Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Ty Gwyn Hall

Elysium Health Care 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 Ty Gwyn Hall Hospital, on 2,3 and 4 October 2023.

The following hospital wards were reviewed during this inspection:

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

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 reviewers. The inspection was led by a HIW Senior Healthcare Inspector.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. Insufficient questionnaires were completed, however, during the inspection we spoke with staff and patients and some of the comments we received appear throughout the report.

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

Patients told us that improvements were required regarding menu choices, and that they would like to be involved in more activities. Patients told us that staff at the hospital were fantastic and looked after them well.

This is what we recommend the service can improve:

- Improvements to menu choices
- More access to activities.

This is what the service did well:

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Care for patients' physical health needs and individual risks.

Delivery of Safe and Effective Care

Overall summary:
Staff were committed to providing safe and effective care and during meetings we attended, the multidisciplinary team worked well together. Care plans were well detailed, individualised, and reflected a wide range of MDT involvement and there was clear and documented evidence of patient involvement.

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

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.

This is what we recommend the service can improve:

- Increase number of personal alarms available for staff and visitors
- Improvements in patient care records.

This is what the service did well:

- Mental Health Act monitoring and records
- Safe and effective medication management.

Quality of Management and Leadership

Overall summary:
We observed a committed staff team who had a good understanding of the needs of the patients at the hospital. There was dedicated and passionate leadership displayed by the hospital manager.

We found an effective governance structure in place in terms of regular audit activities and meetings to discuss incidents, complaints and issues related to patient care.

However, improvements were needed in training compliance for basic life support and mandatory Safe Therapeutic Management of Violence and Aggression (STMVA) training.

This is what we recommend the service can improve:

- Completion rates of STMVA and Basic Life Support mandatory training courses.

This is what the service did well:

- Strong leadership provided to staff by the hospital manager
- Motivated and patient focussed team.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

We handed out HIW questionnaires during the inspection to obtain views on the service provided at the hospital. We received no responses to the questionnaires. However, patients spoken to during the inspection spoke highly of staff and the care provided to them. We also reviewed internal patient feedback logs to help us form a view on the overall patient experience.

Patients we spoke to told us that staff treated them well and were kind towards them. Some of the comments provided by patients included:

"Staff are fantastic here".
"Staff are good here - I understand they are trying their best for me".

Health promotion, protection and improvement
We looked at a sample of patient records and saw evidence that patients received appropriate physical assessments upon their admission in addition to their mental healthcare. Patients also received ongoing physical health checks during their stay.

The furniture, fixtures and fittings at the hospital were appropriate for the patient group. There were up-to-date ligature point risk assessments in place. These identified potential ligature points and what action had been taken to remove or manage these.

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

Patients told us that they would like to access more activities, patients told us they were bored and felt that activities were limited due to staffing numbers.

The registered provider must ensure that patients have access to regular activities.

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 enthusiastic about their roles and how they supported and cared for the patients. We saw most staff taking time to speak with

patients and address any needs or concerns the patients raised, displaying a responsive and caring attitude towards the patients.

Each patient had their own bedroom that provided a good standard of privacy and dignity. Patients could lock their rooms, but staff could override the locks if needed. We saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering. Patients were able to personalise their rooms and store their own possessions. Personal items were risk assessed on an individual basis for the safety of each patient. This included the use of personal mobile phones. A telephone was available at the hospital for patients to use to contact friends and family if needed, and digital devices were available for patients to use with support from staff when required.

Patients told us that staff respected their privacy and dignity. During 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 had conducted patient surveys around this issue and staff were doing their best to check on patients with minimal disruption.

Patient information and consent

Patient boards displayed in the hospital contained relevant information to help patients and their families understand their care. However, the patient information was secured to the board with drawing pins, covered by paper.

The registered provider must consider alternative notice boards to ensure patient safety.

There was information available on the role of HIW, advocacy and other support networks. Most information was displayed in English only, except for the complaints procedure which was bilingual. However, Welsh language materials were available for patients when required.

Communicating effectively

During the inspection we observed staff engaging and communicating in a positive way with patients.

We saw that staff engaged with patients in a sensitive way and took time to help them understand their care using appropriate language.

Care planning and provision

Patients had their own individual weekly activity planner including individual and group sessions based within the hospital and the community (when the required authorisation was in place). During the inspection we observed staff and patients engaging in activities in the hospital and in the community.

We observed staff respecting patient privacy. For example, by understanding when patients preferred their own space and facilitating this whilst maintaining appropriate levels of observation.

We saw evidence that 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.

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

We found that there were active discharge planning arrangements in place for most patients who were ready for discharge. We confirmed that decisions in relation to discharge and future placements were discussed with the patients, and relatives where appropriate, as part of their MDT reviews.

Equality, diversity and human rights

We found that arrangements were in place to promote and protect patient rights.

Legal documentation we saw to detain patients under the Mental Health Act was compliant with the legislation. All patients had access to advocacy services, and we were told that advocates visit the hospital.

Citizen engagement and feedback

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

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

We saw minutes of meetings which showed that staff were keeping patients informed of what actions had been taken in response to issues that had been raised. We reviewed a sample of complaints which evidenced that these were dealt with in line with the registered provider's policy.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
Staff wore personal alarms which they could use to call for help if needed. However, we were told that there were occasions where not all staff had access to personal alarms, staff told us that during shift change over there would not be enough alarms and staff would often have to wait for alarms to be charged before using them.

The registered provider must ensure there are enough alarms for staff and visitors.

There were also nurse call points around the hospital and within patient bedrooms and bathrooms so that patients could summon aid if needed.

During the inspection we noted the outdoor smoking area was situated away from staff populated areas. This meant that female and male patients that frequented were unobserved by staff.

The registered provider should review this and ensure appropriate safety measures are put in place for patient safety.

We saw evidence of various risk assessments that had been conducted including, ligature point risk assessments and fire risk assessments. We were told of the environmental checks that are completed and saw evidence that these were completed.

The hospital had a business continuity plan in place, this is regularly updated, and staff confirmed they were aware of the policy and how to escalate any concerns.

The inspection team considered the hospital environment during a tour of the hospital on the first night of the inspection and the remaining days of the inspection. The hospital appeared clean and tidy; however, we identified that the corridor walls in Skirrid need re-painting and the loose carpet on the stairs leading to the top floor of Ty Gwyn needs to be fixed.

The registered provider must ensure that the corridor walls in Skirrid are re-painted.

The registered provider must ensure that the loose carpet on the stairs leading to the top floor of Ty Gwyn is fixed.

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

Cleaning equipment was stored and organised appropriately. There were suitable arrangements in place for the disposal of clinical waste.

The registered provider employed dedicated housekeeping staff for the hospital. Throughout the inspection we saw that overall, the hospital was visibly clean and free from clutter. However, we noted on the first night of the inspection that the IPC storage cupboard was open on Skirred Ward, this cupboard contained items that could be a risk to patient safety.

The registered provider must ensure that the storage cupboard on Skirrid Ward is always locked.

Nutrition
The hospital provided patients with meals on the ward, making their choices from the hospital menu. We were told that specific dietary requirements were accommodated. Staff said patients make their food choices in advance and stated if a patient changes their mind they can usually be accommodated with another option.

The dining rooms were clean and tidy and provided a suitable environment for patients to eat their meals.

Medicines management
Medicines management was safe and effective. Medication was stored securely with cupboards and medication fridges locked. There was evidence of regular temperature checks of the medication fridge to monitor that medication was stored at the manufacturer's advised temperature. However, there were some gaps where temperature checks had not been recorded on Skirrid ward.

The health board must make sure that temperature checks are consistently recorded.

We noted that there was only one bunch of medicine keys. In addition, the keys have a locked mechanism which was not kept with the senior nurse on duty.

The registered provider must ensure that they have a contingency plan around lost medication keys and that the senior nurse has overall responsibility for the locked key ring tool.

There was regular pharmacy input and audit undertaken that helped the management, prescribing and administration of medication on the ward.

There were 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 nursing signatures confirming that the checks had been conducted.

The paper Medication policy available to staff was due for review in 2020. However, online this was up to date.

The registered provider must ensure that staff have access to the most recent up to date medication policy.

Safeguarding children and safeguarding vulnerable adults

There were established hospital policies and processes in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Hospital staff had access to safeguarding procedures via its intranet. Senior staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff, they were able to show knowledge of the process of making a safeguarding referral.

The hospital had an onsite social worker, who acted as the safeguarding lead for the hospital and dealt with all safeguarding referrals and subsequent workload. 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.

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.

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. However, there was no date of expiry on the AED pads.

The registered provider must ensure that AED pads contain an expiry date.

During staff discussions, it was clear that staff were aware of the locations of ligature cutters in case of an emergency. However, due to the location of the

current ligature cutters we would recommend that the registered provider have an additional set kept elsewhere.

The registered provider should consider the location of the current ligature cutters.

There were up-to-date safety audits in place, including ligature point risk assessments.

Safe and clinically effective care
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.

Strategies were described for managing challenging behaviour to promote the safety and wellbeing of patients. We were told that preventative techniques were used and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the safe physical restraint of patients was used, but this was rare and only used as a last resort.

The inspection team witnessed positive redirection and de-escalation of difficult behaviours during the course of the inspection, all of which were done respectfully and in a very supportive manner.

Restraints had increased on Skirrid Ward recently due to the patient group becoming unsettled with new arrivals. The data for restraints was continually being monitored and reviewed at clinical governance. During a review of the restraint data, we identified that some staff involved in level 1 and level 2 restraints and had not received their refresher training. In addition, current compliance for Safe Therapeutic Management Violence and Aggression training (STMVA) was 64 per cent.

This matter was dealt with as an area of non-compliance which was resolved during the inspection.

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 hospital manager confirmed that all staff had now been booked onto a training course and rotas amended to ensure that when a restraint took place there were sufficiently trained staff available. An interim policy had also been disseminated to staff to ensure compliance.

The registered provider must ensure that all staff are compliant with their STMVA training, and that staff involved in restraints are compliant with their training.

Records management
Patient records were electronic, and password protected.

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

Mental Health Act Monitoring
We reviewed the statutory detention documents for five patients at the hospital.

All patient detentions were found to be legal according to the legislation and well documented. Overall, the records we viewed were well organised, easy to navigate and contained detailed and relevant information.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
We reviewed the care plans of five patients. We reviewed five care files and found that they were kept to a good standard.

Entries were comprehensive and recognised assessment tools were used to monitor mental and physical health.

We saw evidence that care plans were detailed, comprehensive and 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.

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

We saw care files clearly showed patient involvement in care discussions, which were patient focussed and signed by the patient. There were examples of easy read documentation in patients files and all of these were very individualised.

Records also included evidence of the patients' voice to reflect their views, however, we identified some improvements that could be made in patient care plans:

- In one patient record we reviewed, it was difficult to navigate and find details of an up-to-date CTP plan
- Risk assessments had not been completed when there had been a change in the patients presentation
- In some patient records there appeared to be a lack of reference to discharge planning notes.

The registered provider must ensure that care plans are easy to navigate and that risk assessments are updated, and reference is made to discharge planning within patient records.

Quality of Management and Leadership

Governance and accountability framework
There were well-defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. Ongoing improvements need to focus on staff compliance with mandatory training.

During the inspection senior management were able to assure us that internal audits were undertaken and provided the team with evidence of a range of audits and improvements that have taken place, these documents were provided promptly to the team demonstrating that the correct systems and structures are in place.

There was a clear organisational structure for the hospital, which provided clear lines of management and accountability. They defined these arrangements during the day, with senior management and on-call systems in place for the night shift.

There was dedicated and passionate leadership from the hospital manager, who was supported by committed ward multidisciplinary teams and staffing group. We found a friendly, professional staff team who showed a commitment to providing high quality care to patients. Staff were able to describe their roles and appeared knowledgeable about the care needs of most patients they were responsible for.

During our time at the hospital, we observed a positive culture with good relationships between staff who we observed working well together as a team. It was evident that staff were striving to provide high levels of care to the patient groups to expedite recovery and minimise the length of time in hospital. It was clear to see that the hospital manager and team leaders had a very supportive and approachable leadership style, this was also confirmed during staff interviews.

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 learned 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.

Arrangements were in place to quickly share 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
Staff we interviewed spoke passionately about their roles. Throughout the inspection we observed strong team working.

Staff were able to access most documentation requested by the inspection team in a prompt and timely manner, demonstrating that there are good governance systems in place at the hospital.

We saw evidence of staff annual appraisals and supervision in staff files and staff told us that supervision takes place on a regular basis.

The inspection team considered staff training compliance and we were provided with a list of staff mandatory training compliance. Training figures indicated that improvements are required for Basic Life Support with overall compliance currently at 62 per cent. We were told that these figures would be immediately improved, and we were shown evidence that staff were booked on courses. In addition, we were reassured that all shifts had sufficient staff trained in restraint pending the remaining staff completing courses.

The registered provider must ensure that mandatory training compliance for Basic Life Support and restraint training figures are improved.

We were provided with a range of policies, the majority of which were updated however, the following policies were found to be out of date:

- Search Policy review date April 2022
- Consent policy review date April 2023

The registered provider must ensure that policies are reviewed and kept up to date.

The hospital manager told us of future plans for the occupational therapy HUB which was due to be installed at the setting the week following the inspection. There has been a significant delay with the HUB facility for patients and staff

HIW require an update on the current timescales of the HUB.

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. Therefore, we were assured that recruitment was undertaken in an open and fair manner.

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

We were told that 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 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. 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
Cleaning storage cupboard unlocked	Risk to patient safety	Reported to Hospital Manager	Cupboard was immediately locked, and all staff briefed on compliance.
Staff involved in Level 1 and 2 Restraints who had not attended refresher training	Risk to staff and patient safety	Reported to Hospital manager	Briefing with hospital manager All staff booked on STMVA refresher training courses. Rotas checked and amended to ensure staff involved in restraints are trained. Interim policy developed and shared with all staff.

Appendix B - Immediate improvement plan

Service: Ty Gwyn Hall

Date of inspection: 2,3 & 4 October 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 issues identified				

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Ty Gwyn Hall

Date of inspection: 2 - 4 October 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 ensure that patients have regular access to activities.		Installation of the OT hub to provide additional activity space and facilities. Review activity timetables for all service users. Plan and record activities on Meaningful Week application and accurately outcome to evidence level of engagement	Hospital Director Lead Occupational Therapist All Clinicians	November 30th 2023 January 31st 2024. January 31st 2024
The registered provider must ensure there are enough alarms for staff and visitors.	2.1 Managing risk and promoting	Review numbers of personal alarms available within Skirrid	Support Services Manager	January 31st 2024

	health and safety.	View and replace any that are non-functional. Increase numbers of personal alarms from 10 to 15 thus allowing sufficient to be on charge whilst others are deployed. Purchase replacement walkie talkie system for Skirrid View and Ty Gwyn Hall	Andrea Melia - Support Services Manager Andrea Melia- Support Services Manager	January 31st 2024 January 31st 2024
The registered provider must consider alternative notice boards to ensure patient safety.	2.1 Managing risk and promoting health and safety.	Remove drawing pins from the notice boards and replace with adhesive pads.	Andrea Melia - Support Services Manager Mark Cumbes and Kirsty Roberts - Ward Managers	30th November 2023
The registered provider should review the outdoor smoking area and ensure appropriate safety measures are put in place for patient safety.	2.1 Managing risk and promoting health and safety.	Installation of female smoking area to allow a gender specific area for service users to access. Review smoking arrangements in line with Elysium Healthcare smoking reduction and cessation	Shaun Cooper – Hospital Director Shaun Cooper – Hospital Director	February 28th 2024 March 31st 2024

		policy that is being reviewed and released shortly. This will provide clear direction as to whether we can continue to allow the use of tobacco products within hospital grounds. All ground leave to smoking area will need to be approved by RC and supported by staff in line with supportive observation care plan.		
The registered provider must ensure that the corridor walls in Skirrid are re-painted. The registered provider must ensure that the loose carpet on the stairs leading to the top floor of Ty Gwyn is fixed.	2.1 Managing risk and promoting health and safety.	The corridor walls in Skirrid View will be redecorated. A decoration schedule is in place to ensure all areas of the hospital are reviewed regularly and systematically redecorated. The carpet will be repaired or replaced.	Andre Melia - Support Services Manager Rob Penn – Senior Maintenance Rob Penn – Senior Maintenance	31st January 2024. 31st January 2024. 31st January 2024.

The registered provider must ensure that the storage cupboard on Skirrid Ward is always locked.	2.1 Managing risk and promoting health and safety.	Housekeeping staff will be made aware of the error and "Keep locked at all times" signs will be placed on these doors.	Andrea Melia - Support Services Manager	30th November 2023.
The registered provider must make sure that temperature checks are consistently recorded.	Infection prevention and control (IPC) and decontamination.	Ward Managers will make daily checks to ensure these are completed. A Nurse will be allocated responsibility for clinic checks on the daily allocation sheet to ensure that these are then completed.	Mark Cumbes and Kirsty Roberts - Ward Managers Mark Cumbes and Kirsty Roberts - Ward Managers	30th November 2023 30th November 2023
The registered provider must ensure that they have a contingency plan around lost medication keys and that the senior nurse has overall responsibility for the locked key ring tool.	2.1 Managing risk and promoting health and safety.	A review of keys that are currently attached to the secure keyset will be reviewed and keys thinned out as far as is possible.	Mark Cumbes and Kirsty Roberts - Ward Managers	30th November 2023
The registered provider must ensure that staff have access to	2.1 Managing risk and promoting	Elysium Healthcare's Medication policy has been updated	Shaun Cooper - Hospital Director	November 30th 2023

the most recent up to date medication policy.	health and safety.	(October 2023) and a copy issued to all clinicians. A record has been made of this being issued and date of signing by Nurses and Doctors. Copies of the Medicines Policy will be updated in all clinical areas.		
The registered provider must ensure that all staff are compliant with their STMVA training, and that staff involved in restraints are compliant with their training.	25.Workforce planning, training, and organisational development.	Staff compliance with STMVA to be checked at commencement of shift. Staff non-compliant with STMVA will be identified and allocated so they will not be an active participant in any restraint. Larger and more appropriate training space will be secured to increase the numbers of staff that can be trained in practical skills. A training coordinator will be appointed at Ty Gwyn Hall to ensure staff are booked onto	Mark Cumbes and Kirsty Roberts - Ward Managers/Andrew Swithenbank – Charge Nurse Mark Cumbes and Kirsty Roberts - Ward Managers/Andrew Swithenbank – Charge Nurse Mark Cumbes and Kirsty Roberts - Ward Managers/Andrew	Immediate Immediate 30th November 2023

		STMVA on an annual basis for refresher training. All new staff will be allocated to attend the corporate induction where STMVA will form part of their training package. Training compliance in STMAVA will be reviewed every week at the site's leadership meeting and monthly as part of the Hospital's Clinical Governance meeting.	Swithenbank – Charge Nurse Hospital Director Hospital Director	 30th November 2023 30th November 2023 30th November 2023
The registered provider should consider the location of the current ligature cutters.	2.1 Managing risk and promoting health and safety.	An additional two sets of ligature cutters will be procured with these then being located across the service in staff accessible areas. Ligature cutter sets will be identified on the Hospitals Ligature Map.	Andrea Melia - Support Services Manager Andrea Melia - Support Services Manager	31st December 2023 31st December 2023

The registered provider must ensure that care plans are easy to navigate.	20. Records.	Care plans will be reviewed monthly by the MDT to ensure these remain current and easy to navigate.	Mark Cumbes and Kirsty Roberts - Ward Managers/Andrew Swithenbank – Charge Nurse	November 2023 and monthly ongoing
The registered provider must ensure that risk assessments are updated when there is a change in a patient's presentation.	20. Records.	Risk assessments will be reviewed monthly by the MDT to assure they remain current and accurately reflect risk. PSIRF (Patient Safety Reviews) take place daily and any change to risk will be highlighted and assessments updated.	MDT / Mark Cumbes and Kirsty Roberts - Ward Managers/Andrew Swithenbank – Charge Nurse MDT / Mark Cumbes and Kirsty Roberts - Ward Managers/Andrew Swithenbank – Charge Nurse	November 2023 and monthly ongoing. Daily with full PSIRF review of Risk Register every week.

The registered provider must ensure that there is reference to discharge planning within patient records.	20. Records.	Discharge planning is included as an agenda item for every MDT review and CTP meeting. Planned discharge dates are reviewed monthly.	MDT / Mark Cumbes and Kirsty Roberts - Ward Managers/Andrew Swithenbank – Charge Nurse	November 2023 and monthly ongoing.
The registered provider must ensure that mandatory training compliance for Basic Life Support and restraint training figures are improved.	25.Workforce planning, training, and organisational development.	Staff compliance with BLS to be checked at commencement of shift. Staff non-compliant with BLS will be identified and allocated so they will not lead in a medical emergency. Larger and more appropriate training space will be secured to increase the numbers of staff that can be trained in practical skills. A training coordinator will be appointed at Ty Gwyn Hall to ensure staff are booked onto BLS	Mark Cumbes and Kirsty Roberts - Ward Managers/Andrew Swithenbank – Charge Nurse Hospital Director Shaun Cooper - Hospital Director	Immediate Immediate 30th November 2023 Completed 27th November 2023

		on an annual basis for refresher training. All new staff will be allocated to attend the corporate induction where BLS will form part of their training package. Training compliance in BLS will be reviewed every week at the site's leadership meeting and monthly as part of the Hospital's Clinical Governance meeting.	Bea Turton- Training Coordinator Bea Turton - Training Coordinator	30th November 2023 30th November 2023
The registered provider must ensure that AED pads contain an expiry date.	25.Workforce planning, training, and organisational development	AED pads have expiry dates both on the back of the AED and separately identified on the pads. Nurses will be provided with further instruction on where to locate the expiry date to ensure these can be regularly checked.	Mark Cumbes and Kirsty Roberts - Ward Managers Mark Cumbes and Kirsty Roberts - Ward Managers	30th November 2023 30th November 2023

The registered provider must ensure that policies are reviewed and kept up to date.	25.Workforce planning, training, and organisational development.	Search policy to be updated. Consent policy to be updated. The Hospital team will review policies as part of the monthly Clinical Governance process and liaise with Elysium when out of date/non-compliant policies are identified.	Elysium Elysium Shaun Cooper – Hospital Director	October 2023 January 31st 2024. Monthly
The registered provider must provide HIW with an update on the progress of the Occupational Hub.	25.Workforce planning, training, and organisational development.	The Occupational Therapy Hub has now been installed and is fully operational.	Shaun Cooper - Hospital Director	Completed November 27th 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): Shaun Cooper: Hospital Director-Ty Gwyn Hall