitment and employment practices
An appropriate staff recruitment, selection and appointment process was in place at the hospital. Prior to employment, external pre-employment checks were conducted which included enhanced Disclosure and Barring Service (DBS) checks.

Staff employment records were regularly reviewed by the registered manager to ensure that staff were fit to work at the hospital.

We were told that newly appointed permanent staff members received a week-long period of induction during which they were supernumerary to the usual staffing establishment at the hospital. During the induction period, new staff were allocated to a ward supervisor and completed their mandatory training and ward-based competencies under the guidance of an experienced staff member.

A whistleblowing policy was in place should staff wish to raise any concerns about issues at the hospital. The majority of staff who completed a HIW questionnaire agreed that the hospital takes positive action on health and well-being that they were aware of the occupational health support available to them as an employee.

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
We saw a gap at the top of a door frame in the communal bath room on Cilliad.	This posed a ligature risk for patients using the bathroom unsupervised.	We raised this issue to staff.	It was positive to note that this matter was rectified and the door frame was repaired over the course of our inspection.
We saw a plastic bag in the bin of the telephone room of Cilliad where patients made private calls whilst unsupervised.	The bag posed a risk to patients liable to self-harm.	We recommended that the bag should be removed and the area risk assessed to prevent reoccurrence.	This was resolved during the inspection and the bag was removed.
We saw a patient record in which no consent to treatment form had been completed since the date of their admission on 5 April 2023, yet prescribed medication had been administered to the patient without the completed documentation in place.	This posed a health and safety risk to the patient and also a risk to any administrating staff member concerned.	We advised staff that a consent to treatment form must be completed for the patient concerned. We further advised that an audit must be conducted of all patient medical records to ensure there was no duplication of this error within the records of other patients. We recommended that robust additional governance oversight and preventative measures must be put in place to ensure shared learning and prevent reoccurrence of this error.	It was positive to note that staff were receptive to our recommendations and the required actions were completed over the course of our inspection.

Appendix B - Immediate improvement plan

Service: Ty Cwm Rhondda

Date of inspection: 17-19 April 2023

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				

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):

Job role:

Date:

Appendix C - Improvement plan

Service: Ty Cwm Rhondda
Date of inspection: 17 - 19 April 2023

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 hospital garden areas should be tidied and maintained for patient use.	Health promotion, protection and improvement	The garden project had just begun at the time of inspection and it was recognised that due to the winter and particularly variable spring we had that this had been delayed. Garden project is well underway with patients, occupational therapy and maintenance all working together. Tomatoes have been planted and flower beds tidied. All are tended to during planned sessions and independently by the patients who have really enjoyed the recent weather that has enabled them to do this. Plans are to introduce a herb garden that can also be used by the catering team. We would also like to cultivate a larger vegetable patch which will be our autumnal project.	Juliette Merrett Ian Hickman Therapies Department	Initial projects completed however this is an ongoing project.
The registered provider should consider ways in which the outside	Health promotion,	The secure garden adjacent to Cilliad ward is used frequently	Juliette Merrett Therapies Department	30.07.23 to fully embed new

spaces could be used to provide additional therapeutic activities for patients.	protection and improvement	for combined activities. Inclusive of larger scale events. Summer Party is due to be held in August. In the interim we encourage use of the gardens for fresh air, basket ball, foot ball, gardening and walks. New timetables are being developed in line with making the most of the outdoor areas over the summer periods.	Rhiannon Davies Amanda Davies	timetables and make necessary purchases of additional items for the gardens,
The registered provider must reinforce the use of appropriate and professional language by staff and should consider providing values-based training for staff in respect of this.	Dignity and respect	Appropriate and professional language was addressed at the time of inspection. However reflective practices have focused around values based interactions, safe wards has been promoted and additional training needs identified and actioned.	Rhiannon Davies Amanda Davies Beatrix Hurlston-Shoeps	Complete
The registered provider must ensure that patient status information can be quickly and easily accessed by all staff without compromising patient privacy and confidentiality.	Patient information and consent	Patient information at a glance sheets were developed and implemented at the time of the audit. The information is updated by the charge nurses and printed for the observation folder.	Rhiannon Davies Amanda Davies	Complete
The registered provider should ensure that patient information is kept up to date to provide clear guidance to patients and visitors in the hospital.	Patient information and consent	Patient information that was displayed in the airlock was removed at the time of inspection. Request to remove the locked cabinets was made the month prior due to the	Mandy Ferguson Rhiannon Davies	Complete

		locks requiring replacement. Highlighted the importance of information being kept up to date and actions being followed through.		
The registered provider should ensure that the hospital offers language services that meet patient needs that all staff are aware of how they can access translation services.	Communicating effectively	Translation services are provided by Capita Translation & Interpreting services. Information has been cascaded to the staff team and posters printed for information boards.	Rhiannon Davies	Completed 24.04.23
The registered provider must review the out-dated Equality Diversity and inclusion Policy to ensure there the provision of clear and up to date guidance for staff.	Equality, diversity and human rights	Policy was Highlighted as under review on the Intranet. Completed by compliance team and cascaded for review	Legal & Compliance Rhiannon Davies	Completed 23.05.23
The registered provider should ensure that patient spiritual needs assessments are completed in order to and promote inclusion and effective spiritual care.	Equality, diversity and human rights	Spiritual needs and assessments are identified as part of the admission process. The importance of capturing this information was reiterated to the team to ensure needs are accurately reflected. The multi faith space on site is well maintained.	Juliette Merrett Amanda Davies Charge Nurses	Complete
The registered provider must engage with advocacy services to ensure the provision of onsite advocacy visits for the patients at the hospital.	Equality, diversity and human rights	Addressed at time of review and advocacy face to face visits resumed 26.04.23	NYAS Rhiannon Davies	Completed 26.04.23

The registered provider should conduct a review of the hospital's use of urgent treatment under Section 62 of the Mental Health Act in order to ensure full compliance with the Act and full completion of relevant documentation.	Medicines management	External to site compliance review conducted as discussed. Assurance provided by Hospital Director Divisional Lead to provide supervisory support in absence of regional medical director.	Dr Neetha Byrappa	Complete
Discussions regarding consent to treatment must be conducted at the time of first administration of medication in accordance with the code of practice.	Medicines management	With respect to the satisfactory completion of consent to treatment documentation in a timely manner and on admission this will be monitored by Hospital Director and the Mental Health Act administrator. Admission procedure reviewed to ensure that this is reflected as a prompt for completion.	Dr Neetha Byrappa Mental Health Act Administrator Rhiannon Davies	Complete
Consent to treatment forms must be fully completed for all patients at the hospital.	Medicines management	Discussed and addressed at point of inspection. Mental Health Act Administrator to continue to review accurately and Responsible Clinician (RC) to ensure documents are completed as required.	Dr Neetha Byrappa Mental Health Act Administrator	Complete
Measures must be undertaken to ensure that hospital emergency resuscitation equipment is regularly checked and in date.	Medical devices, equipment and diagnostic systems	1 x defibrillator had been missed during medical device annual service the month prior. JPEN medical contacted and machine has now been serviced and complete. Charge Nurses to ensure that checks are	Charge Nurses	Complete

		undertaken as required on the wards.		
PBS plans must be regularly reviewed, updated to reflect the current needs of patients and made accessible to all staff	Safe and clinically effective care	PBS plans are to be reviewed monthly as required – reiterated to team. Charge Nurses to monitor compliance MDT review to occur during planning week every 12 weeks.	Charge Nurses Amanda Davies Rhiannon Davies	Complete
The hospital's records management process must be reviewed to ensure that information is captured and recorded in a streamlined and consistent way to improve efficiency and ensure ease of access for all staff members. Additional training and supervision should be provided for staff in respect of this.	Records management	Feedback regarding care notes was provided via the healthcare data team. Reviewed process for PBS review and cascaded Departmental leads in process of streamlining shared drive	Rhiannon Davies Departmental Leads	August 23 – Shared drive
The registered provider must implement a robust system of audit and governance oversight in respect of the MHA.	Mental Health Act Monitoring	Mental Health Act Audit processes have resumed at Site. Procedural requirements have all been ratified.	Dr Neetha Byrappa Mental Health Act Administrator Rhiannon Davies	Completed
Measures should be taken to ensure the routine appraisal of hospital managers in respect of MHA administration.	Mental Health Act Monitoring	Raised as a concern to Head of Mental Health Act and Mental Capacity Act Operations for review and consideration – development of process for this to be uniform in terms of requirements across the group	Head of Mental Health Act and Mental Capacity Act Operations	Completed
The service should provide robust administrative scrutiny of the	Mental Health Act Monitoring	Mental Health act audit – re-implemented for use	Mental Health Act Administrator	Completed

detention history of patients to ensure that patient records contain all relevant historical documentation.		Missing document highlighted to regional lead where the patient was detained previously – confirmed the document could not be provided by the team. Recommended to contact community team for record.	Rhiannon Davies	
The hospital should conduct a review of patient s17 leave to ensure leave is personalised and tailored to the needs of individual patients, and that patients, family and carers are involved in decision making process.	Mental Health Act Monitoring	Discussed as SMT and requirement for interventions and leaves to be tailored & personalised agreed.	Dr Neetha Byrappa Multidisciplinary Team	Completed
We again recommend that the service must ensure that an entry is made in the patient records by each of the two statutory consultees which documents their views on the medical treatment authorised by the second opinion appointed doctor.	Mental Health Act Monitoring	Requirement of both consultees to document a record of the consultation has been reinforced. Mental Health Act Administrator will follow up in 24 hours if review has not been recorded.	Mental Health Act Administrator Consultees Rhiannon Davies	Completed
The registered provider must ensure that all relevant patient CTP information is transferred to patient care records so that care plans provide a full reflection of patient care and are easily accessible to all staff.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	In the absence of the medical secretary there has been an unfortunate delay in the uploading of complete minutes to care notes. All documentation is present on the shared drive. Medical secretary role has been recruited into and the uploading of information will improve as a result.	Dr Neetha Byrappa Multidisciplinary Team	Completed

		The necessity for all documentation for the relevant meetings being saved in the same place has been reiterated and agreed.		
The registered provider should conduct a review of patient CTPs to ensure that all relevant information is included in accordance with guidance and legislation.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	The process for handovers of information has now changed therefore information is drawn directly from care notes. As a result the information handed over will now be the same as what is recorded in the clinical entries. At time of inspection the handover document was separately completed.	Dr Neetha Byrappa Multidisciplinary Team	Complete
The registered provider must ensure that mental capacity assessments are fully completed and regularly reviewed and updated.	Mental Capacity Act and Deprivation of Liberty Safeguards	Discussed and addressed at point of inspection. Mental Health Act Administrator to continue to review accurately and Responsible Clinician (RC) to ensure documents are competed as required.	Dr Neetha Byrappa Mental Health Act Administrator	Complete
The registered provider should conduct further discussions with staff to discuss ways to improve staff relationships, communication and working practices.	Governance and accountability framework	Whilst the feedback was only reflective from a small pocket of staff as identified in the report, SMT have met to discuss how communication can be improved. Departmental leads have been given clear and concise guidance in the robust and consistent management of staff teams. Expectations of the wider team	Rhiannon Davies Departmental Leads	Complete

		have been conveyed during supervisions, group supervisions, face to face and via email to ensure continuity.		
The registered provider should provide additional instruction, governance oversight and improved communication in relation to medications management and consent to treatment.	Governance and accountability framework	Regional Medical Director has been appointed and will provide regional supervision for the medical team. Due to commence in post Sept 2023. In the interim support is being provided by Regional Forensic Clinical Director	Regional Forensic Clinical Director Dr Neetha Byrappa Rhiannon Davies	Complete
The registered provider should undertake measures to strengthen its leadership and governance systems and provide additional training to ensure that staff are compliant with administrative hospital procedures.	Governance and accountability framework	Bespoke training was identified prior to the review and attended	Rhiannon Davies	18.04.2023
The registered provider should conduct further discussions with staff to consider the implementation of a formal governance structure aligned with Llanarth Court Hospital.	Governance and accountability framework	The vacancy is not at Ty Cwm Rhondda Hospital. However Regional Medical Director has been appointed by Llanarth Court Hospital	Llanarth Court Hospital	13.06.2023
The registered provider should reintroduce a meeting process for staff in order to capture staff feedback and act upon any issues raised.	Dealing with concerns and managing incidents	Regional Medical Director has been appointed and will provide regional supervision for the medical team. Due to commence in post Sept 2023.	Regional Medical Director Regional Forensic Clinical Director	October 2023

		In the interim support is being provided by Regional Forensic Clinical Director		
The registered provider should undertake robust measures to progress the ongoing recruitment to vacant posts in the hospital.	Workforce planning, training and organisational development	Staff Meetings have historically not been well attended across the service when held independently. However, Supervisions and Clinical Governance remain well attended. Individual ward meetings have been implemented by Charge Nurses. Bi Monthly Site service meetings are due to commence - July 23 Quarterly General Site meetings have been advertised. – August 23	Rhiannon Davies Amanda Davies Helen Churches Departmental Leads	13.06.23 – with continuous and ongoing evaluation and review
Continued efforts must made to complete outstanding staff appraisals.	Workforce planning, training and organisational development	Recruitment has continued in to vacant posts. Vacancies in Site services no longer remain with staff fully appointed and commenced into these. Some clinical ward vacancies remain however recruitment, however 6 x Healthcare	Rhiannon Davies & Departmental Leads	13.06.23 – Ongoing process

		assistants appointed, 3 x registered nurses appointed to date.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative
Name (print): Rhiannon Davies
Job role: Hospital Director
Date: 16.06.2023