Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Aberbeeg Hospital

Bevan and Taliesin Wards

Elysium Healthcare Ltd

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Aberbeeg Hospital on 10, 11, and 12 July 2023.

The following hospital wards were reviewed during this inspection:

- Bevan Ward - 12 beds, providing low secure services
- Taliesin Ward – 15 beds, providing medium secure services.

Our team for the inspection comprised of two HIW Healthcare 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.

At the time of the inspection, the hospital was being managed by Elysium Health Care.

Where present, quotes in this publication may have been translated from their original language.

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:
Most patients who completed a HIW questionnaire rated the care and service provided by the hospital as very good. 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 patient group. Patients were provided with a range of therapeutic facilities and activities to support and maintain their health and wellbeing. Patients had access to a mental health advocate who provided information and support with any issues they may have regarding their care.

This is what we recommend the service can improve:

- The registered provider must review the hospital's outdated Statement of Purpose and Patient Guide to ensure they contain up-to-date and relevant information
- Patient information boards must be consistently completed for ongoing patient awareness
- The hospital's multifaith rooms must be tidied and maintained for patient use.

This is what the service did well:

- We found strong evidence that patients could engage and provide feedback to staff on the provision of care at the hospital
- The open nursing station on Taliesin ward strengthened the communication and therapeutic relationship between staff and patients.

Delivery of Safe and Effective Care

Overall summary:
Staff appeared committed to providing safe and effective care. We found an established electronic system in place for recording, reviewing and monitoring incidents but some information was not appropriately linked to patient records. The hospital's furniture, fixtures and fittings were appropriate for the patient group but the ligature audit for Taliesin ward was overdue which posed a potential risk to patient safety. We generally found suitable Infection Prevention and Control (IPC) arrangements in place but the carpets throughout Bevan ward did not support effective IPC and required replacement. The hospital had good multiagency

safeguarding relationships but measures were required to improve the level of detail recorded within hospital safeguarding reports. Staff compliance with mandatory Safe Therapeutic Management of Violence and Aggression (STMVA) training was high but we noted that a recent incident of patient restraint had involved a member of staff who was not compliant with their training.

This is what we recommend the service can improve:

- A PAT testing audit must be undertaken of all portable electrical goods to ensure the ongoing safety of patients, staff and visitors
- The service must ensure all staff are compliant with their STMVA training
- The service must ensure only staff who are compliant with their STMVA training undertake restrictive interventions to protect patients and staff from harm
- Information must be captured and recorded in a streamlined and consistent way within patient records to ensure efficiency and accessibility for staff
- The service must ensure Short Term Assessment of Risk and Treatability assessments and Positive Behaviour Support plans are completed for all patients to support patient care and safety
- Patient Care and Treatment Plans must be reviewed to ensure the patient voice is evident throughout.

This is what the service did well:

- The hospital had robust procedures in place for the safe management of medicines
- Patient photos were linked to their medication records which we noted as good practice
- The hospital's Mental Health Act (MHA) administrator demonstrated good governance oversight of patient MHA records.

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 but we found that some systems and processes were not aligned across the wards. Most staff told us that they felt supported in their roles and satisfied with their organisational management but that there was no formal, dedicated supervision process in place for staff. We found staffing levels were appropriate to maintain patient safety but there were several staff vacancies being recruited to at the time of our inspection. We reviewed overall mandatory training statistics for staff which indicated that

completion rates were high at 87 per cent. However, work was required to improve overall staff compliance with several mandatory training courses.

This is what we recommend the service can improve:

- The service must implement a dedicated and structured supervision process which ensures that staff supervision is conducted at regular intervals
- The service must standardise systems and processes throughout the hospital in order to share best practice and drive quality improvement
- The service must undertake robust measures to progress the ongoing recruitment to vacant posts in the hospital
- The service must support staff to complete all mandatory training courses and scrutinise training compliance on a regular basis to ensure compliance.

3. What we found

Quality of Patient Experience

We invited patients, family and carers to complete HIW questionnaires to obtain their views on the service provided at the hospital. In total, we received twelve completed patient questionnaires. Patient responses were mostly positive across all areas, with most patients rating the service as 'very good'. The majority of patients agreed that staff listen to them and treat them with dignity and respect. Most patients also agreed that staff provide care and treatment to them when needed. Some of the questionnaire results appear throughout this report.

Health promotion, protection and improvement
We looked at a sample of six 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 checks such as health screening. Long term health conditions were supported and managed appropriately. Patients were able to access GP, dental services and other physical health professionals as required.

The hospital provided patients with a range of therapy facilities which supported and maintained their health and wellbeing, including games, gym equipment, an occupational therapy kitchen and spacious garden areas. Since our previous inspection of the hospital, a patient led café had been constructed within the hospital grounds which further supported the provision of therapeutic patient activities. Almost all patients who completed a HIW questionnaire agreed that there were sufficient and appropriate recreational, social and educational activities available to them in the hospital.

The hospital employed a full-time occupational therapist (OT) and two occupational therapy assistants and we witnessed staff undertaking therapeutic activities with patients throughout the inspection. We were assured that there were comprehensive activity timetables in place for patients.

Dignity and respect
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 clear that good professional relationships had been developed to support patient health and wellbeing. Patients told us:

“Staff very helpful and supportive at all times”

“Staff are very kind and helpful and I have a nice room and my own music”

Each patient had their own en-suite bedroom which provided a good standard of privacy and dignity. Patients were able to store possessions and personalise their rooms with pictures and posters. All patient bedroom doors had an observation panel which enabled staff to undertake observations without having to open the door and potentially disturbing the patient. This helped maintain patient privacy and dignity. During the inspection we saw examples of staff respecting the privacy of patients by knocking their door before entering. Patients could lock their rooms, but staff could override the locks if required.

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.

It was positive to note that the newly built Taliesin ward provided an open nursing station which aimed to break down barriers and strengthen the therapeutic relationship between staff and patients by providing an environment without screens and windows. We were told the service was participating in a study which would analyse how this arrangement affected the staff and patient experience and share their findings on a national level. Staff and patients we spoke with during the inspection spoke positively about the open nursing station arrangements, stating that the environment was more relaxed and supported improved communication between staff and patients.

Patient information and consent
The registered provider’s Statement of Purpose described the aims and objectives of the service but was found to be outdated, with an expired review date of October 2022. Patients received a written information guide on their admission that included guidance on the Mental Health Act and how to make a complaint. However, the Patient Guide was also outdated in that it contained no reference to the newly built Taliesin ward which had opened in 2021.

The registered provider must review the hospital’s Statement of Purpose and Patient Guide to ensure they contain up to date and relevant information.

A Patient Status at a Glance board was located in the nursing offices on Bevan ward. The board was covered to protect patient confidentiality. On Taliesin ward,

staff accessed patient status information on the hospital's computer system due to the open plan layout of the nursing station.

We found sufficient patient information displayed in the communal areas of the wards regarding advocacy services, health promotion, the complaints process and legal representation for detained patients. HIW information was appropriately displayed but the contact details for HIW were incorrect and required amendment. We advised staff of this issue which was rectified during the inspection. We observed that patient information was predominantly only displayed in English but were informed that patient information could be made available in Welsh or other languages on request.

During our tour of the wards we saw that the patient information boards which provided details of the nursing staff on duty had been left incomplete on both wards. We discussed this matter with staff and the boards were fully completed over the course of the inspection.

Patient information boards must be consistently completed for ongoing patient awareness.

Communicating effectively

We witnessed staff communicating appropriately and effectively with patients 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 during their time at the hospital.

Daily staff meetings were held each morning to discuss upcoming activities within the hospital and the community and share other relevant information, such as patient activities and medical appointments. Patient representatives had been appointed to act as a point of contact for other patients to talk to about any issues they may have, which we recognised as good practice.

The hospital's rooms were bilingually signposted in Welsh and English and we were informed that Welsh speaking staff were identifiable to patients by lanyards. Translation services were available if required.

The service used digital technology as a tool to support effective communication. The majority of patients had access to their mobile telephones, depending on individual risk assessment.

Care planning and provision

During the inspection we reviewed the care plans of six patients. The care plans were person centred with each patient having their own programme of

care that reflected the needs and risks of the individual patients. 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.

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

Equality, diversity and human rights
During the inspection we looked at the patient records of four individuals that had been detained at the hospital under the Mental Health Act (the Act). 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 were told that all patients had access to a mental health advocate who visited the hospital once a week to provide information and support to patients with any issues they may have regarding their care.

We found that equality and diversity were appropriately promoted within the organisation. The hospital had policies in place to help ensure that staff and patients' equality and diversity were respected. Staff compliance with mandatory Diversity, Equality and Inclusion training was high at 95 per cent. The service participated in an overseas recruitment process which encouraged and supported diverse staffing. Staff demonstrated robust oversight and escalation of equality and diversity incidents which were discussed as a standing agenda item during clinical governance meetings. Reasonable adjustments were in place so that everyone could access and use the hospital’s services on an equal basis.

During the inspection we noted there were designated multifaith rooms for patient use on both wards but they were not decorated as such and were being used as general store rooms.

The multifaith rooms must be tidied and maintained for patient use.

Citizen engagement and feedback
We found strong evidence that patients could engage and provide feedback to staff on the provision of care at the hospital. The service held monthly patient meetings for patients to discuss any developments or concerns they may have. We saw minutes of such meetings which showed that staff were keeping patients informed of what actions had been taken in response to issues that had been raised.

On both wards there were suggestion boxes which invited patient feedback and a 'You said, we did' board which informed patients of changes made as a result of their feedback. We were told that the service conducted 'My care and Treatment' patient satisfaction surveys to help inform improvement activities. Patient suggestions were fed into clinical governance meetings which patients could also attend if required.

The hospital had a complaints policy and procedure in place that provided a structure for dealing with all complaints within the hospital. Staff we spoke to during the inspection described appropriate processes to record and investigate complaints and share learning across the service. We were informed that the hospital director oversaw the complaints process and any associated actions.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
Overall, we were assured that the service had systems in place to manage and review risks to help maintain the health and safety of patients, staff and visitors at the hospital. Each ward provided a clean and comfortable environment for patients and the hospital was equipped with suitable furniture, fixtures and fittings for the patient group. Almost all patients who completed a questionnaire told us they felt safe in the hospital.

The hospital entrances were accessible to everyone and were secured at all times throughout the inspection to prevent unauthorised access. However, we reviewed the June 2023 staff meeting minutes which indicated that the patio doors on the Bevan ward were partially loose due to recent damage. We noted that the matter had been raised with the maintenance team but the doors had not been repaired by the time of our inspection. We highlighted this issue to staff as a potential risk to patient safety and the doors were repaired prior to the end of our inspection.

The hospital had a list of restricted items and there were secure storage arrangements for patient personal items on the wards. There were nurse call points around the wards and within patient bedrooms so that patients could summon staff when required. Staff wore personal alarms and radios which they could use to call for assistance if necessary.

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. We were informed that daily health and safety checks were conducted by staff and noted that ligature cutters were located throughout the hospital for use in the event of a self-harm emergency. However, we found that the annual ligature audit for Taliesin ward was overdue and the ligature audits for both wards contained generic descriptions of response actions which were not bespoke to the risk concerned. We identified that this posed a potential risk to patient safety and raised this issue with staff who completed and amended the ligature audits appropriately during the inspection.

The hospital had an appointed health and safety lead and regular audits were being completed. We noted that the most recent health and safety audit report completed in June 2023 indicated that all the hospital's portable electrical items had been Portable Appliance Tested (PAT). However, during our inspection we

observed that three electrical items in the therapy kitchen had not been PAT tested. We alerted staff to this issue which was rectified during the inspection.

A PAT testing audit must be undertaken of all portable electrical goods to ensure the ongoing safety of patients, staff and visitors.

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

Infection prevention and control (IPC) and decontamination
We generally found suitable Infection Prevention and Control (IPC) arrangements in place at the hospital. The service had an appointed IPC lead. A range of up-to-date policies were available that detailed the various infection control procedures to keep staff and patients safe. Cleaning schedules were in place to promote regular and effective cleaning of the hospital. The training statistics provided by the registered provider indicated that overall compliance with mandatory level 1 Infection Control training was 83 per cent for clinical staff and 100 per cent for support staff. Overall compliance with level 2 Infection Control training was 78 per cent for clinical staff. Most patients who completed a HIW questionnaire agreed that the hospital was 'very clean' and that infection prevention and control measures were being followed.

We saw examples of good practice in relation to infection prevention and control. Patients were encouraged and supported by staff to practice good hand hygiene. Personal Protective Equipment was readily available for staff. Shared equipment and reusable medical devices were decontaminated appropriately. The patient laundry facilities were in very good order. However, we observed that the carpets throughout Bevan ward did not support effective IPC and required replacement. Staff told us they had requested replacement carpets for Bevan ward but advised there were several carpeted patient bedrooms and communal areas on both wards which caused them difficulties in relation to IPC.

The service must consider alternative flooring solutions for the wards to promote effective IPC.

During our tour of the hospital we viewed the hospital's therapy kitchen and found patient communal cereals being stored in unlabelled plastic containers so the date of opening/expiry could not be viewed.

Patient communal foods must be routinely checked and appropriately labelled to ensure patient safety.

We examined the hospital's refrigerator and freezer audits and identified gaps in the therapy kitchen monitoring checklist. We further noted that the hospital's refrigerator temperature monitoring forms included a section to indicate they had been checked and signed by a manager as being correct, but none of the forms we viewed had been signed.

The service must ensure that the hospital's refrigerator temperature monitoring forms are fully completed and signed by management to ensure patient safety.

Nutrition

We saw evidence that patients nutritional and hydration needs were assessed, recorded and addressed appropriately using the Malnutrition Universal Screening Tool (MUST). Care plans had been put in place to manage specific dietary needs where required. Patients received ongoing weight management checks during their stay.

There were suitable facilities available for patients to access hot and cold drinks and snacks throughout the day. 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. Patients could contribute to menu planning and were able to feed back their suggestions about the food at the hospital during their monthly community meetings.

All patients who completed a HIW questionnaire agreed that the food provided by the setting was good and met their dietary requirements.

Medicines management

Relevant policies, such as medicines management and rapid tranquillisation, were in date and 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. We saw evidence of good practice in that the service kept photos of patients alongside medication records which helped to prevent medication errors by unfamiliar staff. The MAR charts were consistently signed and dated when medication was prescribed and administered. Regular medication reviews were completed to ensure they continued to be appropriate. Consent to treatment certificates were well completed and stored with the corresponding electronic medication record. We observed sensitive and appropriate prescribing of medication in accordance with patient needs.

We were told that regular audits of the MAR charts were undertaken by an external, independent pharmacist to monitor ongoing compliance. An internal MAR chart audit process had been introduced on Taliesin ward, but we found there were some gaps within the check list.

We recommend that an internal MAR chart audit process must be implemented and consistently completed on both wards.

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.

The hospital had an appointed safeguarding lead and deputy. We were informed that the hospital had developed good working relationships with multi-agency partners such as the police and the local authority. We saw evidence that safeguarding concerns were recorded and referred to external safeguarding agencies in line with the registered provider's policy. However, we reviewed a sample of recent safeguarding reports and consistently found insufficient details had been recorded regarding sustained injuries and body mapping. We saw two records of a patient-on-patient assault described that a patient had sustained superficial injuries but there was no further information to clarify where exactly the injuries were physically sustained. Another report outlined that an assault had taken place but did not clarify whether any injuries had been sustained during the incident.

The service must ensure all relevant information is captured within safeguarding reports including injury details and body mapping.

We saw evidence that safeguarding concerns were addressed appropriately in line with the registered provider's policy. We viewed minutes of Clinical Governance meetings which evidenced that safeguarding was discussed to help identify any

themes and opportunities for shared learning. We reviewed recent Clinical Governance meeting minutes and noted that the hospital had conducted an internal safeguarding audit in March 2023 which identified that staff compliance with level 3 Safeguarding Adult and Children training was low at 55 per cent. At the time of our inspection we found that compliance among staff at the hospital with levels one, two and three Safeguarding Adults and Children Training courses was 78 per cent, 100 per cent and 70 per cent respectively.

The service must continue to improve staff mandatory safeguarding training compliance.

Medical devices, equipment and diagnostic systems
We saw evidence of regular auditing of resuscitation equipment. Staff had documented when these had occurred to ensure that the equipment was present and in date.

Safe and clinically effective care
The hospital had policies in place to help protect the safety and wellbeing of patients and staff. There was an established electronic system in place for recording, reviewing and monitoring patient safety incidents. The hospital's comprehensive daily meeting template ensured that any risks and concerns were routinely recorded, reviewed and addressed appropriately.

Principles of positive behavioural support were being used as a method of de-escalation to manage challenging behaviour. We were told that staff would observe patients more frequently in line with policy if patients continued to present with increased risks. We found patient observations were conducted and recorded in line with hospital policy.

During the inspection we saw examples of well-completed and person-centred Positive Behaviour Support plans (PBSs) on Taliesin that contained the appropriate amount of detailed information to support patient care. We noted that Taliesin staff kept a copy of patient PBSs with them for reference whilst conducting therapeutic observations, which we recognised as good practice.

On Bevan, we found some patients had no PBS plan in place. Where PBS plans had been completed, they were found to be of poor quality. The plans were not detailed, personalised to patients nor recovery focused. They did not contain sufficient information regarding individual patient triggers for challenging behaviour. Therefore, we were not assured that Bevan staff used PBSs as a basis to provide the most appropriate and effective and safe care of patients. We raised our concerns with staff who agreed that the quality of the Bevan patient PBS plans required significant improvement.

PBS plans must be implemented for all patients and regularly reviewed and updated to reflect their current needs and risks.

During our examination of patient records we saw that the Short Term Assessment of Risk and Treatability (START) tool had been implemented by nursing staff. However, the START forms were empty or partially completed across both wards. This prevented an accurate risk assessment of patient challenging behaviours and their responses to treatment.

START risk assessments must be fully completed to ensure the safety of patients, staff and visitors and to plan future care.

We saw that any use of restraint was documented in patient records and recorded on the corporate electronic system. This included details such as duration of the intervention and type of restraint used. We were told that debriefs take place with staff and patients following incidents to reflect and identify any areas for improvement and shared learning. Incidents of restraint were reviewed by the MDT during the daily morning meeting and discussed during monthly clinical governance meetings.

We reviewed a sample of recorded incidents of restraint and found that they had been appropriately recorded and addressed in line with policy. However, we noted that one recent incident of restrictive intervention had involved a member of staff who was not compliant with their Safe and Therapeutic Management of Violence and Aggression (STMVA) training. We were assured this was a spontaneous, standalone incident which had required the use of restrictive intervention to ensure the safety of staff and other patients. We discussed this issue with staff and highlighted the potential risk posed to staff and patients when non-compliant or untrained staff conduct patient physical interventions.

The service must:

- **Ensure all staff are compliant with their STMVA training**
- **Ensure only staff who are compliant with their STMVA training undertake restrictive interventions to protect patients and staff from harm.**

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 hospital shared drives which were not linked to the patient records. This appeared duplicative and confusing. Some examples of documents we viewed which were not linked to patient records included patient core assessments,

psychology records and one patient pre-admission assessment. It was clear that any new or unfamiliar staff members would not be able to fully navigate patient records without difficulty. We raised our concerns that this could impact on the safety of staff, patients and visitors at the hospital.

The service must ensure that information is captured and recorded in a streamlined and consistent way within patient records to ensure efficiency and accessibility for staff.

Mental Health Act Monitoring

We reviewed the statutory detention documents of four patients detained at the hospital. All records were found to be compliant with the Mental Health Act (MHA) and Code of Practice. The MHA documentation was well organised, easy to navigate and securely stored. The hospital's Mental Health Act (MHA) administrator demonstrated good governance oversight of patient MHA records to monitor compliance with national guidelines and review upcoming deadlines to ensure patient detentions remained lawful.

Comprehensive mental capacity assessments were being undertaken on patients upon admission and regularly reviewed. Patient rights information was clearly documented with an assessment of patient understanding, in accordance with Section 132 of the Act. Information about the section of the MHA under which patients were detained was provided to patients both verbally and in writing. Almost all patients who complete a HIW questionnaire agreed that they had been informed of their rights during their stay in the hospital.

Patient Section 17 leave forms included thorough risk assessments and were appropriately linked to the patients Care and Treatment Plan (CTP). However, within Section 32 and Section 17 documentation we found no documentary evidence of patient nor family/carer involvement. The Section 17 forms did not include a section where patients could sign to indicate their involvement, agreement and understanding in determining the conditions and objectives of their leave. Similarly, the Section 132 forms made no provision for patients to sign to indicate that they had read, discussed and understood their rights.

The service must ensure that Section 17 and Section 132 forms include a section to record patient, family and carer agreement and signature. Where patients refuse or decline, this should be recorded in the records.

It was positive to note that the MHA Administrator was in the process of completing a certificate in MH Law and was also a member of the All Wales MHA Administrators Forum. We were informed that MHA events were regularly arranged for staff to discuss issues and share learning across the service. We further noted

that all staff received mandatory Mental Health Act training. Overall Staff compliance with Mental Health Act Code of Practice training was 80 per cent.

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

We reviewed six patient CTPs and found they were of good quality and regularly reviewed. On both wards the standard of care plan completion was good and the records reflected the domains of the Welsh MH measure. We saw good evidence of risk assessment and management in place within the records. Entries were comprehensive and recognised assessment tools were used to monitor mental and physical health. Patients received appropriate physical monitoring at regular intervals.

Overall, the CTP records were well organised and easy to navigate with clear evidence of multidisciplinary involvement. Patients were offered the opportunity to be involved in the development of their care plans wherever possible. Where they refused, this was appropriately documented within the records. We saw evidence of discharge and aftercare planning and noted that patients and care co-ordinators had been involved in the process.

However, on both wards we noted that the patient voice was not well reflected within the documentation. We found inconsistencies in relation to the use of first-person narrative in the records we viewed. Where this was used to record the patient voice and point of view, professional language and clinical terminology was often evident.

The service must conduct a review of patient CTPs to ensure the patient voice is evident throughout.

Quality of Management and Leadership

Staff Feedback

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 twelve completed questionnaires. Staff responses were mostly positive across all areas, with all respondents recommending their mental health setting as a place to work and all agreeing that they would be happy with the standard of care provided for their friends or family. Most agreed that patient care is the organisation's top priority and that they were content with the efforts of the organisation to keep them and patients safe. They told us:

> *"I have felt valued and that my role is valued"*
>
> *"I am very satisfied and confident in my role. I also have trust in H.D and senior management, they are visible and able to access when required"*
>
> *"The hospital is a good place to work and puts the patients at the heart of everything that we do."*

Governance and accountability framework

Staff were receptive and responsive to our views, findings and recommendations. The staff members 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.

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 were defined systems and processes in place to support the effective operation of the hospital to ensure it focussed on continuously maintaining standards and improving its services. The service had recently introduced the Tendable audit platform to ensure consistent recording and governance oversight of hospital audits. Staff told us the new system will improve performance and working practices for staff by recording all hospital audits on one electronic platform in future.

However, during the inspection we found that the governance oversight, systems and processes of the two wards were not always aligned. Some examples of this

included ward-based audit processes and PBS completion as outlined previously in this report.

The service must standardise systems and processes throughout the hospital in order to share best practice and drive quality improvement.

All staff who completed our questionnaire agreed that their immediate manager could be counted on to help with a difficult task at work and gave them clear feedback on their work. The majority of staff told us that senior managers were visible and that communication between senior management and staff was effective. There were regular staff meetings for staff to raise and discuss any issues and provide feedback on their experience of working in the hospital.

However, during our inspection we found there was no formal supervision process in place for staff. We were advised that supervisors met with their staff on an ad hoc basis or when it was identified that additional supervision was required. Some staff told us they had not had any supervision during their time in the hospital. Whilst we were assured that supervisory staff and the senior management team were approachable to staff, it was clear that staff would benefit from a formal, structured supervision process which ensures that all staff receive equal, regular and appropriate supervision.

The service must implement a structured, dedicated supervision process and ensure that staff supervision is conducted at regular intervals.

During the inspection we viewed clinical governance meeting minutes which indicated that staff were using unoccupied patient bedrooms, visitors' rooms and the hospital's multifaith rooms to take their breaks. We discussed this issue with staff who advised there were few areas where they could take their breaks other than a small portacabin within the hospital grounds which provided insufficient space for them.

The service must consider the provision of additional areas for staff to take their breaks.

We noted that several service policies were out of date during our inspection. These included:

- Business Continuity – Review date expiry - March 2022
- Personal Safety and Security – Review date expiry - April 2023
- Search – Review date expiry - April 2022
- Document Retention – Review date expiry – June 2021.

The service must review any policies which are past review dates to support staff in their roles.

Dealing with concerns and managing incidents
There was an established electronic system in place for dealing with concerns and recording, reviewing and monitoring incidents. Regular incident reports were produced and reviewed at the hospital level, and at a corporate level, to help identify trends and patterns of behaviour. We were told that complaints, incidents and safeguarding issues at the hospital were discussed at clinical governance meetings, with any learning shared with all staff.

All staff who completed a HIW questionnaire said that they would know how to report unsafe practice and would feel secure raising concerns about patient care or other issues at their mental health setting.

Workforce planning, training and organisational development
We found staffing levels were appropriate to maintain patient safety within the hospital. Staffing numbers were high at the time of our inspection as the service was able to temporarily draw on additional resources from a closed sister hospital in the local area. However, we noted a high number of unfilled permanent staff vacancies in the hospital including five Health Care Support Workers, one Registered Mental Health Nurse, one psychiatrist and one psychology assistant. We were told that bank and agency staff were usually used to cover any staffing shortfalls and the hospital actively sought to block-book agency staff who were familiar with the hospital and the patient group wherever possible.

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

Most staff whom we spoke with during our inspection and who completed a questionnaire agreed they could meet the conflicting demands on their time at work and that they had adequate materials, supplies and equipment to do their job. Over half who completed a questionnaire felt that there were enough staff to do their job properly, but others disagreed. They told us:

> *“"Safe Staffing" levels are not enough. There are never enough staff to complete daily tasks and activities with patients. More so there aren't enough staff to respond to incidents that may arise and require physical intervention, especially at night.”*

In addition to the existing job vacancies in the hospital, staff told us that the service would greatly benefit from an additional supervisory staff member within its organisational structure, since the construction of Taliesin ward. We were told

that the recruitment of an additional senior staff member would reduce the high workload and responsibilities of current supervisory staff members and allow them more time to perform their ward-based duties. The service may wish to conduct further discussions with staff in respect of this.

During the inspection we reviewed the overall mandatory training statistics for staff at the hospital and found that completion rates were high at 87 per cent. Most staff who responded to our questionnaire felt they had received appropriate mandatory and role-specific training to undertake their role. However, some staff outlined they would like more classroom-based training and the service may wish to hold further consultations with staff in respect of this. They told us:

> *"Training is far too reliant on e-learning, which is unengaging and tedious. Nothing new can be learned from the courses which remain the same year after year. Now that covid restrictions are over, it would benefit all staff and employers for training to be classroom based, as being able to discuss subject matter with a tutor and people from other departments and setting offers better opportunities to learn new and relevant information and is far more engaging that reading screens of text that don't change from one year to the next."*

During the inspection we viewed the hospital's overall mandatory training compliance figures and found that overall staff compliance with the following training courses required improvement:

- Basic Life Support training - 68 per cent
- Security - 69 per cent
- Safe Administration of Medicines level 2 – 60 per cent
- Epilepsy Awareness - 74 per cent
- National Early Warning Score - 70 per cent
- Oliver Mcgowan Training - 71 per cent
- Safeguarding Adults and Children Levels 1 and 3 – 78 and 70 per cent
- Infection Control Level 2 – Clinical Staff - 78 per cent.

The service must ensure staff are supported to complete mandatory training courses and that training compliance is scrutinised on a regular basis by senior management to ensure compliance.

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 to ensure that staff were fit to work at the hospital.

We were told that newly appointed permanent staff members received an off-ward two-week period of induction followed by a week-long ward-based induction during which they were supernumerary to the usual staffing establishment at the hospital. During the induction period, new employees were overseen by supervisory staff and completed a ward-based competencies booklet under the guidance of an experienced staff member. We were told that staff who were recruited by the hospital's overseas recruitment programme received an additional four-week induction before they commenced the hospital induction process.

A whistleblowing policy was in place should staff wish to raise any concerns about issues at the hospital. All staff who completed a HIW questionnaire agreed that their job is not detrimental to their health and most felt that their organisation takes positive action on health and wellbeing. All staff agreed 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 reviewed the June staff meeting minutes which indicated that the Bevan ward patio doors were loose due to recent damage but had not been repaired by the time of our inspection.	This posed a potential risk to patient safety.	We raised our concerns to staff.	The patio doors were repaired prior to the end of our inspection.
The annual ligature audit for Taliesin ward was overdue and the ligature audits for both wards contained generic descriptions of response actions which were not bespoke to the risk concerned.	This posed a potential risk to patient safety.	We raised our concerns to staff.	The ligature audits were amended and completed prior to the end of our inspection.
During our inspection we observed that three electrical items in the therapy kitchen had not been PAT tested.	This posed a potential risk to staff and patient safety.	We raised our concerns to staff.	The items were PAT tested prior to the end of our inspection. A recommendation for a full hospital PAT testing audit has been made in respect of this issue.

Appendix B - Immediate improvement plan

Service: Aberbeeg Hospital

Date of inspection: 10,11 and 12 July 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 non-compliance concerns about patient safety were identified during the inspection				

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: Aberbeeg Hospital

Date of inspection: 10, 11 and 12 July 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 registered provider must review the hospital's Statement of Purpose and Patient Guide to ensure they contain up to date and relevant information.	Patient information and consent	The senior team have reviewed and updated the statement of purpose.	Jessica Wilson	Completed 21.08.2023.
Patient information boards must be consistently completed for ongoing patient awareness.	Patient information and consent	Monthly ward quality walk rounds include the patient information boards. The most recent one took place on 18th August. This will take place monthly.	Jessica Wilson	18.08.2023 and every month hereafter.
The multifaith rooms must be tidied and maintained for patient use.	Equality, diversity and human rights	Both multifaith rooms have been cleared of unrelated content and transformed into a more appropriate environment that also consists of a laptop computer so that patients can access their faith community by zoom or teams.	Kelly Dorning Joanne Harris	Completed.

A PAT testing audit must be undertaken of all portable electrical goods to ensure the ongoing safety of patients, staff and visitors.	Managing risk and health and safety	All outstanding PAT testing has been completed. The maintenance department has a log to ensure PAT testing is up to date. All new equipment is PAT tested before use.	Stephen J. Smith	Completed.
The service must consider alternative flooring solutions for the wards to promote effective IPC.	Infection prevention and control (IPC) and decontamination	Contractors on site 22.08.2023 to measure up for new vinyl and carpet fitting.	Jessica Wilson & Peter Jones	Completed.
Patient communal foods must be routinely checked and appropriately labelled to ensure patient safety.	Infection prevention and control (IPC) and decontamination	The kitchen manager will ensure all the food labelling in the patient communal area is up to date and correct.	Ruechenda Herd	Completed.
The service must ensure that the hospital's refrigerator temperature monitoring forms are fully completed and signed by management to ensure patient safety.	Infection prevention and control (IPC) and decontamination	Fridge temperature checks have been added to the quality walk round that is completed monthly.	Jessica Wilson	Completed.
An internal MAR chart audit process must be implemented and consistently completed on both wards.	Medicines management	A weekly audit will take place lead by the charge nurses on each ward. A new audit template	Natalie Tetley	Completed.

		has been implemented for weekly completion.		
The service must ensure all relevant information is captured within safeguarding reports including injury detail and body mapping.	Safeguarding children and safeguarding vulnerable adults	Any minor cuts or abrasions will be captured on the body map attached to the Duty to Report forms. If there is significant injury, we would take photographs and attach. Staff will be made aware during safeguarding training that a body map needs to be included if there are injuries sustained as part of the Duty to Report form.	Richard Reese	Completed.
The service must continue to improve staff mandatory safeguarding training compliance.	Safeguarding children and safeguarding vulnerable adults	Ward managers will ensure that staff have adequate protected time to complete mandatory training. This will be demonstrated on the rota system.	Jessica Wilson Joanne Harris Kelly Dorning	This is a rolling action which has commenced.
PBS plans must be implemented for all patients and regularly reviewed and updated to reflect their current needs and risks.	Safe and clinically effective care	Weekly primary nurse session with patients will focus on the PBS plan.	Charge nurses and ward managers.	01.10.2023
START risk assessments must be fully completed to ensure the safety of patients, staff and visitors and to plan future care.	Safe and clinically effective care	Monitoring of the dashboards and allocating the out of date START to the relevant MDT team member.	Sharon Ruck supported by ward managers.	01.10.2023

		Continue to roll out START training by the lead psychologist. The first date for training is Monday 25th September and the second is Friday 13th October.		
The service must: Ensure all staff are compliant with their STMVA training. Ensure only staff who are compliant with their STMVA training undertake restrictive interventions to protect patients and staff from harm.	Safe and clinically effective care	The morning meeting has an extra category to sign off to ensure the ward managers are fully aware of any staff not compliant in STMVA on shift.	Jessica Wilson	Completed.
The service must ensure that information is captured and recorded in a streamlined and consistent way within patient records to ensure efficiency and accessibility for staff.	Records management	All preadmission information is uploaded onto carenotes and can be found on the "core info tab – pre admission."	Jessica Wilson	Completed.
The service must ensure that Section 17 and Section 132 forms include a section to record patient, family and carer agreement and signature. Where patients refuse or	Mental Health Act Monitoring	The Mental Health Act administrator will conduct an audit on monthly basis to ensure this is evident in the care notes and that the patient voice is heard.	Diane Williams	Completed.

decline, this should be recorded in the records.				
The service must conduct a review of patient CTPs to ensure the patient voice is evident throughout.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	Ward managers will supervise staff individually to ensure that the patient voice is recognisable and written in the first person in the CTP document.	Kelly Dorning &Joanne Harris	All CTPs to be conducted in this manner from now on. This process will be completed by end of December 2023.
The service must implement a structured, dedicated supervision process and ensure that staff supervision is conducted at regular intervals.	Governance and accountability framework	Following every supervision, the lead administrator will be informed that supervision has taken place. A spread sheet will be updated once the written record has been submitted to admin for filing.	Callie Jones Jessica Wilson	Completed.
The service must standardise systems and processes throughout the hospital in order to share best practice and drive quality improvement.	Governance and accountability framework	Assistance from the Welsh Regional Quality Assurance lead has been sought to assist with audit and training for the electronic audit platform Tendable. This will contribute to a more consistent overview of quality improvement with action plans attached to each audit.	Jessica Wilson Katerina Pasztorova	In process. Completed by October 2023
The service must consider the provision of additional areas for staff to take their breaks.	Governance and accountability framework	Planning permission has been sought and architect plans drawn up to convert an outbuilding into	Jessica Wilson	Planning permission dependent, the building work will be

		a staff area, which will have shower facilities and rest and recreation facilities.		completed in June / July 2024.
The service must review any policies which are past review dates to support staff in their roles.	Governance and accountability framework	Business Continuity – to be finalised by 10 October 2023 Personal Safety and Security – 6 December 2023 (date of quarterly Health and Safety meeting where policy will be approved) Search – to be finalised by 10 October 2023 Document Retention – to be finalised by 10 October 2023	Jessica Wilson	December 2023.
The registered provider must undertake robust measures to progress the ongoing recruitment to vacant posts in the hospital.	Workforce planning, training and organisational development	• Target recruitment of second- and third-year student nurses to the Elysium Preceptorship vacancies • Provide a clear and formal career pathway which supports both managerial and clinical progression • Support and develop nurses throughout their career pathway, utilising existing systems in	Jessica Wilson and central recruitment team Elysium	Refresh efforts that have been on going. To end once fully recruited.

		Elysium Healthcare such as preceptorship, clinical and managerial supervision, appraisals, and revalidation • Increase research activities by encouraging our nurses to be active in research at all levels • Seek out support from the central recruitment and retention team that Elysium has and attend job fairs and recruitment initiatives.		
The service must ensure staff are supported to complete mandatory training courses and that training compliance is scrutinised on a regular basis by senior management to ensure compliance.	Workforce planning, training and organisational development	Mandatory training will form part of managerial supervision and a plan for protected time off ward to complete all required training. Local clinical governance group will review the training compliance and add an action plan each month as required.	Jessica Wilson	01.10.2023

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): Jessica Wilson

Job role: hospital Director/registered manager
Date: 22.08.2023