Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Ty Llewelyn, Bryn Y Neuadd Hospital, Betsi Cadwaladr University Health Board

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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 inspection at Ty Llewelyn, Bryn Y Neuadd Hospital, Betsi Cadwaladr University Health Board on 3, 4 and 5 July 2023. The following hospital wards were reviewed during this inspection:

- Gwion - Five bed Medium Secure Psychiatric Intensive Care Unit
- Pwyll - Ten bed Medium Secure Acute Ward
- Branwen - Ten bed Medium Secure Rehabilitation Ward.

Our team for the inspection comprised of two HIW Healthcare Inspectors, three clinical peer reviewers 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 three questionnaires were completed by patients and nine were completed by staff. We also spoke to staff working at the service during our inspection. 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:
We found a dedicated staff team that were committed to providing a high standard of care to patients. We saw staff interacting with patients respectfully throughout the inspection.

Patients told us that improvements were required regarding food preparation and menu choices.

This is what we recommend the service can improve:

- Bedrooms require redecoration
- Improvements to menu choices
- Improved access to electronic devices.

This is what the service did well:

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Good activities programme for patients.

Delivery of Safe and Effective Care

Overall summary:
Staff appeared committed to providing safe and effective care. Patient care and treatment plans were being kept to a good standard.

Safe and therapeutic responses were in place to manage challenging behaviour and promote the safety and wellbeing of patients.

Suitable protocols were in place to manage risk, health and safety and infection control. Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation.

This is what we recommend the service can improve:

- Improve ventilation in bathrooms and gym areas
- Redecoration of ward and communal areas
- Bespoke audit activity tasks for mental health setting.

This is what the service did well:

- Safe and effective medicine management

Quality of Management and Leadership

Overall summary:
We observed a committed staff team who had a good understanding of the needs of the patients at the hospital. We found a friendly, professional, and kind staff team who demonstrated a commitment to providing high quality care to patients.

There was dedicated and passionate leadership displayed by staff, the ward managers and senior leadership team. However, whilst not a finding during the onsite inspection, our staff survey received some negative responses. These were in relation to staff not feeling encouraged or supported to raise concerns, a lack of confidence that the organisation acts in response to concerns, and culture. We have asked the health board to review this feedback with a particular focus on the relationship between ward staff and senior managers.

We found an effective governance structure in place in terms of meetings to discuss incidents, complaints and issues related to patient care. However, some improvements are required in relation to updating policies.

This is what we recommend the service can improve:

- Recruitment of staff into vacant posts
- Review and update policies.

This is what the service did well:

- Motivated and patient focussed team
- Staff team were cohesive and positive about the support and leadership they received from managers
- Strong leadership provided to staff by ward managers and senior management team
- Wellbeing provisions for staff.

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

3. What we found

Quality of Patient Experience

Patient Feedback

We handed out HIW questionnaires during the inspection to obtain views on the service provided at the hospital. We received three responses to the questionnaires; this low number needs to be borne in mind when considering these responses. We also reviewed internal patient feedback, complaints, and survey logs to help us form a view on the overall patient experience.

Some of the comments provided by patients on the questionnaires included:

"Meals no longer freshly cooked on site".

We asked what could be done to improve the service. Comments included the following:

"Menu choices could be more variable for us long term patients".

Person centred

Health Promotion

Ty Llewelyn had a range of facilities to support the provision of therapies and activities along with regular access to the community for patients that were authorised to leave the hospital.

Patients were able to access GP, dental services and other physical health professionals as required. Patient records evidenced detailed and appropriate physical assessments and monitoring.

We observed patients and staff participating in a range of activities throughout the inspection. The occupational therapy staff had an excellent variety of activities programme in place, and it was clear to see that the OT department were providing some beneficial therapeutic activities for the patient group. Although the activities programme was good, we were told that there are often delays in the health board approving occupational therapy equipment which can impact on the therapies available to patients.

The health board must ensure that the health board deal with requests for equipment in a more timely manner.

There was also an occupational therapy kitchen that patients could use to prepare meals; however, this room was not being used effectively and needed updating.

The health board must ensure that the occupational therapy kitchen is used more effectively and is updated.

The hospital had a gym, and sports hall which provided patients with suitable fitness equipment to keep fit. We noted that some patient complaints had been made in relation to the temperature and ventilation in these areas.

The health board must review the ventilation and temperatures in these areas to improve quality of patient experience.

Patients also had access to the spacious hospital grounds. The grounds were well maintained and patients were seen using this area throughout the inspection.

Dignified and Respectful Care

We noted that all employees; ward staff, senior management, and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect.

The staff we spoke with were enthusiastic about their roles and how they supported and cared for the patients. We saw most staff taking time to speak with patients and address any needs or concerns the patients raised, this showed that staff had responsive and caring attitudes towards the patients.

It was noted that the ward entrances were locked and an intercom system to the ward prevented any unauthorised access.

Only one bedroom on each ward provided en-suite facilities. The bedrooms required redecoration, wardrobe doors had also been removed and this made the bedroom areas look untidy and undignified.

The health board must improve the appearance of patient bedrooms.

Patients could lock their rooms, but staff could override the locks if needed. We saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering. However, some patients told us that when repairs are required in their bedrooms or bathrooms they are not notified and are sometimes shocked to find maintenance staff in their rooms.

The health board must ensure they update patients when maintenance work is being carried out in bedroom and bathroom areas.

Patients were able to personalise their rooms and store their own possessions. Personal items were risk assessed on an individual basis for the safety of each patient.

Patients told us that they were sharing one iPad between three wards and that this was not enough.

The health board should review this and make more iPads available for the patient group following relevant risk assessments being completed.

Patient information

Written information was displayed on the ward for patients and their families. We saw that posters displayed information about advocacy services and how patients could provide feedback on the care they received on the wards.

Monthly patient forum meetings are chaired by a manager or senior member of staff and Caniad representatives attend. During the inspection we saw minutes of these meetings and actions taken to address any issues raised by the patients.

Individualised care

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

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

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

Some patients told us that multiple appointments are booked for them to attend, and often there are clashes meaning that they miss some appointments.

The health board needs to ensure that coordination of patient appointments is managed more effectively.

Timely

Timely Care

Overall, we found evidence that patients were provided with timely care during their time on the ward. Patient needs were promptly assessed upon admission, and we observed staff assisting patients in a timely manner when requested.

The ward held daily safety huddle meetings which adequately established the bed occupancy levels, observations, staffing levels and any emerging patient issues.

Equitable

Communication and language

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

We saw that staff engaged with patients in a sensitive way and took time to help them understand their care using appropriate language. There was clear mutual respect and strong relational security between staff and patients.

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

Rights and Equality

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

There were facilities for patients to see their families in private. Rooms were also available for patients to spend time away from other patients according to their needs and wishes. Arrangements were in place for patients to make telephone calls in private.

We looked at the records for patients who were detained under the Mental Health Act (the Act) and saw that documentation required by legislation was in place within the sample of patient records we saw. This showed that patient rights had been promoted and protected as required by the Act.

All patients had access to advocacy services, and we were told that advocates visit the hospital. Staff told us that patients are invited to be part of their MDT meetings and that the involvement of family members or advocates was encouraged where possible.

Delivery of Safe and Effective Care

Safe

Risk management
Access to the wards was secure to prevent unauthorised access. Staff could enter the ward with swipe cards and visitors rang the buzzer at the ward entrance.

Staff wore personal alarms which they could use to call for help if needed. There were also nurse call points around the hospital and within patient bedrooms and bathrooms so that patients could summon aid if needed. We identified that some patient call buttons in patient bedrooms were not within patients reach from the bed areas.

The health board must ensure that the call bells in patient bedrooms are easily accessible for patients.

We saw evidence of various risk assessments that had been conducted including ligature point risk assessments workbooks and fire risk assessments. We were told of the environmental checks that are completed and saw evidence of ward manager checks on all wards.

The inspection team considered the hospital environment during a tour of the hospital on the first night of the inspection and the remaining days of the inspection. Overall, the ward appeared clean and tidy, however we identified several decorative and environmental issues that required attention:

- Mould and poor ventilation in shower rooms and toilets on all three wards. This has also been raised in patients complaints
- Privacy curtain on Pwyll Ward with no date of disposal and no privacy curtain in the shower on Branwen Ward
- Ward bathrooms equipment need to be replaced, potentially ligature risk and need to be made safe for the patient group (included in the risk assessment)
- Redecoration of bedrooms, the empty cupboards made the bedroom areas look untidy and undignified
- Old phone sockets in bedrooms need to be removed
- Wards and communal areas would benefit from painting and redecoration
- Review the ventilation, temperature and airflow in gym and seclusion suite
- Occupational therapy kitchen needs to be improved.

The health board should consider the above environmental issues.

Infection, prevention, control and decontamination

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

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

We saw evidence to confirm that the health board conducted necessary risk assessments and updated relevant policies and procedures. Staff we spoke to were aware of infection control obligations.

We also saw that staff had access to, and were using, personal protective equipment (PPE) where appropriate. Staff we spoke to confirmed that PPE was always readily available. Sufficient hand washing and drying facilities were available.

There was evidence of nursing cleaning schedules, however no cleaning activity schedule were in place for domestic staff.

The health board should ensure that cleaning activity schedules are in place for domestic staff.

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

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

Medicines management
On the first night of the inspection, we found medication fridges were left unlocked. This was raised with staff and rectified immediately, all fridges remained locked during the inspection.

We found that there were suitable arrangements for the safe and secure storage and administration of controlled drugs. We saw evidence of regular temperature checks of the medication fridge to monitor that medication was stored at the advised temperature of the manufacturer. However, there were some gaps where temperature checks had not been recorded.

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

Overall, the clinical areas were clean, tidy, and well organised.

MAR charts were generally well completed on the wards. However, we found that patient legal status section of the MAR chart was not consistently completed. Without this information it is difficult for those administering medications to do so in the context of the correct legal framework. There were also a small number with missing signatures.

The health board must ensure that MAR charts are fully completed.

There was limited pharmacy input and audit activity undertaken that assisted the management, prescribing, and storage of medication at the hospital.

The hospital would benefit from more frequent pharmacy support and input.

Staff were knowledgeable and confident when administering medication. We saw several medication rounds, and saw that staff undertook these appropriately and professionally, interacting with patients respectfully and considerately.

We saw evidence of regular auditing of resuscitation equipment. Staff had documented when these had occurred to ensure that the equipment was present and in date. However, we noted that after the checks had been undertaken the emergency bag had not been resealed.

The health board must ensure that the emergency bag is resealed after the relevant checks have been undertaken.

During staff discussions, it was evident that staff were aware of the locations of ligature cutters in case of an emergency.

Challenging behaviour

Strategies were described for managing challenging behaviour to promote the safety and wellbeing of patients. We were told that preventative techniques were used and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the safe physical restraint of patients was used. Any use of restraint was documented and discussed in governance meetings. We reviewed restraint data and noted that some forms were not fully completed with gaps on position data and some timings missing.

The health board must ensure that restraint forms are fully completed.

There was an established electronic system in place for recording, reviewing, and monitoring incidents. Incidents were entered on to the health board's incident reporting system (DATIX).

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed so that the occurrence of incidents could be reviewed and analysed. Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation.

Effective

Effective care

Overall, we found that systems and governance arrangements were in place, which helped ensure that staff provided safe and clinically effective care for patients. Staff confirmed that de-briefs take place following incidents. Meetings we attended and evidence obtained during the inspection confirmed that incidents and use of physical interventions are checked and supervised.

Patient records

Patient records were a combination of electronic and paper records. Electronic records were password protected and paper documentation were stored securely within locked offices to prevent unauthorised access and breaches in confidentiality. We observed staff storing the records appropriately during our inspection.

We used the electronic record system throughout the inspection and found patient records to be comprehensive and well organised.

Nutrition and hydration

Most patients indicated that they were not happy with the menu choices available at Ty Llewelyn. Some patients told us that the portion sizes were small, the food was often not hot, and the menu lacked variety.

The health board must review the patient feedback and improve menu choices and how the food is prepared at Ty Llewelyn to ensure that the menu choices are meeting the nutritional requirements of the patients.

Mental Health Act Monitoring

We reviewed the statutory detention documents of five patients all found to be fully compliant with the MHA and Code of Practice for Wales,1983 (revised 2016)

Mental Health Act records were appropriately stored, well organised, and maintained and very easy to navigate.

The Mental Health Act administrator ran an efficient and effective system to support the implementation monitoring and review of the legal requirements of the Mental Health Act.

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

We reviewed five care plans in total across all wards.

The records were well organised, accessible, and easy to navigate via the electronic health record system when familiar with the system.

Overall care plans were comprehensive and well written with clear smart goals. However, two patient care plans on Gwion Ward had incorrect information on the current care and treatment for the patients. Also, levels of observations had not been updated in the care plan since the last care and treatment review meeting. In addition, we were not sure that the current record keeping audits which were generic health board audits were appropriate for the mental health setting.

The health board should consider the domains of record keeping audits on their audit system and review them to establish how relevant the audits are in providing assurances over the record keeping standards and expectations in mental health settings.

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

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

Physical health monitoring is consistently recorded in patient records and are embedded throughout patient files. There was a wide range of evidence based physical health assessments completed. It was also positive to see evidence of local GP's attending the hospital and contributing to patients health needs.

We reviewed seclusion records and noted that the health board were compliant with the frequency and level of professional involvement prescribed in the code of practice and health board seclusion policy. At the time of the inspection a patient in seclusion was involved in a clinical incident, this unusual and complex situation was managed effectively by ward staff and senior management team.

The inspection team attended meetings relating to the incident in seclusion where lessons learnt and information sharing, and clinical decisions were made in a prompt and timely manner. It was positive to note that within these meetings less

restrictive options were being discussed with the MDT recognising the difficulties associated with long term segregation in seclusion.

Quality of Management and Leadership

Staff feedback

We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital. In total, we received nine responses from staff at the setting. Staff responses when asked if the organisation encourages staff to raise concerns when something has gone wrong with a patient were mixed, 22 per cent strongly agreed with this statement whilst 22 per cent of staff disagreed.

Over 33 per cent of staff who completed the questionnaire strongly disagreed with the organisation being supportive and supporting staff to identify and solve problems. Over 44 per cent strongly disagreed with the statement that the organisation takes swift action to improve where necessary.

Staff comments included:

“Frequent staff shortage impacts on patient care and increases stress among regular employees”

“There are not enough experienced or permanent staff members to ensure consistent or safe patient care at times”.

Leadership

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

During interviews with staff, they were fully aware of the on-call systems in place at the hospital.

The operation of the hospital was supported by the health board's governance arrangements, policies, and procedures.

We found a friendly, professional staff team who showed a commitment to providing high quality care to patients. Staff were able to describe their roles and appeared knowledgeable about the care needs of patients they were responsible for.

Throughout our inspection, all staff made themselves available to speak to the HIW inspection team and engaged very positively with the process.

During our feedback meeting at the end of the inspection, senior ward staff and hospital managers were receptive to our comments. They demonstrated a commitment to learn from the inspection.

Workforce

Skilled and enabled workforce
Staff we interviewed spoke passionately about their roles. Throughout the inspection we observed strong team working, sense that all staff pull together.

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

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

- Workplace health and safety review date July 2021
- Recruitment and selection practices review date June 2019
- Equality, diversity, and human rights policy review June 2023
- Rapid tranquilisation protocol review March 2022.

The health board must ensure that policies are reviewed and kept up to date.

We noted a number of staffing vacancies in the hospital which the health board was attempting to recruit into. Gaps in staffing were covered by bank staff or agency staff who were usually familiar with the patient group. Staffing issues were discussed in the daily safety huddles.

The health board must ensure that staff vacancies are filled, and future initiatives are explored to encourage recruitment into the hospital.

It was positive to note the recent appointment of two nurse therapists who worked alongside psychology, helping to promote a psychologically informed practice at Ty Llewelyn.

A comprehensive staff induction and student placement pack was currently in the process of being completed to assist and support staff and students who were due to commence their roles in Ty Llewelyn.

Culture

People engagement, feedback and learning
Arrangements were in place to quickly share information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the service provided.

The inspection team considered staff training compliance and provided with a list of staff mandatory training compliance. Training figures provided to us on the inspection indicated that overall compliance figures were 88.8 per cent.

We saw that information had been provided to staff on the new Duty of Candour requirements and internal forms had been amended to capture this data. Staff also told us that they would feel secure raising concerns about patient care or other issues at the hospital and felt confident that the health board would address their concerns. A whistleblowing policy was in place to provide guidance on how staff can raise concerns.

Staff also had access to a wellness resource centre situated within the hospital grounds. This was a safe and supportive space where staff could attend. Staff spoke positively about this resource during the inspection, however staff comments within the survey included,

"Having so called "well-being services" does not replace the importance of ensuring a healthy and safe working environment or prevent staff from burnout."

Staff described the senior leadership team as being always approachable and accessible and there appears to be a strong and supportive leadership culture at the hospital. This was supported by staff who described the leadership team as supportive, visible, and accessible at all times.

Although not a finding during the inspection, the staff survey indicated that relationships between ward staff and senior managers could be improved, comments included:

"Senior managers need to stop the constant micromanaging and professional bullying that takes place throughout the service".

"Management appear to be more concerned about risks to the organisation than patient care".

The health board should review this feedback and see how they can develop relationships between ward staff and senior managers.

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

Daily safety huddle was well structured and covered key domains relating to patient safety, incidents, safeguarding and resource planning.

Improvements had been made since our last inspection in 2020, with well-defined systems and processes in place from a governance and operational perspective.

Information

Information governance and digital technology

The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and the General Data Protection Regulations 2018 within the wards.

We were told that all staff had their own computer access login to help ensure information governance was maintained. All staff spoken to understand their roles and responsibilities in respect of accurate record keeping and maintenance of confidentiality.

Through examination of training records, we confirmed that staff had received training on information governance. The training statistics showed a high level of staff compliance with information governance training at 86 per cent.

Learning, improvement and research

Quality improvement activities

It was pleasing to see the amount of ongoing research projects and quality improvements taking place in the health board. There were many examples of collaboration with other local health boards on improvement projects such as The Forensic Transformation Programme.

We saw a monthly news bulletin where topic matters included thanking staff and news updates. Staff questionnaires had also been completed and a 'you said we did' report was completed for staff. It was also positive to see that the senior leadership team were taking actions from the staff survey results and reporting back to staff on the actions taken.

The leadership team also recently presented at the NICE National Network For Wales on how to support staff wellbeing. In addition, a new intranet page was being developed for staff to access news bulletins, staff interactive forum, and monthly questions and answers with the senior leadership team. Good news stories and celebration of good work would also be included, alongside hyperlinks to staff wellbeing initiatives.

Ty Llewelyn was also aiming to achieve silver to gold standard for the ward led teams, under the Ward Accreditation Framework and there was an action plan in place on how they were aiming to achieve this.

Whole system approach

Partnership working and development
Staff were able to describe how the service engaged with partners to provide patient care and implement developments. They told us they engaged with outside partner agencies including local authorities, General Practitioners, housing, community health services and Caniad to ensure a whole systems approach to patient care.

We were told that senior staff attended regular joint agency meetings and monthly mental health leads meetings to discuss issues and build strong working relationships. During the inspection we attended a number of meetings where the health boards safeguarding lead was always available to provide advice and support.

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
Medication fridge left unlocked.	This presented a risk of unauthorised access to medication.	We raised this with staff.	This issue was rectified immediately, and all fridges were locked.

Appendix B - Immediate improvement plan

Service: Ty Llewelyn - Bryn Y Neuadd Hospital

Date of inspection: 3 - 5 July 2023

The table below includes any immediate 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.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
No immediate assurance issues				

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Ty Llewelyn - Bryn Y Neuadd Hospital

Date of inspection: 3 - 5 July 2023

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

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
Delays in obtaining occupational therapy equipment for patients.	The health board must ensure that the health board deal with requests for equipment in a timelier manner.	The ordering process for Occupational Therapy equipment, in line with Oracle Procurement procedures will be reviewed to identify any causes for delays and an improvement plan will be made available to the Operational Lead Management Team to ensure timely and appropriate equipment is provided as required	Strategic/Operational Lead for Specialist Commissioned Services (SCS)	30.09.2023

Patient complaints regarding ventilation and temperature in sports hall and gym.	The health board must review the ventilation and temperatures in these areas to improve quality of patient experience.	An estates request will be submitted to review the option of installing a window in the gym foyer. A portable air conditioning unit will be purchased as an interim measure. The ventilation and temperature of all areas across Ty Llewelyn will be monitored and reviewed in collaboration with Estates and the outcome monitored via Quality and Operational Delivery Group.	Strategic and Operational Lead	30.09.2023
Patients not being notified or informed of repairs taking place in the hospital.	The health board must ensure they update patients when maintenance work is being carried out in bedroom and bathroom areas.	Ward Manager to provide at least two weeks' notice on schedules of work unless the work is urgent. The ward will also look to provide information to patients regarding any proposed estates work during the morning meetings. Record of	Team Managers	30.08.2023

		discussions via morning meetings with patients to be provided as evidence.		
Patients told us that they were sharing one iPad between three wards and that this was not enough.	The health board should review this and make more iPads available for the patient group.	The Senior Management Team will undertake a review of the IT requirements for each ward. The outcome will be presented in an improvement plan to the Operational Leadership and Senior Management Team.	Strategic and Operational Lead	30.11.2023
Some patients told us that multiple appointments are booked for them to attend, and often there are clashes meaning that they miss some appointments.	The health board needs to ensure that coordination of patient appointments is managed more effectively.	A timetable of all schedules will be developed and shared with patients and the multi-disciplinary team. An electronic diary system will be established to ensure access for all staff to prevent cross over of appointments.	Clinical Site Manager	30.08.2023
Patient call buttons in bedrooms were not within	The health board must ensure that the call bells in patient bedrooms are easily accessible for patients.	A minor works request will be submitted to ensure that a programme of work takes	Strategic and Operational Leads	30.09.2023

patients reach from the bed areas.		place to move call bells to appropriate position, ensuring these are accessible from patient beds		
We identified several decorative and environmental issues that required attention: • Mould and poor ventilation in shower rooms and toilets on all 3 wards. This has also been raised in patients complaints • Privacy curtain on Pwyll Ward with no date of disposal and no privacy curtain in the shower on Branwen Ward • Ward bathrooms equipment need to be replaced, potentially ligature risk and need to be made safe for the patient group • Redecoration of bedrooms, the empty	The health board should consider and resolve the environmental issues.	Task and Finish Group will be established in collaboration with the estates department to work through each item identified within this report. The outcome from The Task and Finish Group will be shared and monitored with the Senior Leadership Team. All items will be cross referenced with the Ty Llewelyn Estate's Log with clear objectives and timescales for completion and discussed at the next monthly meeting.	Strategic and Operational Lead	31.12.2023

cupboards made the bedroom areas look untidy and undignified • Old phone sockets in bedrooms need to be removed • Wards and communal areas would benefit from painting and redecoration • Review the ventilation, temperature and airflow in gym and seclusion suite • Occupational therapy kitchen needs to be improved.				
No cleaning activity schedule were in place for domestic staff.	The health board should ensure that cleaning activity schedules are in place for domestic staff.	The senior management team will liaise with domestic colleagues to obtain a	Clinical Site Manager	30.08.2023

		cleaning schedule which will be shared with each ward to ensure clear communication.		
There were some gaps where Medication fridges temperature checks had not been recorded.	The health board must make sure that temperature checks are consistently recorded.	Ward Managers will be tasked to oversee compliance with Fridge temperature checks. A memo will also be developed outlining and reiterating the need to ensure temperature checks are consistency recorded. This will be audited monthly via the IRIS system and monitored in the monthly patient safety and quality activity reports.	Clinical Site Manager	31.08.2023
Patient legal status section of the Mar chart was not consistently completed. There were also a small number with missing signatures.	The health board must ensure that MAR charts are fully completed.	Clear instructions and guidance will be provided to both nursing and medical staff regarding the appropriate completion of MAR Charts.	Head of Nursing	31.08.2023

		This will be monitored monthly at Care and Treatment Meetings.		
There was limited pharmacy input and audit activity undertaken that assisted the management, prescribing, and storage of medication at the hospital.	The hospital would benefit from more frequent pharmacy support and input.	The clinical operational lead for Ty Llewelyn will undertake a review of the availability of pharmacy support. The outcome of the review will be presented to Operational Leadership Management Team and Senior Leadership Team.	Clinical Operational Lead	30.09.2023
We noted that after the checks had been undertaken the emergency bag it had not been resealed.	The health board must ensure that the emergency bag is resealed after the relevant checks have been undertaken.	A memo providing guidance will be issued to Team Managers and all Nursing staff regarding routine emergency bag is re-sealed. This will also be brought as an agenda item at the Local Team meeting. This will be monitored via team manager's monthly	Head of Nursing	31.08.2023

		audits and monthly team meetings.		
We reviewed restraint data and noted that some forms were not fully completed with gaps on position data and some timings missing.	The health board must ensure that restraint forms are fully completed.	Guidance will be provided, and memo will be issued to Team Managers and Nursing staff regarding restraint documentation requirements. Training requirements will be reviewed. Head of nursing to link in with the training department to consider the development of Webinars in areas where staff benefit from additional training. Compliance will be monitored via team managers monthly audits.	Head of Nursing	
Most patients indicated that they were not happy with the menu choices available at Ty Llewelyn. Some patients told us that the portion sizes were small, the food was often not	The health board must review the patient feedback and improve menu choices and how the food is prepared at Ty Llewelyn to ensure	In collaboration with Utilities, Catering Department, and our patients a review of menu choices and nutritional requirements for patients at Ty Llewelyn will	Clinical Operational Lead	31.01.2024

hot, and the menu lacked variety.	that the menu choices are meeting the nutritional requirements of the patients.	be undertaken. The recommendations for the review will be presented at Ty Llewelyn Senior Leadership Team and the Divisional Service Quality Delivery Group meeting to ensure actions are agreed and implemented.		
		Ty Llewelyn Ward Managers have met with the catering managers on the 08/08/23. During the meeting Cook Chill Equipment was discussed including the option of improved menu choices.	Ward Managers	30.09.2023
		Food and Nutrition is a routine agenda item on the Together for Recovery (T4R)	Ward Managers	30.08.2023
		The Occupational Therapy Team to continue offering Healthy Eating session with all patients and link with Dieticians Services for advice and support.	Occupational Therapy Team	31.08.2023

		In conjunction with the Catering Department and Ward Managers supplementary food be offered to all patients via the weekly Tesco shop, to promote healthy choices.	Ward Managers	31.08.2023
		Cook Chill Equipment to be considered and purchase options to be explored which will be shared via an improvement plan with the Operational Leadership and Management Team.	Strategic/Operational Lead SCS	31.12.2023
		Improvement plan for the Occupational Therapy kitchen to be developed in line with the Estates task and Finish Group	Strategic/Operational Lead SCS	31.01.2024

Incorrect information on the current care and treatment plans for two patients. Also, levels of observations hadn't been updated in the care plan since the last care and treatment review meeting. In addition, we were not sure that the current record keeping audits which were generic health board audits were appropriate for the mental health setting.	The health board should consider the domains of record keeping audits on their audit system and review them to establish how relevant the audits are in providing assurances over the record keeping standards and expectations in mental health settings.	The Clinical Site Manager will undertake monthly Care and Treatment Planning record keeping audits to ensure high standards and accurate records are maintained. The audit standards will be aligned to the requirements of the Mental Health Act Measures (2012). In addition, annual audits are undertaken by Mental Health Measures Team on Care and Treatment Plans. The above will be monitored and recorded within the monthly patient safety and quality activity reports.	Clinical Site Manager	30.09.2023
The following policies were found to be out of date:	The health board must ensure that policies are reviewed and kept up to date.	We will work collaboratively with Corporate Services to ensure the timely progression of the policies.		

- Workplace health and safety review date July 2021
- Recruitment and selection practices review date June 2019
- Equality, diversity and human rights policy review June 2023
- Rapid tranquilisation protocol review March 2022.

The following update from Corporate Services demonstrates the documents are scheduled to be finalised and approved in due course

Updates:

a) Workplace Health and Safety review date July 2021 - completed December 2022, next review date December 2023.

b) Recruitment and Selection Practices review date June 2019 – WP1 Policy For Safe Recruitment & Selection Practices currently out to consultation with key stakeholders, with a further review to take place then will be sent for service wide consultation

c) WP8 will be presented to the

		Equality and Human Rights Strategic Forum in September 2023, then to policy group for approval. d) MM54 Rapid Tranquillisation Protocol has been reviewed and approved by the Division, awaiting PQSG for approval.		
We noted a number of staffing vacancies in the hospital which the health board was attempting to recruit into.	The health board must ensure that staff vacancies are filled, and future initiatives are explored to encourage recruitment into the hospital.	To engage with the Divisional Mental Health & Learning Disability Recruitment and Retention working group to progress the recommendation from the MH&LD Recruitment and Retention Plan. To nominate recruiting managers to be included on the shortlisting and interview panel annual schedule aligned to the talent pool process.	Head of Operations and Service Delivery Head of Nursing Head of Operations and Service Delivery	

		To review the monthly Divisional Vacancy and Recruitment report to view any themes to aid recruitment including skill mix, flexible working, succession planning and career pathway development to aid recruitment. Progress Streamlining processes for student nurses for recruitment of B5 nurses on preceptorship will commence in September 2023. To review actions and support with progressing the Health Education and Improvement Wales (HEIW) Nursing Workforce Plan. Local area Performance reports to summarise recruitment activity, highlighting any barriers with filling any vacancies. This will include populating the local vacancy trackers.		

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): Maria Atkin

Job role: Head of Nursing, SCS

Date: 4th August 2023