Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Llanarth Court Hospital

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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 Llanarth Court Hospital on 13, 14 and 15 February 2023.

The following hospital wards were reviewed during this inspection:

- Awen Ward – 16 beds providing female medium secure services
- Treowen Ward – 11 beds providing male low secure services
- Deri Ward – 11 beds providing male low secure services
- Teilo Ward – 20 beds providing male low secure services
- Howell Ward – 16 beds providing male medium secure services
- Iddon Ward – 17 beds providing male medium secure services

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

At the time of the inspection, the hospital was being managed by The Priory Group.

Note the inspection findings relate to the point in time that the inspection was undertaken. This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Staff interacted and engaged with patients appropriately and with dignity and respect. Patients had their own programme of care that reflected their individual needs and risks. Good facilities were available onsite such as a social club and café which gave opportunities for patients to engage and relax outside of their immediate environment of care. Patients could engage and provide feedback about their care in a number of ways. 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:

- The communal shower areas need suitable storage facilities for patients to be made available.

This is what the service did well:

- The physical healthcare needs of patients were being well provided for through an onsite healthcare and medical team
- A quarterly newsletter was being produced which helped bring patient experiences to life.

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. The clinic rooms had been reconfigured since our previous inspection to improve the privacy and dignity of patients receiving their medication. Robust procedures were in place for the safe management of medicines on each ward. Patient care plans were being maintained to a good standard. The statutory documentation we saw verified that the patients were appropriately legally detained. Some maintenance work was needed to improve the standard of the environment of care for patients.

This is what we recommend the service can improve:

- Fridge and room temperatures checks in the clinic rooms must always be documented
- Sharps bins must be stored safely and removed for collection in a timely way
- Resuscitation and emergency equipment must be stored separately and in a clear and accessible place for staff to identify quickly in an emergency

- All mental capacity assessments must be documented and stored within patient records to be accessible by staff.

This is what the service did well:

- The medicines management procedures on Treowen Ward were of a particularly high standard, demonstrating excellent initiatives and practice.

Quality of Management and Leadership

Overall summary:
The majority of staff who completed HIW questionnaires provided positive feedback about working at the hospital. Established and effective governance arrangements were in place to provide oversight of clinical and operational issues. Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. Some members of staff reported that they had faced discrimination at work from patients within the last 12 months. We have asked the service to outline the actions that will be taken to try and eliminate this discrimination and describe the support that is available to staff following such incidents.

This is what we recommend the service can improve:

- The service must ensure all recruitment follows the open and fair process set out in the safer recruitment and selection policy.

3. What we found

Patient and Staff Feedback

We invited patients and staff to complete HIW questionnaires during and following the inspection to obtain their views on the service provided at the hospital. While we only received a small number of completed questionnaires from patients, our patient experience reviewer spent time on the wards and spoke to many patients throughout the inspection to obtain their views.

We received 56 completed questionnaires from staff members at the hospital. Staff responses were positive, with the majority recommending Llanarth Court as a good place to work and agreeing that they would be happy with the standard of care provided by the hospital for themselves or for their friends or family.

Feedback from patients, and comments and questionnaire results from staff, appear throughout the report.

Quality of Patient Experience

Health promotion, protection and improvement
Patients at the hospital have access to an onsite physical healthcare and medical team. We looked at a sample of six patient records and saw evidence that patients had received appropriate physical assessments upon their admission. We also saw that patients received regular reviews and had access to appropriate screening services and had been referred to other primary care health professionals when required.

Smoking was not allowed onsite, but patients were individually risk assessed to be allowed access to electronic cigarettes (vapes) in some parts of the hospital.

Patients had access to a range of therapy facilities either on their ward or on the wider hospital site. This included facilities such as gardening, woodworking, occupational therapy kitchens, art skills, and a well equipped gym and sports hall. It was positive to see that since our previous inspection outside gym equipment had been installed on the hospital grounds to provide more opportunities for patients to be active.

Throughout the inspection we saw activities taking place and it appeared that there was sufficient staff available to facilitate these with patients. However, one staff member who completed a questionnaire commented:

"… I feel that the wards having more staff on shift would provide more opportunities for patients in terms of being able to facilitate more 1:1s, and being able to provide escorting staff for more sessions to take place/ groups to run etc."

The service should consider this feedback and review whether the current provision of activities and sessions taking place is sufficient for the needs of the patients on all wards.

A social club was available onsite which gave opportunities for patients to engage and relax with each other for games and film nights outside of the standard therapeutic timetable. A café and patient shop was also available that provided patients with 12 week working opportunities to develop and gain employment experience and skills.

Dignity and respect
Throughout the inspection we observed staff treating patients appropriately and with dignity and respect. All patients provided positive feedback about staff at the hospital and it was clear that good interpersonal relationships had been built. Patients said that they felt as though staff 'really cared' about them and that they felt listened to. All staff members who completed a questionnaire agreed that the privacy and dignity of patients is maintained and that patients are informed and involved in decisions about their care.

All patients had their own bedroom. Each bedroom door had an observation panel which enabled staff to undertake observations without having to open the door and disturb patients. Patients were able to personalise their rooms with pictures and posters. We were told that personal items are individually risk assessed for patients and that restricted items are kept in secure patient lockers which could be accessed under staff supervision. Some bedrooms had en-suite facilities while other patients had to access communal toilets and showers. We had raised in a previous HIW inspection in November 2021 that the shared shower areas did not have a storage area to keep clothes and possessions dry.

The service must ensure communal shower areas have suitable storage facilities for patients.

Patient information and consent
The hospital had a written statement of purpose that met the requirements of the regulations. Easy read patient information guides were available for patients on each ward. We were provided with an example for Deri Ward, and saw it was comprehensive and of good quality.

Information for patients was also displayed on notice boards on each ward. This included information such as the weekly activity timetable, healthy eating, advocacy services and how to make a complaint or raise a concern. We noted that patient information was predominantly only available in English. However, we saw that the patient information leaflets referred to language requirements and stated that interpreters would be made available and that key information could be translated if required.

We saw that each ward had a 'Who's who' board which contained a picture and some information about each staff member working on the ward. This was in line with the 'know each other' domain of the safewards model. We noted this as good practice as an attempt to remove barriers between the staff and patients.

Communicating effectively

Staff communicated appropriately and effectively with patients throughout the inspection.

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 noted that a positive improvement since our previous inspection was the development of a child friendly visiting suite. A telephone was available on each ward for patients to use if required. Patients had access to a basic mobile phone and were individually risk assessed for use of smart phones and other digital devices.

Each ward has a monthly community meeting to provide an opportunity for patients to raise any issues with ward staff. Patient representatives are identified to represent each ward at monthly patient council meetings, which allows patients to raise issues and ideas with senior managers at the hospital. Minutes of both the community and patient council meetings are made available to all patients to inform them of what was discussed. The patients we spoke with during the inspection felt that these meetings were worthwhile and helped to make them feel listened to.

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 the needs and risks of the individual patients. It was also evident that patients had been involved in the development of their care plans. More findings on the care plans can be found in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Equality, diversity and human rights

During the inspection we looked at the patient records of five individuals that had been detained at the hospital under the Mental Health Act (the Act). The legal documentation we reviewed was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code) to help uphold the rights of patients.

The care and treatment plans we reviewed evidenced that the social, cultural and spiritual needs of patients had been considered. We saw that the hospital had an Equality, Diversity and Inclusion policy available to help ensure that patients' equality and diversity were respected. However, we noted that the policy was out of date having been due to be reviewed in November 2022.

The service must ensure the policy is reviewed as required to ensure it remains relevant and in line with relevant legislation and guidance.

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 through the community meetings and patient council. We were told that patient satisfaction surveys are also used as a way to capture patient feedback. These are issued to current patients as well as patients that have recently been discharged. We saw that 'You said, we did' boards were displayed on each ward to inform patients of changes made as a result of patient feedback.

The patients we spoke with told us that they knew how to make a formal complaint should they need to do so.

The hospital produces a quarterly newsletter which includes items written by patients. We were provided with a copy of the January 2023 newsletter and saw it included pictures of previous activities undertaken at the hospital, a poem written by a patient from Teilo Ward and a puzzle page which patients could complete for the chance to win a prize. We noted the newsletter as an example of good practice for existing and new patients to help bring patient experiences to life.

Delivery of Safe and Effective Care

Safe Care

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

We noted that some improvements had been made to the environment since the previous inspection. We were also told that plans were in place to build a new wing at the hospital to accommodate two new wards. Changes to the footprint of the Awen Ward were also in the development stage. The current environment of the hospital is tired and well worn, and these plans to modernise conditions for staff and patients is a positive step. Throughout this inspection we identified the following areas which were in need of improvement:

- The walls in the courtyard of Teilo need to be painted to improve their appearance
- The hot drink bays for patients throughout the hospital need refurbishing and cleaning. The bay in Teilo Ward has paint peeling off, the fridge on Iddon Ward is dirty and the worktop on Iddon Ward is stained
- Drink stains on the wall in the TV lounge on Iddon Ward need to be cleaned
- The fixtures and fittings of the communal bathrooms throughout the hospital are in need of modernisation
- The patio outside the intensive care suite on Awen Ward was very mossy and potentially dangerous to patients in wet weather
- There was a hole in one of the walls on Awen Ward that needs to be repaired
- Rooms throughout the hospital need to be kept clear of clutter. For example, we saw Christmas decorations being stored on the floor in the art room on Iddon Ward.

The service must ensure upkeep and maintenance of the wards is undertaken to provide a suitable standard of living for patients as part of their environment of care.

A range of up-to-date health and safety policies were available for staff. We saw that a health and safety inspection and audit had been undertaken in August 2022 by members of the corporate health and safety team at The Priory Group. We

noted that the hospital achieved a ‘good’ overall rating for health and safety management in the audit.

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.

There were nurse call points within patient bedrooms and communal bathrooms so that patients could summon assistance if required. Staff wore personal alarms and carried radios which they could use to call for assistance if required.

A number of contingency plans were in place that set out the procedures to follow in the event of a major incident occurring at the hospital. These included events such as fire, loss of water and electricity supply and severe weather conditions.

Infection prevention and control (IPC) and decontamination
Apart from the areas identified within the Managing risk and health and safety section of this report, the environment of the wards and the wider hospital was generally clean. We saw evidence of cleaning schedules being maintained. Each ward had a designated IPC lead and there appeared to be a collective approach towards implementing IPC procedures among nursing, housekeeping and maintenance staff.

Medical equipment across the hospital was mostly disposable, but we saw evidence that re-usable equipment was being regularly cleaned between usage. Hand gel dispensers were available at the entrances to all wards for both staff and patients to use before entering. 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 saw staff encouraging patients to wash their hands before eating which we noted as good IPC practice. Visitors were required to complete a risk assessment before attending on site to help control the risk of transmitting COVID-19 throughout the hospital.

A range of up-to-date policies were available that detailed the various IPC procedures in place to help keep staff and patients safe. Regular audits had been completed to monitor compliance with hospital procedures. The staff we spoke with seemed clear about their individual responsibilities in relation to effective infection prevention. Staff compliance with mandatory IPC training was high at 90 per cent.

Nutrition
We saw evidence that the dietary needs of patients had been assessed on admission

using the Malnutrition Universal Screening Tool (MUST). We saw that specific dietary needs had been identified where necessary. All patients receive ongoing weight management checks during their stay.

We were given a positive example of quality improvement implemented at the hospital in relation to ensuring patients with eating disorders are handled and treated appropriately. Staff were provided with training to fill the skills deficit and care plans have subsequently been updated and improved to reflect the better understanding of treating eating disorders.

Patients had access to hot and cold drinks. Staffed kitchens were located on site to provide patients on each ward with a variety of meals throughout the day. The majority of patients we spoke with provided positive feedback about the quality and choice of food, and said they were able to have input into the menus and suggest any changes.

We were informed that the catering service at the hospital was going to be outsourced in the near future. The service may wish to consider implementing a programme of evaluation once the new catering service has started to ensure it meets the needs of patients.

Medicines management

We reviewed the hospital's clinic arrangements and found that robust procedures were in place for the safe management of medicines on each ward. We noted that the medicines management procedures in place on Treowen Ward were of a particularly high standard, demonstrating excellent initiatives and practice. The service should consider sharing this good practice with the other wards.

Relevant policies, such as medicines management and rapid tranquillisation, were in date and were available to staff in the clinic rooms or electronically on the intranet.

It was positive to see that the clinic rooms had been reconfigured since our previous inspection to improve the privacy and dignity of patients receiving their medication. The clinic rooms were clean and tidy and well organised, and medication was being stored securely at all times. Medication fridges were locked when not in use. We saw that daily temperature checks of the medication fridges and clinic rooms were being completed to ensure that medication was stored at the manufacturer's advised temperature. However, we found a small number of gaps in the recording of the fridge and room temperatures on Howell Ward.
The service must remind staff of the importance of undertaking and documenting such checks.

During the inspection we noted that there were a number of full sharps bins being stored on the floor in the clinic room on Awen Ward. We raised this with staff and it was positive that the full bins were immediately removed.

However, the service must ensure all full sharps bins are removed for collection in a timely way.

We saw that appropriate arrangements were in place for the storage and safe use of controlled drugs and drugs liable to misuse on wards where this was applicable. Drugs were being stored securely and the records we viewed evidenced that stock was accounted for when administered and that daily stock checks were being undertaken. Weekly audits were being undertaken internally by clinical staff and externally by an independent pharmacist to monitor ongoing compliance.

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

Safeguarding children and safeguarding vulnerable adults
We found processes in place to help ensure that staff at the hospital safeguarded patients appropriately. Monthly safeguarding quality assurance meetings were being held to discuss recent safeguarding incidents and identify themes or trends. We saw minutes of previous meetings and saw that they were well attended and provided evidence of good oversight. 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. Compliance among staff at the hospital with safeguarding training was high at 83 per cent.

Medical devices, equipment and diagnostic systems
We saw evidence of weekly checks being undertaken on resuscitation and emergency equipment held on each 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.

During our tour of Howell Ward we saw that the resuscitation and emergency equipment was being stored in the cupboard in the staff office. However, the equipment was located on a shelf amongst numerous other rucksacks belonging to staff working on the ward that night. We were not assured that in an emergency

staff would be able to quickly distinguish the resuscitation and emergency equipment bag from all the other bags in the cupboard.

The service must ensure that the resuscitation and emergency equipment is stored separately and in a clear and accessible place for staff to identify quickly in an emergency.

Safe and clinically effective care
We found that there were policies and procedures in place to help staff provide safe and effective care. All staff who completed a questionnaire agreed that they were satisfied with the quality of care and support they give to patients.

The hospital has adopted the principles of the safewards model. Each ward had a clear philosophy setting out its role, function and the staff employed on the ward. Principles of positive behavioural support were being used to determine level of risk and encourage positive risk taking. Care and treatment plans included personalised strategies for managing challenging behaviour and physical interventions appeared to be used as a last resort. We were told that staff would observe patients more frequently in line with the supportive observation and engagement policy if patients continued to present with increased risks.

Intensive care suites were available on each ward and were being used as a way to manage short periods of aggressive and disturbed behaviour from patients. The documentation around the use of the intensive care suites was robust and compliant with the reviews stated in the Code. We saw evidence that exit strategies were in place with some patients being able to set their own goals to support reintegration back into the main ward environment.

Staff were knowledgeable about the needs and risks of each patient which resulted in a confident approach to patient care in a high-risk environment. Restricted and prohibited items were clearly identified on each ward and where permitted, individualised risk assessments were completed to access personal possessions. The governance and implementation of restrictive items and interventions was being regularly reviewed through security meetings and at the patient council meetings.

A ‘flash’ meeting was being held every morning for nursing staff to update the multi-disciplinary team (MDT) and senior management team on any concerns, issues or incidents that had taken place the day before. We attended a flash meeting during the inspection and it was positive to see that discussions were held around identifying and communicating which two staff members were working during the day shift on each ward that had immediate life support (ILS) training to assist in the event of an emergency. However, we noted that a similar discussion was not being had to identify which two staff members with ILS training were

working during the night shifts. During a review of staff rotas we found some examples where the qualified staff nurses working during the night shifts had fallen out of compliance with the ILS training.

The service must ensure discussions are had during the evening handover meetings to identify which staff working during the night shift have up-to-date ILS training.

Records management
Patient records were being maintained electronically and were 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. It was evident that nursing staff and MDT professionals were writing detailed and regular entries that provided up to date information on the patient and their care.

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 of five patients currently residing at the hospital. All records verified that the patients were being legally detained.

We looked at the arrangements in place at the hospital to assess the capacity of patients to make decisions for themselves. We saw evidence that consent to treatments certificates were being completed. We also saw one example where it was documented by the responsible clinician that the patient had capacity to consent to treatment. However, in all five patient records we reviewed we could not see any documented evidence of the formal capacity assessments that had been undertaken to determine that patients were able to make decisions for themselves.

The service must ensure all capacity assessments are documented and stored within patient records to be accessible by staff.

All relevant consent to treatment certificates were being stored alongside the MAR charts for each patient as required, which was a positive improvement since our previous inspection. We noted that earlier consent to treatment certificates were also being stored alongside the MAR charts on Teilo Ward and we advised staff to remove the earlier forms and just keep the current certificate to avoid the potential for confusion.

We saw that information was being provided to patients following their admission about their detention and their legal rights. 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. We spoke with the advocate who provided examples of many positive outcomes in relation to supporting patients, for example, helping patients make arrangements for their discharge from the hospital.

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. However, in four of the five patient records we reviewed, we could not see evidence that patients had been involved in determining the conditions and outcomes of their leave.

The service must ensure patients are involved in this process.

It was also unclear in the patient records whether patients had agreed with the conditions and outcomes of their leave, or been offered or provided with a copy of the form. We advise the service to consider recording patient signatures to indicate their agreement with their leave arrangements and to document whether the patient has been provided with, or refused to accept, a copy of the form.

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 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.

Monthly individual care reviews were being held for each patient to ensure they are kept updated to reflect current needs and risks. We attended an individual care review for a patient and found the MDT worked well together and that everybody had a voice in regard to patient care. It was also positive to see that the views of the family had been sought before the meeting.

We saw evidence that care and treatment plans were being reviewed every six months. However, we noted that there appeared to be a delay in recording the minutes of these meetings within the electronic patient records. For example, the minutes of a care and treatment plan review that had occurred on 06 December 2022 had not been uploaded onto the electronic patient record.

The service must ensure minutes of meetings are uploaded in a more timely manner to ensure the patient records are contemporaneous and provide more clarity to staff members.

Quality of Management and Leadership

Governance and accountability framework
It was positive that throughout the inspection staff were receptive to our views, findings and recommendations. The majority of staff members who completed a questionnaire told us that the hospital encouraged teamwork and that they are supported to identify and solve problems. One staff member provided the following positive feedback in the questionnaires:

> *"There is always a good sense of team work on all the wards, lots of peer support is evident throughout the workplace. I would not hesitate for a friend or family member to be cared for here, I know that they would receive the best possible care."*

We found established and effective governance arrangements in place to provide oversight of clinical and operational issues. A 'flash' meeting was being held every morning for nursing staff to update the multi-disciplinary team (MDT) and senior management team on any concerns, issues or incidents that had taken place the day before. We attended a flash 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.

A suitable electronic system was in place for reporting incidents, complaints and documenting clinical and governance audits. This helped the service to focus on continuously maintaining standards. Agendas for clinical governance meetings showed a wide range of standing items to help ensure that the hospital focussed on all aspects of the service. Further oversight of the performance of the hospital is managed corporately through The Priory Group corporate teams.

The staff we spoke with during the inspection were passionate about their roles and appeared to have an understanding of their own responsibilities. However, one staff member provided the following comment in the questionnaires:

> *"… staff are not aware of the different roles within the hospital and what different people do. This creates confusion."*

The service should reflect on this aspect of the feedback to help ensure all staff understand the roles and remit of key job roles at the hospital.

Dealing with concerns and managing incidents
There was an established electronic system in place for recording, reviewing and monitoring incidents. Regular incident reports were produced and reviewed at the hospital level, and at a corporate level, to help identify trends and patterns of behaviour.

Individual incidents were being discussed with members of the MDT and senior staff at the daily flash meetings, monthly patient safety meetings and the monthly clinical governance committees. We saw that lessons learned was a standing agenda item at staff meetings for each ward.

All staff who completed a HIW questionnaire said that they would know how to report unsafe practice. The majority of staff also said they would feel secure raising concerns about patient care or other issues at the hospital.

Workforce planning, training and organisational development
Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. We were told that regular agency staff who were familiar with working at the hospital and the patient group have been used to cover any staffing shortfalls. We were also informed about the recruitment initiatives currently being undertaken to attract new staff.

The majority of staff members who completed a questionnaire agreed that there was enough staff at the hospital for them to do their job properly and that they had enough time to give patients the care they need. The majority of staff members also felt that there was an appropriate mix of staff skills at the hospital and that they were able to meet all the conflicting demands on their time at work. However, we received the following comment from one member of staff in the questionnaires in relation to how the service could improve:

> *"Be more consistent. Stop moving staff so frequently and without explanation. Have more emphasis on care and less on process."*

The service should consider this feedback and identify ways to improve communication with staff on any movements across wards.

We saw that suitable processes were in place for senior staff to monitor compliance with mandatory training. The overall rate for staff compliance with mandatory training was 77 per cent. Staff members who completed a questionnaire told us that training helped them do their job more effectively, stay up to date with professional requirements and deliver a better patient experience.

We were told that opportunities are available for staff to develop, including clinical supervision. Staff receive annual performance development reviews to discuss their performance and set annual objectives. We saw that 92 per cent of staff had received their latest performance development review which was positive.

Workforce recruitment and employment practices
A safer recruitment and selection 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. However, we received the following comment from one member of staff in the questionnaires:

> *"There have been examples of nepotism throughout my time here which is frustrating to see."*

The service must reflect on this feedback and ensure all recruitment follows the open and fair process set out in the safer recruitment and selection policy.

Newly appointed permanent staff receive a period of induction where they are required to read company policies and complete mandatory training. Staff must be able to evidence their competency over the first six months in order to pass the probationary period.

A whistleblowing policy was in place should staff wish to raise any concerns about issues at the hospital without fear of 'victimisation, subsequent discrimination or disadvantage'. Staff were able to contact a 'freedom to speak up' guardian to raise any issues in confidence.

Some members of staff who completed a questionnaire reported that they had faced discrimination at work within the last 12 months. One staff member commented:

> *"A patient used [discriminatory] language against me…"*

The service must provide assurance to HIW on actions that will be taken to reduce incidents of discrimination at work for staff members and describe the support offered to staff following such incidents.

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: Llanarth Court

Date of inspection: 13, 14 and 15 February 2023

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate non-compliance concerns were identified on this inspection.				

Appendix C - Improvement plan

Service: **Llanarth Court**

Date of inspection: **13, 14 and 15 February 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 communal shower areas have suitable storage facilities for patients.	Dignity and respect	Site to source storage facility for shower areas	Ross Morris delegates to Alexander Hore	May 2023
The service must ensure the Equality, Diversity and Inclusion policy is reviewed.	Equality, diversity and human rights	Operational policy currently under review. Site liaising with central HR team for completion.	Ross Morris	May 2023
The service must ensure upkeep and maintenance of the wards is undertaken to provide a suitable standard of living for patients as part of their environment of care.	Managing risk and health and safety	Site Improvement Plan in place and reviewed on a monthly basis to highlight areas of concern and remedial actions. The SIP contains a rolling maintenance schedule that is continually reviewed.	Ross Morris delegates to Alexander Hore	May 2023

The service must remind staff of the importance of undertaking and documenting fridge and room temperatures checks in the clinic rooms.	Medicines management	Areas of good practice highlighted within the report to be shared and rolled out across site.	Ross Morris delegates to Treeve Brooks	July 2023
The service must ensure all full sharps bins are removed for collection in a timely way.	Medicines management	Areas of good practice highlighted within the report to be shared and rolled out across site.	Ross Morris delegates to Treeve Brooks	July 2023
The service must ensure that the resuscitation and emergency equipment is stored separately and in a clear and accessible place for staff to identify quickly in an emergency.	Medical devices, equipment and diagnostic systems	This action was resolved immediately. Subsequently, shift checks are completed by Charge Nurses and Night Managers.	Ross Morris delegates to Treeve Brooks	April 2023
The service must ensure handover meetings identify which staff working during the night shift have up-to-date ILS training.	Safe and clinically effective care	ILS trained staff are identified and documented on daily handover. This includes day and night staff	Ross Morris delegates to Treeve Brooks	April 2023
The service must ensure all capacity assessments are documented and stored within patient records to be accessible by staff.	Mental Health Act Monitoring	All patients are assumed to have capacity unless otherwise stated. CO2's are now in place within the MARS folders.	Ross Morris	July 2023

		These will be accessible on the new e-prescribe system rolling out in May 23. There is also a capacity assessment tab on care notes, but no patients currently require this.		
The service must ensure patients are involved in determining the conditions and outcomes of their Section 17 leave.	Mental Health Act Monitoring	All service users are involved in their individual care review, including discussion of section 17 leave conditions. This will be documented within care notes on their section 17 leave form.	Ross Morris delegates to Dr Stephen Hunter	July 2023
The service must ensure relevant minutes of meetings related to patient care are uploaded in a timely manner to the patient records.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	Resources have been allocated to ensure minutes are uploaded in a timely manner.	Ross Morris delegates to Alexander Hore	July 2023
The service must ensure all recruitment follows the open and fair process set out in the safer recruitment and selection policy.	Workforce recruitment and employment practices	As an SMT we have reflected on our recruitment process. We hold a regular recruitment forum which contain staff from various departments. We also follow stringent recruitment practices,	Llanarth SMT	April 2023

		regarding interviewing, advertisements.		
The service must provide assurance to HIW on actions that will be taken to reduce incidents of discrimination at work for staff members and describe the support offered to staff following such incidents.	Workforce recruitment and employment practices	Safewards strategy across site to reduce incidents of discrimination. Incidents of discrimination are discussed on morning handover meetings. Site then ensure staff are supported and encouraged to report to the police if desired. Patients are also met with to discuss the incidents. Staff will also be encouraged to report and record incidents of discrimination to ensure support.	Llanarth SMT	July 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): **Ross Morris**

Job role: **Hospital Director**

Date: **19 April 2023**