Independent Mental Health Service Inspection (Unannounced)

Ty Gwyn Hall

Elysium Healthcare

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

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

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care
Promote improvement:	Encourage improvement through reporting and sharing of good practice
Influence policy and standards:	Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection of Ty Gwyn Hall, Llantilio Pertholey, Abergavenny, NP7 6NY on the evening of 5 October and following days of 6 October, and 7 October 2021. The hospital is owned by Elysium Healthcare. The following sites and wards were visited during this inspection:

- Ty Gwyn Hall
- Skirrid View
- Skirrid Annexe
- Pentwyn House

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

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

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

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

2. Summary of our inspection

We found a dedicated staff team that were committed to providing a high standard of care to patients.

We observed staff interacting with patients respectfully throughout the inspection.

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

Staff were positive about the support and leadership they received.

However some improvements are required in relation to mandatory training compliance.

This is what we found the service did well:

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Patients were provided with a good range of therapies and activities
- Established governance arrangements that provided safe and clinically effective care.

This is what we recommend the service could improve:

- Some areas of medicines management
- Review location of ligature cutters
- Staff usage of alarms and radios
- Completion of some mandatory training
- Review and update of policies.

3. What we found

Background of the service

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

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

The service compromises of four wards

- Ty Gwyn Hall - 17 bed mixed gender rehabilitation unit
- Skirrid View Main - 12 bed mixed gender assessment unit
- Skirrid View Annex - 3 bed mixed gender assessment unit
- Pentwyn House - 4 bed mixed gender 'step down' unit.

At the time of inspection, there were 33 patients at the hospital.

The service was first registered in January 2005.

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

The hospital employs a service support manager and a team of maintenance workers, administrative staff, catering staff and domestic staff. The management and organisational structures of Elysium Healthcare support the hospital.

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

Quality of patient experience

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

We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed staff interacting with patients respectfully throughout the inspection.

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

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

Health promotion, protection and improvement

Ty Gwyn Hall had a range of facilities to support the provision of therapies and activities along with regular access to the community for patients that were authorised to leave the hospital. However, due to the restrictions of the COVID-19 pandemic, patients have been accessing leave less frequently following government and organisational guidance.

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

Patients in Skirrid View and Ty Gwyn Hall had access to gym equipment and a tuck shop had been set up for patients to purchase snacks and essential items. The lounge areas provided patients with a number of useful resources, such as board games, arts and crafts, and a vast selection of DVD's and books.

We observed that patients on the wards were involved in a range of activities throughout the inspection. These activities included arts and crafts, board games, reading books and watching TV. We also observed patients playing football and participating in fitness classes. Patients also had access to the spacious hospital grounds.

At the time of our inspection the occupational therapists had no office space to work from. However, plans were in place to build a new occupational therapy eco pod in the garden area. The registered provider is requested to keep HIW informed of the developments to ensure that all environments will continue to reflect appropriate standards for in-patient provision.

Improvement needed

The registered provider should keep HIW updated on progress made on the occupational therapy eco pod.

Dignity and respect

We noted that all employees: ward staff, senior management and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients. We observed staff taking time to speak with patients and address any needs or concerns the patients raised; this demonstrated that staff had responsive and caring attitudes towards the patients.

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

We noted that there were no vision panels on the bedroom doors, which enable staff to do observations without opening doors and disturbing patients' sleep. The registered provider must ensure that staff are able to check on patients with minimal disruption and put an appropriate solution in place.

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

Hospital policies and the staff practices we observed, contributed to maintaining patients' dignity and enhancing individualised care at the hospital. There were regular ward meetings to review and discuss practices to minimise the restrictions on patients based on individual patient risks.

Improvement needed

The registered provider must ensure that they consider options on ensuring staff can check on the well-being of patients in their bedrooms with minimal disruption.

Patient information and consent

A patient information guide is available to patients and their relatives/carers, along with the hospital's written statement of purpose. We saw advocacy posters that provided contact details about how to access the service. Registration certificates from Healthcare Inspectorate Wales and information on how to raise a complaint were on display.

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

Ty Gwyn Hall had suitable rooms for patients to meet ward staff and other healthcare professionals in private. Representatives from the advocacy service were visiting patients, and in addition patients were able to contact a representative of the statutory advocacy service either by telephone or making an appointment to speak to a representative which would be facilitated via video calls.

Communicating effectively

All patients we spoke with stated that they felt safe and able to speak with a staff member should they need to. Patients told us they were happy at the hospital and that staff were kind and helpful. There was clear mutual respect and strong relational security between staff and patients.

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

We frequently observed patients and staff engaged in activities together. The hospital director and clinical director were also observed talking to patients who responded well to them both, evidencing that they had spent time getting to know

the patients on an individual basis. It was clear to see that the hospital director and clinical director were familiar and friendly faces to the patients.

There were a number of meetings involving patients and staff. These meetings included formal individual care planning meetings and group community meetings.

Care planning and provision

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

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

We saw evidence that monthly multidisciplinary reviews were being undertaken with patients fully involved in the process. We also saw that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals. Our findings showed clear evidence of multidisciplinary involvement in the care plans; this helped support the hospital in being able to deliver comprehensive care to the patients.

Equality, diversity and human rights

Established hospital policies and systems ensured that patients' equality, diversity and rights are maintained. Mental Health Act detention papers had been completed correctly to detain patients at the hospital.

Due to Welsh Government restrictions associated with COVID-19 legislation, visitors were not allowed on to the hospital wards. However, some patients could meet with family and friends within the spacious hospital grounds, or depending on individual risk assessments, patients and families could meet in the community. Other patients could maintain contact with family and friends by telephone and video calls.

Facilities were available for patients to spend time with family and friends; a visitor room was available when government restrictions eased.

Citizen engagement and feedback

There were regular patient meetings and surveys to allow for patients to provide feedback on the provision of care at the hospital. Information was also available to inform relatives and carers on how to provide feedback. We saw evidence of

recent patient surveys and action plans demonstrating how the hospital was implementing improvements and changes based on the outcome of the patient survey.

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

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

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

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

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

We found that staff were completing clinical processes and documentation as required.

There were established processes and audits in place to manage risk, health and safety and infection control. This enabled staff to continue to provide safe and clinically effective care.

Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation.

Managing risk and health and safety

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

We were told that staff used radio communications which they could use to call for assistance if required. However during our inspection we noted that a number of staff were not using radios or personal alarms. The registered provider must review security provisions for staff at the hospital and ensure that all staff are using staff radios and alarms to support staff and patient safety on the wards.

There were also nurse call points around the units and within patient bedrooms so that patients could summon assistance if required.

The furniture, fixtures and fittings at the hospital were appropriate for the patient group. Staff were able to report environmental issues to the hospital estates team who maintained a log of issues and work required and completed. We were informed that hospital estates team were responsive and made referrals to contractors quickly when required.

It was positive to see that a number of areas around the hospital were being redecorated at the time of the inspection, and lots of improvements had been made to the environment since our last inspection. A new kitchen had been fitted in Skirrid Ward and new flooring was being fitted in the lounge area. In addition the bathroom near the reception area in Ty Gwyn Hall had been refurbished.

Although some refurbishments were ongoing there were still some areas of the hospital that required improvements, for example the flooring in the bedrooms in Ty Gwyn Hall were worn making the bedroom areas untidy.

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

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

Ligature cutters on Skirrid ward are located in the nurse's office in locked room accessed only by one key. This breaches the Elysium policy we viewed and doesn't allow quick access to ligature cutters for all staff. The registered provider needs to review the location of ligature cutters so that all staff can have access in an emergency situation.

There were weekly audits of resuscitation equipment; staff had documented when these had occurred to ensure that the equipment was present and in date.

Improvement needed

The registered provider must continue to make improvements to environmental areas of the hospital

The registered provider must ensure that all staff are using radios and personal alarms

The registered provider must ensure that ligature cutters are available and accessible to all staff.

Infection prevention and control (IPC) and decontamination

A system of regular audit of infection control arrangements was described. This was completed with the aim of identifying areas for improvement so that appropriate action could be taken where necessary. Staff confirmed that cleaning schedules were in place to promote regular and effective cleaning of the hospital. Staff were aware of their responsibilities around infection prevention and control and staff were observed undertaking cleaning duties effectively.

The hospital was clean, tidy and organised. Cleaning equipment was stored and organised appropriately. There were hospital laundry facilities available so that

patients could undertake their own laundry with an appropriate level of support from staff based on individual needs.

We saw evidence to confirm that Ty Gwyn Hall conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands of the COVID-19 pandemic. Staff we spoke to were aware of infection control obligations. We also examined COVID-19 documents, which had been produced to support staff and ensure that staff remained compliant with policies and procedures. On the first night of the inspection staff demonstrated that they were compliant with COVID-19 protocols for visitors and ensured that the inspection team complied with the hospitals procedures.

Ty Gwyn Hall had areas set aside where if a patient became symptomatic, they could be isolated and barrier nursed in their bedroom within a protected area. Additional cleaning schedules were also in place. None of these areas were in use at the time of inspection because there were no symptomatic cases.

Regular communication via meetings, information boards, and emails ensured everyone has up to date advice and guidance on COVID-19.

During our discussions, no issues were highlighted in relation to access to Personal Protection Equipment (PPE). PPE, including masks and gloves were available at the ward entrance and bins were provided for the disposal of equipment. Staff were wearing masks in communal areas and on the ward.

There were suitable arrangements in place for the disposal of clinical waste. However on Skirrid Ward, safety lids were not closed on sharps boxes and not all tracking labels had been filled in.

The sharps boxes were also being stored on the floor making them easy to knock over. Safety lids must be closed and stored appropriately to prevent injury and harm. Tracking labels must be filled in prior to first use, and completed when the bin is full to ensure appropriate and safe tracking at the point of disposal.

Improvement needed

The registered provider must make sure that sharps boxes are stored appropriately and that the tracking label is completed correctly.

Nutrition

We found that patients were provided with a choice of meals. On Skirrid View a blackboard is updated on a daily basis with the day's lunch and tea choices. However patients told us that the blackboard is not always updated.

Patients are provided with breakfast, lunch, tea and supper every day. Patients said they choose what they want at the time and don’t have to make their choice in advance. We were also told that patients with specific dietary needs are accommodated. Kitchen staff will regularly meet with patients to discuss their dietary needs and wishes and make every effort to meet their requirements. Patients told us of examples where they have requested alternatives and these had been provided.

Patients also told us that they can buy and store drinks and snacks in their bedrooms. As well as the meals provided, patients were able to purchase food when out in the community and order take-away deliveries to the hospital.

Improvement needed

The registered provider must ensure that the chalk board menu is updated on a daily basis.

Medicines management

Medicines management on each of the wards was safe and effective. Medication was stored securely within cupboards and medication fridges were locked. There was regular pharmacy input and audit undertaken that assisted the management, prescribing and administration of medication at the hospital. There was also a process in place if emergency medication orders were required.

There was evidence that there were regular temperature checks of the medication fridge and clinic rooms to ensure that medication was stored at the manufacturer's advised temperature. However we noted three missing dates for fridge temperature recordings in September 2021. The registered provider must ensure that fridge temperatures are recorded and are maintained within the required range to ensure that medication is stored at the correct temperature.

There were appropriate arrangements in place on the ward for the storage and use of Controlled Drugs and Drugs Liable to Misuse. Records we viewed evidenced that twice-daily checks were conducted with the appropriate nursing signatures confirming that the checks had been carried out.

We observed a number of medication rounds, and saw that staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

The Medication Administration Records (MAR Charts)[1] reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages, their Mental Health Act legal status and all current consent to treatment forms were present with the charts.

It was positive to note from the records we reviewed that we did not see any excessive use of antipsychotic or PRN[2] medication, and when PRN was used, the reasons were recorded in patient records.

We identified that there were a number of outdated medication policies, specifically, safe storage, control and administration of medication policy which had expired in September 2020 and the rapid tranquilization policy had expired in July 2021. We were not assured that staff were obtaining or being provided with the most up to date guidance to direct their professional practise. The registered provider must make sure that all policies are updated and reviewed.

Improvement needed

The registered provider must ensure that fridge and clinical room temperatures are recorded on a daily basis

The registered provider must ensure that all clinical policies are reviewed and updated.

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

[1] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

[2] PRN Medication is administered as and when required as opposed to medication administered at regular times

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

Medical devices, equipment and diagnostic systems

There were regular clinical audits undertaken at the hospital and 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

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

Clinical governance arrangements for the hospital fed through to Elysium Healthcare central governance arrangements, which facilitated a two way process of monitoring and learning.

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

When restraint or verbal de-escalation are used there is an incident form completed; the incident is then discussed at governance meetings and any lessons learned are shared with staff. Debriefs take place following incidents and this process is used as a learning and reflective practice technique supported by psychology.

The hospital director spoke passionately about least restrictive practice being used at the hospital. The hospital director encouraged and ensured that all staff worked with patients towards maintaining a least restrictive model of care at the hospital.

During the review of hospital's figures for physical intervention, these figures reflected that physical intervention is used infrequently at the hospital. This

demonstrated that the use of least restrictive model of care was being used effectively at the hospital creating a safer and calmer working and therapeutic environment for both staff and patients.

Participating in quality improvement activities

During our discussions with the hospital director we were provided with numerous examples where they were reviewing the service provision and looking to develop some aspects of the hospital. At the time of our inspection there were a number of ongoing improvements being made across the hospital site. In addition to the new eco pod for occupational therapies, areas of the hospital were being decorated at the time of the inspection.

Information management and communications technology

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

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

Staff we spoke with told us that the WIFI access was problematic and often delayed some of their work when updating electronic documents. The hospital director assured us that this issue had been escalated and a new broadband connection was being fitted in November.

Improvement needed

The registered provider must ensure that staff have adequate WIFI to enable them to carry out their duties efficiently.

Records management

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

It was evident that staff from across the multi-disciplinary teams were writing detailed and regular entries that provided a live document on the patient and their care.

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

Mental Health Act Monitoring

We reviewed the statutory detention documents of five patients; all records were found to be compliant with the Mental Health Act and Code of Practice.

Electronic documents on the ward and paper records were stored securely and held in the Mental Health Act administrator's office. The records we viewed were well organised, easy to navigate and contained detailed and relevant information.

Robust systems of audit were in place for the management and auditing of statutory documentation. We also noted that Mental Health Act compliance forms part of the clinical governance meetings.

All staff have Mental Health Act training as part of the induction programme and specific mental health training is part of staff mandatory training modules. The Mental Health Act Administrator is also member of the All Wales Mental Health Act Forum.

All patients are provided with information relevant to their section on admission and patients are introduced to the Mental Health Act Administrator. In addition, the patients' rights are discussed with them on a monthly basis. There was clear compliance with the Second Opinion Appointed Doctor (SOAD) process, for example, timescales and administration had improved significantly and this was evidenced through their audit process.

Through examination of patient section 17 leave forms we highlighted that there was no information to indicate patient involvement or agreement with the conditions of leave, or if the patient had been offered a copy of the leave form. The registered provider must ensure that there is a place on the section 17 leave form to indicate if patient agrees and if they have been offered a copy of the form.

Improvement needed

The registered provider must ensure that there is a place on the section 17 leave form to indicate if the patient agrees to the leave and that they have been offered a copy of the form.

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

We reviewed the care plans for five patients.

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

There were comprehensive needs and risk assessments completed throughout the patient admission which directly linked to the plan of care and risk management strategies implemented on the ward. There was clear evidence of multidisciplinary involvement in the care plans, which reflected the domains of the Mental Health (Wales) Measure 2010.

Management of patients' behaviours were reflected in their care plans and risk management profile, along with staff training to use skills to manage and diffuse difficult situations.

It was positive to see that care files clearly demonstrated patient involvement in care discussions, which were patient focussed and signed by the patient. Records also included the views of the patients and quotes from the patients were used to reflect their views. However in one patient file we examined there was no annual Care and Treatment plan review undertaken and no date for this review had been documented on the care notes system. It is important that reviews of patient care plans are undertaken to monitor progress and to determine if the plan is still effective in meeting patient needs.

Overall, the nursing documentation viewed was very good and physical assessments were well completed.

Improvement needed

The registered provider must ensure that care and treatment plan reviews are undertaken and that dates for these reviews are endorsed on records.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Independent Health Care Regulations and National Minimum Standards.

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

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

There was dedicated and passionate leadership displayed by the hospital director who is supported by a committed multidisciplinary team.

Mandatory training, supervision and annual appraisal completion rates were generally high. However, improvements are required in mandatory training compliance figures.

Governance and accountability framework

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

There was dedicated and passionate leadership displayed by the hospital director who was supported by committed multi-disciplinary teams. The team was a cohesive group of leaders and interviews with them demonstrated that they valued and cared for the staff and patients.

It was positive that, throughout the inspection, the staff at the hospital were receptive to our views, findings and recommendations.

Dealing with concerns and managing incidents

As detailed earlier, there were established processes in place for dealing with concerns and managing incidents at the hospital.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the service provided.

Workforce planning, training and organisational development

We reviewed the mandatory training and clinical supervision statistics for staff at the hospital and found that the following training compliance was low. Conflict Resolution was 38%, GDPR was 69%, Infection Control Level 2 was 50 %, and Safe Administration of Medicines level 2 was 50%.

We have recognised that training figures may be due to staff absences and that face-to-face training has been difficult due to the pandemic, however, improvements are still required in these areas.

There was a programme of training so that staff would receive timely updates. The electronic records provided the senior managers with details of the course completion rates and individual staff compliance details.

Staff appraisals take place annually based on staff start dates. Copies of appraisal documents for staff are kept on individual staff files. Line managers tend to monitor compliance along with administration staff at the hospital who keep records to ensure that staff are in compliance.

To cover any shortfalls in the staffing rota, the registered provider had a staff bank system in place. We were told that agency staff are hardly used. Rotas are prepared in advance and are reviewed regularly.

Improvement needed

The registered provider must ensure that staff mandatory training figures are improved.

Workforce recruitment and employment practices

It was evident that there were systems in place to ensure that recruitment followed an open and fair process. Prior to employment staff references were

received, Disclosure and Barring Service (DBS) checks were undertaken and professional qualifications checked.

Newly appointed staff undertook a period of induction under the supervision of the heads of care.

The hospital had a clear policy in place for staff to raise any concerns. Occupational health support was also available and staff spoke highly of the welfare support provided by the management team. There were good systems in place to support staff welfare. We were told of support programmes available from Elysium Healthcare to assist staff with many aspects of work and personal life including an independent counselling service.

4. What next?

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

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

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect independent mental health services

Our inspections of independent mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of independent mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent mental health services.

Further detail about how HIW inspects mental health and independent services can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection			

Appendix C – Improvement plan

Service: Ty Gwyn Hall

Date of inspection: 5 – 7 October 2021

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

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The registered provider should keep HIW updated on progress made on the occupational therapy eco pod	3. Health promotion, protection and improvement	A planning application has been submitted to the local council for the installation of a timber framed EcoPod building that will provide for an Occupational Therapy Service at Ty Gwyn Hall. The Hospital Director will appraise HIW on a monthly basis with progress towards the installation of the EcoPod and confirm the date when this is to become operational	Shaun Cooper Hospital Director	Ongoing HIW to be updated

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that they consider options on ensuring staff can check on the well-being of patients in their bedrooms with minimal disruption.	10. Dignity and respect	This issue will be raised with our service users so we can seek their views and opinions as to how we can maintain supportive observations whilst in bedrooms. Where possible we use the least restrictive levels of observations for our service users, specifically during the night so as to minimise disruption. Within Skirrid View we have two designated rooms with observation windows that would be used where appropriate for individuals with increased risks. This issue will be raised within our Regional and Local Clinical Governance Meetings for further discussion and look at best practice within other Elysium Services.	Shaun Cooper Hospital Director	Ongoing HIW to be updated
Delivery of safe and effective care				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must continue to make improvements to environmental areas of the hospital.	12. Environment	The Hospital has an Environmental Action and newly identified environmental actions The Business Support Manager and Ho highlights areas of work that needs to be identify as Capital Works through Elysium Weekly Service User meetings are held requests are fed into our environmental a	Shaun Cooper Hospital Director	Completed
The registered provider must ensure that all staff are using radios and personal alarms.	22. Managing risk and health and safety	The Support Services Manager and Main to service and repair any issues. A full review of the radio equipment has n The Clinical Services Manager and Ward these are effectively utilised by staff within the services.	Shaun Cooper Hospital Director	Completed
The registered provider must ensure that ligature cutters are available and accessible to all staff.	22. Managing risk and health and safety	The ligature cutters are located behind a fob operated door and accessible to all staff. All staff, including Bank and Agency are issued with a door fob when on shift.	Shaun Cooper Hospital Director	Completed
The registered provider must make sure that sharps boxes are stored appropriately and that the tracking label is completed correctly.	13. Infection prevention and control (IPC) and	All Registered Nurses have received a direction from the Clinical Services Manager reminding them to correctly	Shaun Cooper Hospital Director	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	decontaminati on	label and store sharps boxes in the clinical areas of the hospital.		
The registered provider must ensure that the chalk board menu is updated on a daily basis.	14. Nutrition	Kitchen staff have been reminded to update the Chalk Board with the day's menu at the commencement of every shift. The Support Services Manager will audit the completion on a regular basis. Service user Reps have been requested to monitor compliance and when not completed to make the Hospital Director aware so this can be immediately resolved.	Shaun Cooper Hospital Director	Completed
The registered provider must ensure that fridge and clinical room temperatures are recorded on a daily basis	15. Medicines management	All Registered Nurses have received a direction from the Clinical Services Manager reminding them to record fridge and clinical room temperatures. A weekly audit will be completed by our external Pharmacist and areas of non-compliance around clinic checks raised with the Clinical Services Manager so they can be immediately resolved.	Shaun Cooper Hospital Director	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The registered provider must ensure that all clinical policies are reviewed and updated.	15. Medicines management	Elysium Healthcare are currently reviewing all outstanding policies and procedures and these will be re-issued.	Shaun Cooper Hospital Director	Ongoing
The registered provider must ensure that staff have adequate WIFI to enable them to carry out their duties efficiently.	19. Information management and communications technology	Ty Gwyn Hall is currently having a new superfast broadband line installed by Openreach. Once operational this will provide a vastly improved internet speed and WIFI connection. All outstanding works are projected to be completed by 30th November 2021.	Shaun Cooper Hospital Director	30 November 2021
The registered provider must ensure there is a place on Section 17 leave form to indicate patients agreement or that they have been offered a copy of the form.	20. Records management	Ty Gwyn Hall has implemented the use of an additional recording form that will be used alongside our S17 leave documentation and will record that a patient has been offered a copy of their S17 form.	Shaun Cooper Hospital Director	Completed
The registered provider must ensure that care and treatment plan reviews are undertaken and that dates for these reviews are endorsed on records	20. Records management	All service users will have a review of their care and treatment plans as part of their Individualised Care Review (ICR) that takes place on a monthly basis. Ward Managers will use our In-Charge Dashboard software to monitor	Shaun Cooper Hospital Director	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		compliance on a weekly basis, ensuring Primary Nurses are updating and recording review dates on our care records.		
Quality of management and leadership				
The registered provider must ensure that staff mandatory training figures are improved.	25. Workforce planning, training and organisational development	A weekly review of training compliance has been implemented. This includes the attendance of the Hospital Director, HR Admin lead and Clinical Services Manager. Compliance with My Elysium Learning training modules will be reviewed and specific actions with deadlines issued to non-compliant staff members. We have a schedule of training in place for ILS, TMVA, Conflict Management, Breakaway and BLS that will pick up all non-compliant staff. Elysium Healthcare have a regional training centre that provides regular	Shaun Cooper Hospital Director	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		induction for all staff newly employed within the South Wales services. All staff will attend a two week induction where F2F training will be delivered as part of this process. Elysium Healthcare are supporting two additional staff from Ty Gwyn Hall to become Trainers in TMVA to increase resources and ensure scheduled training courses take place.		

Service representative

Name (print): Shaun Cooper

Job role: Hospital Director

Date: 18/11/2021