Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Tŷ Grosvenor

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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 Tŷ Grosvenor in Wrexham on 06, 07 and 08 November 2023.

The following hospital wards were reviewed during this inspection:

- Alwen Ward – an acute emergency admission service for 14 patients
- Brenig Ward – a rehabilitation inpatient service for 15 patients.

Our team for the inspection comprised of two HIW Healthcare Inspectors, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

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. A total of six questionnaires were completed by patients or their carers, and 23 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
The patients we spoke with were complimentary about the care provided at the hospital. Patients told us they felt safe, which was an improvement since our last inspection at the hospital in July 2022, when some of the patients told us that they did not feel safe from other patients.

Each ward provided a clean and comfortable environment with appropriate fixtures and fittings for the patient group. We observed staff interacting and engaging with patients appropriately and with dignity and respect. Patients had their own programme of care that reflected their individual needs and risks. Positive attempts were being made to tailor activities to the interests of patients and initiatives such as pet therapy were being used to help engage patients.

Patients had received regular physical health checks throughout their stay, and we saw that patients had accessed other health services when required. Patients had weekly access to a mental health advocate who provided information and support with any issues they may have regarding their care.

This is what we recommend the service can improve:

- Information recorded on the 'patient safety at a glance' boards must be kept up-to-date.

This is what the service did well:

- Patients were being kept informed about their rights and supported to apply to the Mental Health Review Tribunal to have their detention reviewed
- Patients could engage and provide feedback about their care in a number of ways.

Delivery of Safe and Effective Care

Overall summary:
Staff were committed to providing safe and effective care. Suitable protocols and policies were in place to manage risk, health and safety and infection control. Medication was being managed and stored appropriately within each clinic. We found effective processes in place to help ensure that staff at the hospital

safeguarded patients appropriately. Regular checks were being undertaken of resuscitation and emergency equipment.

The dietary needs of patients had been assessed on admission and specific dietary requirements had been identified and acted upon where necessary. Patient care and treatment plans were being maintained to a good standard.

Immediate assurances:

During our review of the Mental Health Act (MHA) statutory detention documentation we were concerned to find instances where the documentation was not compliant with the MHA and Code of Practice. For example:

- Capacity assessments were not always being undertaken to determine whether patients had the capacity to consent to treatment
- Some patients at the hospital had been prescribed medication without the statutory certificate of consent form in place to authorise the treatment
- Some patients at the hospital had been prescribed types or doses of medication that had not been stated on the statutory certificate of consent form in place to authorise the treatment
- Nursing staff had administered medication to patients without checking that the type and dosage had been consented to, or authorised by a Second Opinion Appointed Doctor
- Discrepancies between the medication being administered to patients and the medication stated on their certificate of consent forms identified by the external pharmacy had not been rectified by the hospital in a timely manner
- The clinical audits undertaken internally by hospital staff had not been effective in identifying these discrepancies.

Due to the severity of these issues, Tŷ Grosvenor was designated as a Service of Concern following the inspection in line with HIW's Escalation and Enforcement process for independent healthcare services. This meant we continued to engage with senior management in order to seek sufficient assurance. The service was de-escalated from a Service of Concern in January 2024 after HIW was satisfied that it had addressed the required improvements. Details of the remedial action taken by the service are provided in Appendix B.

This is what we recommend the service can improve:

- A 'locked door' policy must be developed to ensure the rights of informal patients are upheld while protecting detained patients who may be vulnerable

- All checklists and audits must be completed accurately to ensure they remain effective at identifying issues of non-compliance with internal procedures
- Daily nursing entries within patient records must provide more detail about staff interactions with each patient under their care.

This is what the service did well:

- Helpful '30-day summaries' were being produced for staff which provided a detailed overview of the recent history of each patient, including their risks or any recent incidents
- One member of staff on each shift is allocated the role of security lead, who takes responsibility for ensuring all staff are wearing their personal alarms and that items such as cutlery are accounted for.

Quality of Management and Leadership

Overall summary:
The majority of staff who completed HIW questionnaires provided positive feedback about working at the hospital.
Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection.

Improvements were required to ensure that individual incidents are discussed among the multidisciplinary team and reviewed and signed off by senior managers to identify lessons learned and prevent recurrence.

This is what we recommend the service can improve:

- The service must ensure that all staff are kept informed about incidents and any lessons learned
- The service should ensure there is always a sufficient number of staff available to ensure patients are able to take their Section 17 leave.

This is what the service did well:

- Mandatory training compliance rates were very high among staff at the hospital
- Recruitment was being undertaken in an open and fair process with appropriate employment checks being carried out prior to employment.

3. What we found

Quality of Patient Experience

Patients provided positive feedback about their experiences at the hospital. The patients we spoke with were complimentary about the care provided and about their interactions with staff. All patients who completed a HIW questionnaire rated the care and service provided by the hospital as 'good'.

Health promotion, protection and improvement
We looked at a sample of six patient records during the inspection and saw evidence that patients had received appropriate physical healthcare assessments upon their admission. Patients had received regular physical health checks throughout their stay, and we saw that patients had accessed other health services such as podiatry and diabetic clinics when required. We were told that a dedicated physical healthcare assistant had recently been appointed at the hospital to ensure that the physical healthcare needs of patients are continually met.

We found the occupational therapy team were engaging well with patients on both wards with attempts being made to find out the interests of patients. A weekly timetable of tailored therapeutic activities was available for patients to access. This included activities both on-site and within the local community. Other positive initiatives included access to animals, such as a pet parrot, and weekly visits by a pet therapy dog, which the patients enjoyed engaging with.

Sessions on life skills such as budgeting and healthy eating were being offered to patients. A real work opportunities programme was in place for patients to develop practical working skills and increase their confidence before discharge. We were told that an improvement project was to begin shortly to review the quality of the real work opportunities available for patients to participate in. Patients were being paid for each role, and the service may wish to consider as part of their review whether the monetary rewards on offer should be equivalent to the UK minimum wage.

Patients on each ward had access to outdoor spaces, and all patients who completed a questionnaire confirmed that they are able to go outside for exercise and wellbeing purposes.

Dignity and respect
Throughout the inspection we observed staff on both wards treating patients appropriately and with dignity and respect. Staff took the time to speak with

patients to understand their needs, and it was clear that good interpersonal relationships had been built. All patients who completed a questionnaire said that staff treated them with dignity and respect and were always polite. All staff who completed a questionnaire also felt that patients' privacy and dignity is maintained.

Each patient had their own en-suite bedroom, which provided a good standard of privacy and dignity. Each bedroom door had an observation panel which enabled staff to undertake observations without having to open the door and disturb patients. During the inspection we saw examples of staff respecting the privacy of patients by knocking their door before entering. Patients could lock their rooms, but staff could override the locks if required.

We saw that patients were able to store possessions and personalise their rooms with pictures and posters.

Patient information and consent
We were told that patients receive written information about the hospital on their admission. We reviewed the information leaflets for both wards and saw they were comprehensive, up-to-date and of good quality. There was also a wide range of patient information being displayed on each ward; this included information on advocacy services, how to raise concerns and the contact details for HIW.

'Patient status at a glance' boards were located in the nursing offices on each ward. The boards had covers which helped protect patient confidentiality. However, we noted that some of the information recorded on the patient safety at a glance board on Alwen ward was out of date.

The service must ensure the information recorded on the 'patient safety at a glance' boards remains accurate and up-to-date.

Communicating effectively
Staff communicated effectively with patients throughout the inspection. Patients who completed a questionnaire felt that staff listened to them. Patients were each allocated their own key nurse, and patients told us that they were able to speak to their key nurse daily. Each ward also held weekly community meetings to provide an opportunity for patients to raise any issues with staff.

Suitable rooms were available for patients to meet staff and other healthcare professionals in private. Visiting arrangements were in place for patients to meet friends and family at the hospital where appropriate. We were told that patients can alternatively meet friends and family in the community if suitably risk assessed to do so.

We noted that patient information was predominantly only available in English. However, we were told that the language preference of patients is discussed on admission and arrangements would be made for translation services if required.

Care planning and provision

During the inspection we reviewed the care and treatment plans of six patients. We found that care plans were person centred, with each patient having their own programme of care that reflected their individual needs and risks. It was also evident during our review that patients had been involved in the development of their care plans. Patients who completed a questionnaire confirmed that they were given the opportunity to discuss any aspect of their care and treatment plan and felt very involved in the process. All staff who completed a questionnaire also felt that patients are kept informed and are involved in decisions about their care.

More findings on the care plans can be found within the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Equality, diversity and human rights

The hospital had suitable policies in place to help ensure that patients' equality and diversity were respected. We saw evidence that all staff had completed mandatory Diversity, Equity and Inclusion training as part of their role.

The care and treatment plans we reviewed evidenced that the social, cultural and spiritual needs of patients had been considered. We were told that an individual care plan would be developed for a patient if any needs were identified.

The patients we spoke with during the inspection said that they had been informed about their rights while at the hospital. We saw evidence within patient records that patients that had been detained at the hospital under the Mental Health Act had been appropriately supported to apply to the Mental Health Review Tribunal to have their detention reviewed. It was positive to see that part of this support came from the Mental Health Act administrator, who visited patients to ensure they understood their rights to an appeal. All patients had weekly access to a mental health advocate who provided information and support to patients with any issues they may have regarding their care.

Citizen engagement and feedback

We found that patients could engage and provide informal feedback to staff on the provision of care at the hospital in a number of ways. We saw minutes of the weekly community meetings which showed that staff were keeping patients informed of what actions had been taken in response to issues that had been raised. The patients we spoke with told us that they knew how to make a complaint should they need to do so.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
Overall, we were assured that the service had suitable and effective processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors at the hospital. The hospital entrance was accessible to everyone and was secured at all times throughout the inspection to prevent unauthorised access.

The doors to each ward were locked for general security purposes. Some of the patients at the hospital during the inspection were informal patients, and therefore had the right to leave anytime they wish to do so. We asked to see a 'locked door' policy that described the arrangements in place at the hospital to manage this. However, we were told that there was no such policy.

The service must develop a 'locked door' policy that sets out the arrangements and procedures to ensure the rights of informal patients are upheld while protecting detained patients who may be vulnerable.

Nurse call points were located within patient bedrooms so that patients could summon assistance if required. Staff wore personal alarms which they could activate in the event of an emergency. We were told that one member of staff on each shift is allocated the role of security lead, who is responsible for ensuring all staff are wearing their personal alarms and that items such as cutlery are accounted for.

Health and safety risk assessments had been undertaken and we saw that regular audits were being carried out of the environment to identify and issues. There were up-to-date ligature point risk assessments in place and a number of ligature cutters located throughout the hospital for use in the event of a self-harm emergency. Suitable fire safety measures and precautions were being taken to protect patients and staff in the event of a fire.

Each ward provided a clean and comfortable environment with appropriate fixtures and fittings for the patient group. The wards were split over two floors and lifts were available to assist people with mobility difficulties. However, the only way to access the garden area directly from the Brenig ward was via steps. The service should be mindful of this and ensure any patients on Brenig with mobility difficulties are fully supported to access the garden whenever they wish to do so.

Infection prevention and control (IPC) and decontamination
We found suitable IPC arrangements in place at the hospital. Some areas of the hospital had been refurbished since our previous visit which helped to promote effective cleaning. A designated IPC lead had been appointed for each ward, and there appeared to be a collective approach towards implementing IPC procedures among nursing, housekeeping and maintenance staff.

A range of up-to-date IPC policies were available that detailed the various procedures in place to keep staff and patients safe. We saw evidence of cleaning schedules being maintained. There were suitable arrangements in place for the disposal of clinical waste. Regular audits had been completed to check the cleanliness of the environment and check compliance with hospital procedures. At the time of the inspection staff were not expected to wear face masks, but we saw that face masks and other PPE were available if required. We were told that patients are encouraged to wash their hands or use sanitiser before eating, which we noted as good IPC practice.

We saw that all staff had completed their mandatory IPC training. All staff members that completed a questionnaire provided positive feedback about the IPC arrangements in place on the ward.

Nutrition
We saw evidence that the dietary needs of patients had been assessed on admission and that specific dietary requirements had been identified and acted upon where necessary. All patients received ongoing weight management checks during their stay.

There were suitable facilities available for patients to have hot and cold drinks and we saw patients accessing these throughout the inspection. Staffed kitchens are located on site to provide patients on each ward with a variety of meals throughout the day. We saw that fruit was readily available and were told that patients are encouraged to eat healthily. Daily menu options were on display which included helpful pictorial guides to help patients understand the choices.

Patients were able to securely store their own snacks and food should they wish to do so. We saw evidence that individual food items were labelled appropriately.

The patients we spoke with provided positive feedback about the quality and choice of food and said that the catering staff would offer an alternative should they not want anything from the menu. Patients are able to feedback their suggestions and opinions to members of the catering team about the food at the hospital during their weekly community meetings.

Medicines management
We reviewed the hospital's clinic arrangements and found that suitable procedures were in place for the safe management of medicines on each ward. Relevant policies, such as medicines management and rapid tranquillisation, were in date and were available to staff in each clinic room.

The clinic rooms were clean and tidy and well organised. Medication fridges were locked when not in use. We saw that daily temperature checks of the medication fridges and clinic rooms were being completed accurately to ensure that medication was stored at the manufacturer's advised temperature.

Appropriate arrangements were in place for the storage and safe use of controlled drugs and drugs liable to misuse. Drugs were stored securely and the records we viewed evidenced that stock was accounted for when administered and that stock checks were being undertaken.

We viewed a sample of Medication Administration Records (MAR charts) and found they were being maintained to a good standard on both wards. The MAR charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered.

There was good support available from an external pharmacy who visited the hospital weekly to undertake audits. However, we noted that any discrepancies identified by the external pharmacy were not always actioned in a timely manner by the service. Further information in relation to our concerns on this can be found in the Mental Health Act Monitoring section of this report.

We saw evidence of internal checklists and audits being completed to help monitor compliance and identify any errors or missing information. However, we were not assured that these checks were being completed accurately by staff. For example, one completed checklist on Alwen ward indicated that an instance of IM medication administered to a patient had been recorded on the patient safety at a glance board and in the staff diary. Upon review, it was clear to us that the administering of the IM medication to the patient had not been recorded on either the patient safety at a glance board or the staff diary.

The service must ensure that checklists and audits are completed accurately to ensure they remain effective at identifying issues of non-compliance with internal procedures.

Safeguarding children and safeguarding vulnerable adults
We found effective processes in place to help ensure that staff at the hospital safeguarded patients appropriately. A comprehensive safeguarding policy was in

place and up to date. A flow chart for escalating safeguarding concerns was available and on display to all staff.

The social worker was the designated safeguarding lead and was responsible for managing any safeguarding incidents. We observed safeguarding issues being discussed by staff in the morning handover meeting. Monthly safeguarding quality assurance meetings were also being held to identify themes or trends. We noted that safeguarding was also included at monthly clinical governance meetings as a standing agenda item to help identify any lessons learned.

We saw that safeguarding incidents at the hospital had been recorded internally and had also been referred to the appropriate external safeguarding agencies. All staff had completed their mandatory safeguarding training.

Medical devices, equipment and diagnostic systems
We saw evidence of weekly checks being undertaken on resuscitation and emergency equipment held on the ward. Staff had documented when these had occurred to ensure that the equipment was present, in date and safe to use in the event of an emergency such as patient collapse.

Safe and clinically effective care
The hospital had policies in place to help protect the safety and wellbeing of patients and staff. All staff members who completed a questionnaire felt that patient care is the organisation's top priority and that they are content with the efforts of the organisation to keep them and patients safe.

During our last inspection at the hospital in July 2022, some of the patients told us that they did not feel safe from other patients while at the hospital. It was therefore positive to hear of an improvement in this regard during this inspection, with patients we spoke with, and patients completing a questionnaire, all informing us that they felt safe while at the hospital.

Principles of positive behavioural support were being used as a primary method of de-escalation to manage challenging behaviour. Posters were displayed reminding staff about using de-escalation techniques and least restrictive practice. Each patient had a positive behaviour support plan in plan which included personalised strategies for managing challenging behaviour. We were told that staff would observe patients more frequently if patients continued to present with increased risks. We saw that records of observations being undertaken on patients were being completed appropriately by nursing staff.

We saw evidence that staff had completed Safe and Therapeutic Management of Violence and Aggression training. The number of incidents of physical restraint was

minimal, which indicated that physical interventions appeared to be being used as a last resort.

We saw that any use of restraint was documented in patient records and recorded on the corporate electronic system. This included details such as duration of the intervention and type of restraint used. We were told that debriefs take place with staff following incidents to check on their welfare, reflect, and identify any areas for improvement.

Records management
Patient records were being maintained on paper files and electronically. We saw that paper records were being stored securely. The electronic system was password protected to prevent unauthorised access and breaches in confidentiality.

The patient records we reviewed during the inspection were well organised which made it easy to navigate through the sections. 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 Mental Health Act (MHA) statutory detention documentation of four patients currently residing at the hospital. All records verified that the patients were being legally detained.

However, during our review we were concerned to find instances where the documentation was not compliant with the MHA and Code of Practice. We were not assured that the processes in place at the hospital protected patients against the risks associated with the unsafe administration of medication. This was because:

- Capacity assessments were not always being undertaken to determine whether patients had the capacity to consent to treatment
- Some patients at the hospital had been prescribed medication without the statutory certificate of consent form in place to authorise the treatment
- Some patients at the hospital had been prescribed types or doses of medication that had not been stated on the statutory certificate of consent form in place to authorise the treatment
- Nursing staff had administered medication to patients without checking that the type and dosage had been consented to, or authorised by a Second Opinion Appointed Doctor

- Discrepancies between the medication being administered to patients and the medication stated on their certificate of consent forms identified by the external pharmacy had not been rectified by the hospital in a timely manner
- The clinical audits undertaken internally by hospital staff had not been effective in identifying these discrepancies.

Our concerns were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection issuing a non-compliance notice requiring that urgent remedial actions were taken. Details of the actions taken by the service are provided in Appendix B.

We did also identify some areas of good practice during our review. The individual MHA patient files and documentation were well organised, easy to navigate and were being stored securely. We saw that Section 17 leave for patients was being suitably risk assessed and that the forms determined the conditions and outcomes of the leave for each patient. There was evidence that patients had been provided or offered a copy of their leave form. Discussions were held between staff and patients following their return from leave to review how it went.

We noted that the detention history of each patient began from their time of admission to Tŷ Grosvenor. For example, some patients had arrived at the hospital from a place a safety (Section 136), but we could not find any documentation that provided details of the circumstances that led to their arrival at the place of safety. We suggested to staff that it may be beneficial to also record the historical paperwork prior to their admission, to ensure staff have the full background for each patient.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
The six care and treatment plans we reviewed were being maintained to a good standard. Appropriate risk assessments for patients were being undertaken and documented. Each patient had their own programme of care that reflected their individual needs and risks. The domains of the Welsh Measure were being adhered to and nature of interventions were appropriate to the needs of the patient. We saw instances where efforts had been made to capture the voice of the patient within the care and treatment plans, and that they demonstrated a shared responsibility with the patient towards helping them to achieve their objectives. We saw that a positive initiative had been introduced at the hospital where staff were producing a '30-day summary' for each patient, which provided a detailed overview of the recent history of the patient, including their risks or any recent incidents. We felt the summaries were a useful and helpful guide for staff to gain a quick understanding of each patient.

There was evidence of discharge and aftercare planning, and we noted that patients and care co-ordinators had been involved in the process.

We did identify that daily nursing entries being recorded within the patient records could be strengthened. We often saw that staff had written ‘patient appeared settled’, which did not provide much context to the multidisciplinary team about the presentation and engagement of each patient throughout the day.

The service must ensure daily nursing entries within patient records provide more detail about staff interactions with each patient under their care.

We noted that the previous historical documentation for patients prior to their admission to the hospital was not available to staff. We suggested that obtaining and having this information would help staff and the multidisciplinary team make decisions based on all the available information and risks that may not have been evident during their time at Tŷ Grosvenor.

Quality of Management and Leadership

Staff Feedback

We received positive feedback from staff members who completed a HIW questionnaire. The majority of staff said that they would recommend Tŷ Grosvenor as a place to work and that they would be happy with the standard of care provided by the setting for themselves, friends or family.

Staff comments included the following:

> *"The hospital offers first class care to patients, is spotlessly clean and comfortable to work in. Management staff are fair, supportive and always available. Feedback from my manager is available and positive."*

> *"I have worked at Tŷ Grosvenor as a housekeeper for over five years and I have been treated with respect from all the management teams. I am respected, I love working at this unit and will be with the company until I decide to retire. I have always worked in care as a support worker but my role now as just a housekeeper is just as rewarding."*

Governance and accountability framework
It was positive that throughout the inspection staff were receptive to our views, findings and recommendations. Staff we spoke with were passionate about their roles. The majority of staff members who completed a questionnaire told us that they know who the senior managers are, that they are visible, and that they are committed to patient care. One staff member commented:

> *"They provide you with support and guidance when required. The Hospital Director's door is always open."*

The majority of staff members who completed a questionnaire also provided positive feedback about their line managers. Staff felt that their line manager can be counted on to help with a difficult task at work and gives them clear feedback on their work.

Governance arrangements were in place, such as audit activities and monitoring systems, to help provide oversight of clinical and operational issues. However, in light of the non-compliance issues we identified in relation to the Mental Health Act, we were not assured that these processes were effective, as they were not helping the hospital meet best practice and legislative requirements.

The service must provide assurance to HIW on how it will strengthen its audit and governance processes both at the hospital, and across other Elysium Healthcare sites in Wales, to ensure that it continuously monitors and improves the quality of service it provides.

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

Dealing with concerns and managing incidents
There was an established electronic system in place for dealing with concerns and recording incidents. Regular summary reports of incidents occurring at the hospital were being produced and reviewed to help identify overall trends and patterns of behaviour. However, we felt improvements were required in relation to reviewing individual incidents. For example:

- Individual incidents were being reviewed at the daily handover meetings. However, at the handover meeting we attended, it appeared that the discussion was more around quality assuring the data recorded on the electronic system, rather than a focus on identifying learning from the incident itself
- We reviewed previous incident forms and saw missing entries for manager comments and sign off. This meant we could not be assured that managers were aware of the incident or that preventative actions were being taken.

While ensuring the accuracy of the incident reporting is important, the service must also ensure that individual incidents are discussed among the multidisciplinary team and reviewed and signed off by senior managers to identify lessons learned and prevent recurrence.

The majority of staff members who completed a questionnaire told us that they would know how to report unsafe practice, and that their organisation encourages them to report errors, near misses or incidents. However, some staff members reported that they were not always given feedback about changes made in response to reported errors, near misses and incidents. This sentiment was echoed by night staff members that we spoke with during the first night of the inspection. They were unaware of a recent incident that had occurred at the hospital and told us that they were not always kept informed about errors, near misses or incidents.

The service must ensure that all staff are kept informed about incidents and any lessons learned.

Workforce planning, training and organisational development
Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. During our last inspection in July 2022 staff informed us about the difficulties and challenges they faced to retain and employ sufficient staff. It was therefore positive to see an improvement in this regard during this inspection, and we were told that there was currently only one staff vacancy which has enabled the use of agency staff to be kept to a minimum.

All staff members who completed a questionnaire felt they could meet the conflicting demands on their time at work and that they have adequate materials, supplies and equipment to do their job. The majority of staff members also felt that there are enough staff to do their job properly. However, we did receive the following comment from one staff member:

> *"At times ward staff cannot fulfil patient requests or Section 17 leave due to staffing levels. Although there is a safe level of staff on the ward, leave requests and other tasks cannot be fulfilled as this would leave the ward low on numbers."*

The service should reflect on this feedback and ensure there is always a sufficient number of staff available to ensure patients are able to take their Section 17 leave.

All staff members who completed a questionnaire felt that they have had appropriate training to undertake their role. We saw that suitable processes were in place for senior staff to monitor compliance with mandatory training. It was positive to see that overall compliance among staff with such training was very high. We also saw evidence that staff had received an annual appraisal to discuss their performance and set annual objectives.

Workforce recruitment and employment practices
A recruitment policy was in place that set out the arrangements to ensure recruitment followed an open and fair process. Safety checks are undertaken prior to employment to help ensure staff are fit to work at the hospital. These include the provision of two professional references, evidence of professional qualifications and a Disclosure and Baring Service (DBS) check. Newly appointed permanent staff receive a period of induction where they are required to read company policies and complete mandatory training.

A freedom to speak up / raising concerns (whistleblowing) policy was in place should staff wish to raise any concerns about issues at the hospital without suffering any detrimental treatment as a result. Staff were able to contact a 'freedom to speak up' guardian to raise any issues in confidence.

The majority of staff members who completed a questionnaire felt that their job is not detrimental to their health and that their organisation takes positive action on health and wellbeing.

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
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Service: Tŷ Grosvenor

Date of inspection: 06, 07 and 08 November 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
The service must ensure that statutory certificate of consent forms are always in place to authorise treatment administered to patients.	15(5a)	All consent forms and medication charts were immediately audited on 08/11/2023 by RC and Lead Nurse to ensure all patients have appropriate legal authority in place. Group Mental Health Administrator Lead carried out urgent remote audit on the 8/11/2023 of all patients consent forms to ensure legally compliant. All Doctors have been emailed by Lead Nurse on the 10/11/23 to remind them of the importance of ensuring statutory certificates of consent forms are always in place to authorise treatment administered to patients. External pharmacy audit will be completed every Tuesday to monitor compliance. External pharmacy audit actions are published on a live view portal following the pharmacy visit to site. The Actions from this audit will be sent out by ward managers by email to RC's, and Lead nurse where actions are required. An access request to the

		live portal has been submitted on 16/11/23 by Lead nurse to request access for the MHA Administrator and Medical Secretary to support the RC's in completion of tasks. Outcomes of external pharmacy audit will be discussed at the Quality Assurance Morning meeting as a standing agenda item every Wednesday to ensure that any issues raised are immediately actioned. Mental Health Administrator will carry out an internal legal audit of all patients every Thursday to further ensure that any matters raised on the external pharmacy audit has been actioned. Training in relation to Part 4 of the Mental Health Act is being delivered to Doctors and Nurses on the 17 /11/23 by external law firm Browne Jacobson Solicitors. Training around MHA, consent to treatment and administration of medication is being delivered on 28/11/23 by external pharmacist. Discussion in relation to consent to treatment certificates will be a standing agenda item in every ward round.
The service must ensure that statutory certificate of consent forms always state the correct type and dosage of medication that has been prescribed to patients.	15(5a)	All consent forms and medication charts were immediately audited on 08/11/2023 by RC and Lead Nurse to ensure that statutory certificate of consent forms always state the correct type and dosage of medication. Group Mental Health Administrator attended the Hospital on the 15/11/23 and checked relevant documentation and confirmed she found that statutory certificate of consent forms always stated the correct type and dosage of medication.

		All Nurses have been emailed on 15/11/23 by Lead Nurse to inform them of the importance of ensuring that the statutory certificate of consent forms always state the correct type and dosage of medication. Email read receipts requested and this email will be discussed as a standing agenda item at shift handover for the next 2 Weeks to ensure that it has been effectively communicated. External pharmacy audit will be completed every Tuesday to monitor compliance. External pharmacy audit actions are published on a live view portal following the pharmacy visit to site. The actions from this audit will be sent out by email to RC's, and Lead nurse where actions are required. These actions will also be discussed and monitored at the Quality Assurance Morning meeting every Wednesday. This is to provide assurance all actions have been completed. Actions will be reviewed at the end of Wednesday by ward managers. A clinical weekend audit will be carried out by Nurses every week to ensure that statutory certificate of consent forms always state the correct type and dosage of medication that has been prescribed to patients and that any actions raised by the external audit have been actioned. Discussion in relation to consent to treatment certificates will be a standing agenda item in every ward round.

The service must ensure that nursing staff always check the certificate of consent forms kept alongside the MAR charts to ensure the medication they are administering to patients has been authorised.	15(5a)	Nurses have been emailed by ward managers on the 9/11/23 and Lead Nurse on 15/11/23 (with email read receipt) to inform them that they must cross check consent forms with the medication chart prior to the administration of medication. This issue has been discussed at shift handovers and will continue to be regularly raised as a standing agenda item. Training around consent forms is being delivered on 28/11/23 by external pharmacist. Consent to treatment and medication administration will be added to the Registered nurse's monthly supervision template. Nurse meeting to be arranged by end of November 23 to discuss issues and process around the medication administration and consent.
The service must ensure that any discrepancies between the medication being administered to patients and the medication stated on their certificate of consent forms identified by Ashtons is corrected immediately.	15(5a)	External pharmacy audit actions are published on a live view portal following the pharmacy visit to site. The actions from this audit will be sent out by email to RC's, and Lead nurse where actions are required. These actions will also be discussed and monitored at the Quality Assurance Morning meeting every Wednesday. This is to provide assurance all actions have been completed. Actions will be reviewed at the end of Wednesday by ward managers. A clinical weekend audit will be carried out by Nurses every week to ensure any actions raised by the external audit have been actioned.

		The clinical weekend audit will be a standing agenda item brought to the Monday Quality Assurance meeting to be reviewed and checked by Lead Nurse and Hospital Director. Discussion in relation to consent to treatment certificates will be a standing agenda item in every ward round.
The service must review the clinical audit processes in place and identify where improvements can be made to ensure nursing staff can identify similar discrepancies.	15(5a)	The clinical audit process was discussed and reviewed at the local Clinical governance meeting 14/11/23. Ashtons pharmacist attended and agreed to attend the monthly governance meeting to feed back any trend's themes in medication management. Training will be delivered on 28/11/23 to all nursing staff by external pharmacist regarding auditing of consent to treatment alongside medication. The Clinical weekend audit will be a standing item agenda brought to the Monday Quality Assurance meeting to be reviewed and checked by Lead Nurse and Hospital Director. A check the checker audit will be completed on a random basis by Hospital Director and Lead Nurse to check for any discrepancies.
The service must ensure capacity to consent to treatment for patients is regularly assessed using the framework set out in the	17(1), 17(3)	All capacity assessments for consent to treatment of all patients were completed on the 10/11/23. Capacity Assessments to be recorded under the legal tab of the patient's electronic record.

Mental Capacity Act and guidance set out in the Mental Health Act Code of Practice for Wales (13.8) and recorded within their patient records.		Training in relation to Part 4 of the Mental Health Act is being delivered to Doctors and Nurses on the 17 /11/23 by external law firm Browne Jacobson Solicitors A dashboard review is completed of clinical records at the Quality assurance meeting every Thursday to check the consent to treatments are compliant. This data is pulled through from the legal tab of the patient's electronic records. A new feature of the Dashboard has been introduced which highlights compliance with capacity assessments and best interests. This data is pulled through from the legal tab of the patient's electronic records.

Appendix C - Improvement plan

Service: Tŷ Grosvenor

Date of inspection: 06, 07 and 08 November 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 service must ensure the information recorded on the 'patient safety at a glance' boards remains accurate and up-to-date.	Patient information and consent	All boards have been reviewed to ensure accuracy and are up to date. The process for recording the information has been reviewed. The Alwen Clerking in room board has been cleared as this is no longer required. New patients are added to the board as part of the admission process, nurses update the board as actions have been completed. The night site co-ordinators monitor and ensure the clinic room boards are up to date.	Lead Nurse	Completed

The service must develop a 'locked door' policy that sets out the arrangements and procedures to ensure the rights of informal patients are upheld while protecting detained patients who may be vulnerable.	Managing risk and health and safety	Hospital Director has developed a locked door policy, this has been ratified at local clinical governance. It has been discussed in regional Clinical Governance and in the next monthly Acute Clinical network group.	Hospital Director	20/03/24
The service must ensure that checklists and audits are completed accurately to ensure they remain effective at identifying issues of non-compliance with internal procedures.	Medicines management	The Weekly internal clinic audit is brought to Quality Assurance morning meeting every Monday to ensure oversight by SMT. This will be checked by ward managers and Lead Nurse. Weekly External pharmacy audit report is reviewed by the MDT the morning after the visit to site to ensure all actions are allocated and completed in a timely manner.	SMT	Ongoing
The service must ensure daily nursing entries within patient records provide more detail about staff interactions with each patient under their care.	Care planning and provision	A Nursing team meeting will be held on the 19th and 21st February to capture both shift patterns and ensure high attendance. Clinical entries and quality have been added to the agenda. All minutes will also be circulated via email. This has been added to staff supervision for the month of March and additional training can be given to staff on clinical entries and documentation if highlighted by supervision.	Hospital Director	30/03/24

		Lead Nurse will audit random sample of Clinical Entries weekly and feedback in local clinic governance.	Lead Nurse	Ongoing
The service must provide assurance to HIW on how it will strengthen its audit and governance processes both at the hospital, and across other Elysium Healthcare sites in Wales, to ensure that it continuously monitors and improves the quality of service it provides.	Governance and accountability framework	A MHA weekly audit has been introduced within the hospital and all Elysium healthcare sites this overseen by the MHA Lead for the company. Weekly External pharmacy audit report is reviewed by the MDT the morning after the visit to ensure all actions are allocated and completed in a timely manner. Ashtons external pharmacist has been requested to attend local clinical governance to feedback any issues/concerns. Any concerns are raised by Hospital Director at regional clinical governance . A Mental Health Act Dashboard review is undertaken corporately monthly for all sites, and a report is also provided to the Corporate Clinical Governance meeting.	Nursing team/MHA administrator SMT Hospital Director Hospital Director Group Mental Health Act Administration Lead	Ongoing Ongoing Completed Ongoing

		Annual Mental Health Act compliance audit to be undertaken for all sites.		
The service must ensure that individual incidents are discussed among the multidisciplinary team and reviewed and signed off by senior managers to identify lessons learned and prevent recurrence.	Dealing with concerns and managing incidents	All Incident data is reviewed in quality assurance morning meeting by the SMT. Any post incident action is now allocated to someone to complete, for example reflective practice, debriefs, changes in risk management, care plan reviews. PSIRF (patient safety incident response framework) has been introduced to the quality assurance morning meeting, the incidents are discussed and a decision on a learning response is decided. The aim is to ensure learning, and this will influence the service plans that aid the development or review of patient safety plans.	SMT SMT	Completed Completed
The service must ensure that all staff are kept informed about incidents and any lessons learned.	Dealing with concerns and managing incidents	A summary of Local Clinical governance and local operational meeting minutes are now circulated via email. All Incident data is reviewed in quality assurance morning meeting by the SMT. Any post incident action is now allocated to someone to complete, for example reflective practice, debriefs, changes in risk management,	Hospital Director SMT	Completed Ongoing

		care plan reviews and dissemination of information to staff.		
The service should ensure there is always a sufficient number of staff available to ensure patients are able to take their Section 17 leave.	Workforce planning, training and organisational development	Safe staffing levels are reviewed every morning as part of the Quality Assurance meeting to ensure that the wards have sufficient numbers. Ward Managers will check the daily allocation board to ensure escorted section 17 leaves are fairly allocated. Regular group leave is allocated once a week for each ward and service users decide where they would like to go as part of community meeting. Patient led audit to be completed around Section 17 leave to gather feedback from service users and ideas that the hospital can improve in this area.	SMT Ward Managers OT	Ongoing Ongoing 30/03/24

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): **Louise Burrows**

Job role: **Hospital Director**

Date: **20 February 2024**