Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Meadow Ward, Ty Glyn Ebwy 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 Ty Glyn Ebwy Hospital, on 15, 16 and 17 April 2024.

Ty Glyn Ebwy is a specialist service providing care and treatment for female patients over the age of 18, experiencing eating disorders.

The following hospital wards were reviewed during this inspection:

- Meadow Ward – 15 beds providing eating disorder service.

Our team, for the inspection comprised of two HIW healthcare inspectors, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one patient experience reviewer).

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 two questionnaires were completed by patients or their carers and seven were completed by staff.

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 had access to a variety of activities, and during the inspection it was positive to see staff encouraging and supporting the patients to participate in activities. However, patients told us that they would like activities to be more relevant and tailored towards recovery for eating disorders.

In addition, patients told us that improvements were required around meal provisions.

Patients could engage and provide feedback to staff on the provision of care at the hospital in a number of ways. Patients had 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:

- Provide therapeutic activities relevant to eating disorders and recovery
- Improvements regarding meal provisions.

This is what the service did well:

- Staff interacted and engaged with patients respectfully
- Patients spoke highly of staff and told us that they were treated well.

Delivery of Safe and Effective Care

Overall summary:

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

Care plans were well detailed, individualised, and reflected a wide range of Multi-Disciplinary Team (MDT) involvement and there was clear and documented evidence of patient involvement.

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

During the first night of the inspection staff were unable to locate the ligature cutters in a timely manner.

There was some confusion over staff and patient awareness and knowledge of secure storage and access and availability to keys for bedroom areas.

This is what we recommend the service can improve:

- Staff knowledge on location of ligature cutters
- Staff knowledge on secure storage availability in patient bedrooms
- Staff knowledge on patients availability to access bedroom keys.

This is what the service did well:

- Medication records were comprehensive and complete, and we saw evidence of audits taking place
- Care plans were detailed and there was clear evidence of patient involvement
- Cleanliness of hospital and clinical rooms.

Quality of Management and Leadership

Overall summary:
We saw that suitable processes were in place for senior staff to monitor staff compliance with mandatory training and that overall compliance was high. A safety meeting was being held every morning for staff to update senior management on any concerns, issues or incidents that had taken place the day before.

Staff and patient meetings were taking place on a regular basis and the hospital manager encouraged staff attendance and views on how to improve the service.

We found that staff were committed to providing patient care to a high standard and that staff were eager to attend further training to help them further support the patient group.

Staff engaged positively with our inspection and demonstrated a clear commitment to improvements.

This is what we recommend the service can improve:

- Provide additional bespoke training to staff
- Feedback is provided to staff on performance.

This is what the service did well:

- Staff and patient meetings were regularly taking place
- Mandatory training compliance figures were good.

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 only received one patient response and one family response to the questionnaires. However, patients spoken to during the inspection spoke highly of staff and the care provided to them. We also reviewed internal patient feedback logs to help us form a view on the overall patient experience.

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

Patient comments included:

> *"Lifts are always broken".*
> *"Staff are kind".*

Health promotion, protection and improvement
Ty Glyn Ebwy had a range of facilities to support the provision of therapies and activities. We observed patients at the hospital being involved in a range of activities throughout the inspection. These activities included arts and crafts, gardening club, and mindfulness activities. However, patients told us that they would benefit from more therapeutic activities relevant to eating disorders and recovery. In addition, patients and families told us that they would like to have more activities available over the weekend.

The registered provider must ensure that patients are provided with more therapeutic activities relevant to eating disorders and recovery.

The registered provider must ensure that patients have access to activities over the weekend.

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.

A number of health promotion leaflets and details of support organisations were available in the hospital for patients.

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

The staff we spoke with were enthusiastic about their roles and how they supported and cared for the patients. We saw 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.

Patients had access to en-suite rooms that provided a good standard of privacy and dignity. Each bedroom door had a vision panel which enabled staff to undertake observations from the corridor without opening the door to minimise any potential disruption to patients sleeping, patients were also able to adjust and control the observation panel.

There was some confusion during the inspection over patients having access to keys and lockable secure storage in their bedrooms. Patients and staff, we spoke to told us that there was no secure storage in patient bedrooms and that patients did not have keys to access their rooms. Upon speaking to senior staff, it was established that secure storage and keys for patients to lock their bedrooms were available.

The registered provider must ensure that staff and patients are fully informed on the secure storage and key availability for rooms.

Patients appeared to know staff; however, we only saw a pictorial board displaying pictures of the occupational therapy team. The registered provider should consider a board displaying pictures of all staffing teams.

Patient information and consent
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 ward.

Information on visiting times was also displayed. We saw that there was clear signage on the walls.

The registered provider's statement of purpose also described the aims and objectives of the service. This document was up to date and contained all the relevant information required by the regulations. Registration certificates from Healthcare Inspectorate Wales and information on how to raise a complaint were on display.

Communicating effectively
During the inspection we observed staff engaging with patients in a sensitive way and took time to help them understand their care using appropriate language.

Patient meetings were minuted and taking place regularly to obtain feedback from patients. It was evident that patients were attending these meetings, however some patients indicated that they often did not feel comfortable in raising issues in the meetings. This was discussed with the hospital manager who was looking at ways of introducing anonymous feedback.

Some patients told us that whilst they provide feedback, they don't always feel it is listened to but then went on to state that improvements and changes are sometimes made after their feedback.

The registered provider must ensure that feedback on issues raised by patients is listened to, and updates are provided to patients in a prompt and timely manner.

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

The hospitals complaints procedure was displayed on an information board so that patients could easily see the process. Complaints processes were also set out on the nursing station door.

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

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

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. Care plans were very detailed and

personalised, this helped support the hospital in being able to deliver comprehensive care to the patients.

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

Equality, diversity and human rights
We found that arrangements were in place to promote and protect patient rights.

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

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.

During our discussions with staff, they demonstrated suitable regard for upholding patient rights and individual patient preferences. The Care and Treatment Plans (CTPs) we reviewed evidenced that the social, cultural, and spiritual needs of patients had been considered.

Citizen engagement and feedback
Information was also available to inform relatives and carers on how to provide feedback. Twice yearly surveys are being planned to send to families and carers. The hospital manager was also introducing a suggestion box so that patients and or family members could give anonymous feedback and suggestions.

There was a complaints policy and procedure in place. The patient information guide provided to patients on admissions also had details of how patients could make complaints.

Delivery of Safe and Effective Care

Safe Care

Environment

The hospital car park was secured via a locked gate and access is gained via the intercom for visitors or an electronic key fob for staff. Based on how the service is currently operating the entrance gate and perimeter fencing appear at this time to be restrictive. It is acknowledged that there are plans to expand the service, however whilst the service is operating as it is, the registered provider needs to review the current security restrictions to ensure they are not impacting on the current patient group.

The registered provider must review the locked gates and perimeter fencing to ensure it is reflective of the service its currently providing.

Visitors were required to enter the hospital via a reception area and register on arrival. The hospital was organised over two floors. There was level access to the main entrance and ground floor with a lift available to provide access to the first floor. These arrangements allowed patients and visitors, including those with mobility difficulties, safe and easy access to the ward. Patients told us that the lifts were often broken and sometimes it took time for the lifts to be fixed, however at the time of the inspection the lifts were all in working order.

The registered provider must ensure that lifts when not working are fixed in a prompt and timely manner.

Staff carried radios which they could use to call for assistance if required. There were also nurse call points around the wards and within patient bedrooms so that patients could summon assistance if required.

Overall, the environment of care was clutter free and there was a relaxed, calming atmosphere on the ward. Patients had access to pleasant outdoor areas, such as a 'zen garden' which patients could use, however the garden was often locked and not accessible for patients to access freely without having to ask staff to unlock the garden during the day.

The registered provider must ensure that patients can access the garden areas freely during the day.

Managing risk and health and safety

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

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

The hospital had a business continuity plan in place, fire safety policies were all up to date and fire risk assessments had all been completed.

Restraint figures were low, and each incident was well-documented. It is noteworthy that restraints are so low and focused on supportive management. There was also evidence of adequate debrief taking place.

There was a restraint policy in place, however, the policy from Elysium did not make specific reference to restraint within eating disorder services.

The registered provider must ensure that the current policy is updated and makes specific reference to restraints within eating disorders.

Infection prevention and control (IPC) and decontamination

A system of regular audit of infection control arrangements was described. This was completed with the aim of identifying areas for improvement so that appropriate action could be taken where necessary.

Staff confirmed that cleaning schedules were in place to promote regular and effective cleaning of the hospital. Staff were aware of their responsibilities around infection prevention and control and staff were observed undertaking cleaning duties effectively.

The hospital was very clean, tidy, and organised. Cleaning equipment was stored and organised appropriately.

Throughout the inspection, the inspection team noted a high level of cleanliness at the hospital, which contributed to the patients having a better experience whilst staying at the hospital.

Nutrition

Patients told us that the main issues they complained about was meal provisions. Concerns had been raised that portion sizes were incorrect and the way in which food is prepared and served to patients did not assist their recovery.

The hospital manager had set up meetings and training with the kitchen staff to make improvements and had also arranged meetings with patients to try and address the concerns, however patients told us that there were still issues.

The registered provider must ensure that improvements are made relating to portion sizes and meal preparations to ensure the individual needs of all patients are met.

During the mealtimes we identified that staff did not engage with patients even in a casual way when eating. We noted that patients were clearly struggling to finish their food and staff did not employ any techniques to manage distress or support patients. In addition, we did not observe any pre meal support being provided prior to patients being served their meals. This was similar post meal, where staff followed a patient who appeared emotional following their meal but did not attempt to engage with them and provide post meal support. It is important that staff are adequately trained in providing support to patients pre and post meal.

The registered provider must ensure that patients are provided with support from staff pre, and post mealtimes and that staff have adequate training to enable them to effectively support patients during these times.

Patients told us that they had raised concerns regarding incorrect portions being prepared by kitchen staff, and that food is served to them in a way that is not conducive to eating disorder treatment. It appears that there have been changes made where staff now give meals and snacks without calorie identifiable information, and portion planning training has been completed with kitchen and ward staff.

During the meal that we observed, meals were served appropriately for the client group. However, patients reported feeling dread at returning for mealtimes due to the number of times they have had to repeat meal planning, some patients described meal plans going missing or that the kitchen has served inaccurate meals not in accordance with their plan. Hospital staff were aware that this was an issue and were making every effort to correct their processes.

The registered provider must ensure that patient meal plans and portion sizes are adhered to by kitchen staff.

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

Medicines management

Medicines management was safe and effective. Medication was stored securely with cupboards and medication fridges locked. There was evidence of regular temperature checks of the medication fridge to monitor that medication was stored at the manufacturer's advised temperature.

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

The Medication Administration Records reviewed were fully completed by staff. We saw several medication rounds, and saw that staff undertook these appropriately and professionally, interacting with patients respectfully and considerately.

We noted that the medication policies in the clinical room was out of date.

The registered provider must ensure that policies in clinical room are up to date.

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

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

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

Through conversations with staff, it was evident that the social worker had built up a close working relationship with the local authority. This collaborative approach is key to effective safeguarding processes and demonstrated that the hospital placed a strong emphasis on safeguarding their patients.

Medical devices, equipment and diagnostic systems
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.

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

Oxygen cylinders stored in the clinical room, had just expired. This was brought to the attention of the hospital manager who had already ordered replacements.

During staff discussions, it was evident that some staff were aware of the locations of ligature cutters in case of an emergency. On the first night of the inspection there was a slight delay in staff locating the ligature cutters.

The registered provider must ensure that all staff area aware of the location of ligature cutters and that the ligature cutters are easily accessible in an emergency.

Safe and clinically 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.

There was an established electronic system in place for recording, reviewing, and monitoring patient safety incidents. All data regarding incidents is collated and a detailed incident analysis is prepared for discussions at governance meetings.

Evidence obtained during the inspection confirmed that incidents and use of physical interventions are rare. This demonstrated that the use of least restrictive model of care was being used effectively at the hospital focusing on therapeutic engagement between staff and patients which created a relaxed atmosphere on the ward. When a restraint does take place, all completed paperwork is checked and robustly supervised and any lessons learnt are disseminated to staff. Staff confirmed that de-briefs take place following incidents.

The staff were able access lots of online training and have accessed secondments in other services, however their clinical experience with actual eating disorder patients seemed limited. Staff told us that they would benefit from more bespoke training related to eating disorders and patients also confirmed that they felt that staff required more specialist training.

The registered provider must ensure that staff have further training which is bespoke to eating disorders.

Participating in quality improvement activities
During our discussions with the hospital manager, we were provided with numerous examples where they were reviewing the service provision and looking to develop some aspects of the hospital. At the time of our inspection there were several ongoing improvements being made across the hospital site, such as improvements to the garden and outdoor areas and significant improvements had been made across the hospital environment.

The Occupational Therapy team (OT) had been supporting the patient group with fundraising with Beat Eating Disorder charity and had been engaging patients in the charities eating disorder awareness week. The OT team had also started up a café club for patients to access in the local community.

In addition, the consultant psychiatrist was working hard to foster and develop collaborative partnerships with other eating disorder networks. The Consultant was being proactive in his attempts with setting up an eating disorder network in acknowledgment of the fact that the service is new and developing, and that being part of a network would strengthen relations with other eating disorder facilities, as well as strengthening practices and procedures at the hospital.

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

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

Records management
Patient records were a combination of electronic and paper records. Electronic records were password protected and paper documentation was 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.

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

Mental Health Act monitoring
We reviewed the statutory detention documents of three patients all found to be fully compliant with the Mental Health Act (MHA) and Code of Practice for Wales,1983 (revised 2016).

All patient detentions were found to be legal according to the legislation and well documented.

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.

The records we reviewed contained detailed evidence of appropriate discharge and aftercare planning, with good involvement from the MDT, care co-ordinators and relevant partner services within the local community.

We identified that copies of leave authorisation were not routinely given to patients or family members who accompany patients on leave.

The registered provider must ensure that copies of leave are provided to patients or family members whilst on leave.

Advocacy reported a positive and supportive relationship with staff and patients and patients told us they were aware of the advocacy service and how to access it.

There was clear evidence of people's rights and responsibilities as an informal patient being recorded and signed for. This was supported by signage on the ward informing patients on how they could leave. In addition, it was positive to see that blanket restrictions such as locking of communal toilets to prevent incidents after meals were identified on the restrictive practice register.

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

We reviewed the care plans of four patients and found that they were kept to a good standard.

Care plans contained detailed risk assessments and risk management strategy plans.

We saw care files clearly showed patient involvement in care discussions, which were patient focussed and signed by the patient. Records also included evidence of the patients' voice to reflect their views and there was evidence of regular dietician input and advice.

Risk assessments were being completed however we noted that there was no evidence of the Warrn assessment being completed. The absence of the All-Wales risk assessments means that the service provides a less consistent risk assessment given that all services in Wales are encouraged to use this.

Clinical records were well kept and gave a comprehensive picture of the patient and their current presentation. They are reviewed regularly and changed when necessary. However, in one patient record we noted an entry had been inputted relating to a different patient.

The registered provider must ensure that patient records entries are completed for the correct patient.

Physical health assessments on admission were very comprehensive, this was identified as an area of noteworthy practice, and there was evidence of ongoing input from the physical health nurse. In addition, it was positive to see that there

was lots of evidence based and peer reviewed practice for eating disorders contained in records, where the sources of the information were referenced appropriately.

Quality of Management and Leadership

Staff Feedback
We invited staff to complete a questionnaire to tell us their views on working for the service. A total of seven were completed by staff.

Some results from the survey indicated that most staff who had completed the survey did not feel that they have feedback on their work performance from their managers. In addition, some staff felt that they are often not included in decision making or asked their opinions on decisions that may affect their work.

Most staff stated that they would benefit from leadership training and specific training related to their roles and responsibilities. It was positive to see that all staff who completed the questionnaire felt that they are encouraged by their managers to report errors, near misses and incidents and that they were confident and knew how to raise concerns about unsafe practice.

The registered provider must reflect on the staff survey and ensure that there is a provision for leadership training and specific training on staffing roles and responsibilities.

Governance and accountability framework
Ty Glyn Ebwy became a registered provider with HIW in October 2023 and is part of Elysium Health Care. It is a new service offering care and treatment for women with eating disorders. Although the service is relatively new there were well-defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. Senior staff acknowledged during the inspection that staff require additional training to equip them with the specialist skills required to care for a new patient group.

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

There was dedicated and passionate leadership from the hospital manager and clinical lead, who are supported by committed multidisciplinary teams and staffing group. We found a friendly, professional staff team who showed a commitment to providing high quality care to patients, whilst acknowledging that they were learning and developing the service.

Staff were able to describe their roles and appeared knowledgeable about the care needs of most patients they were responsible for and were aware of the additional training that needed to be made available to improve the service delivered to patients.

At the time of the inspection patient numbers were low, when bed occupancy levels increase the registered provider must ensure that the staffing team continue to meet the needs of all patients and that staff have a good knowledge and understanding of the patients tailored and personalised therapeutic programme.

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

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

Workforce recruitment and employment practices
It was evident that there were systems in place to ensure that recruitment followed an open and fair process. Prior to employment staff references were received. Disclosure and Barring Service (DBS) checks were undertaken, and professional qualifications checked. Therefore, we were assured that recruitment was undertaken in an open and fair process.

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

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

Workforce planning, training and organisational development
We reviewed the mandatory training and clinical supervision statistics for staff at the hospital and found that completion rates were high. There was a programme of training so that staff would receive timely updates. The electronic records provided the senior managers with details of the course completion rates and individual staff compliance details. In addition to mandatory training some staff had been trained in nasogastric tube feeding (NG) and phlebotomy training.

We were told that the staffing group were becoming more settled and were developing a greater awareness on how to effectively support and care for the patient group, however most staff and patients we spoke to, stated that they would benefit from further specialist training. The hospital manager confirmed that specialist training courses were being arranged for staff and that some staff had received additional training and had spent some time at other eating disorder services to gain further skills to support the patient group.

Regular staff meetings were taking place and staff were encouraged to attend and contribute ideas on how to make improvements at the hospital. There was also evidence of regular supervision taking place.

There were some mixed responses from staff regarding the visibility of the senior management team on the ward, most staff stated that some were visible, whilst others indicated that management are not often seen on the ward.

The registered provider must ensure that the senior management team are visible and engaged with the staffing team.

During our time at the hospital, we observed some workplace tensions and conflicting opinions on roles and responsibilities amongst the staffing group. The registered provider must ensure that the staffing group work together as a cohesive and supportive team and that any differences of opinions are discussed confidentially in private areas of the hospital away from patients and visitors. It was however evident that staff were striving to provide high levels of care to the patient group.

The registered provider must ensure that the staffing group is a cohesive and supportive staffing group who have a good level of understanding on their individual roles and have an awareness and understanding around managerial roles and responsibilities.

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.

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

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
Oxygen cylinders had just expired	Oxygen being unavailable in an emergency	Raised with Hospital manager	New oxygen cylinders ordered

Appendix B - Immediate improvement plan

Service: Ty Glyn Ebwy

Date of inspection: 14 - 16 April 2024

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.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate assurances identified during the inspection					

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 Glyn Ebwy

Date of inspection: 14 - 16 April 2024

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	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Patients told us that they would benefit from more therapeutic activities relevant to eating disorders and recovery	The registered provider must ensure that patients are provided with more therapeutic activities relevant to eating disorders and recovery.	Health promotion, protection, and improvement	Embed therapy evidence-based document. Patient information relating to therapies and groups offered and relevance to eating disorder. So as patients can be knowledgeable as to the relevance of groups and sessions to eating disorders.	Hospital Director Vicki Wheeler	Completed and ongoing in terms of groups and informing patients

2.	Patients and families told us that they would like to have more activities available to them over the weekend.	The registered provider must ensure that patients have access to activities over the weekend.	Health promotion, protection, and improvement	Acknowledged and MDT discussed. OT Lead has identified structured activities for the weekends and added to Meaningful week which will be outcomed as completed and sessions offered evidencing in care notes every shift.	Ward Manager Lisa Murphy	Completed
3.	Patients and staff, we spoke to told us that there was no secure storage in patient bedroom and that patients did not have keys to access their rooms.	The registered provider must ensure that staff and patients are fully informed on the secure storage and key availability for rooms.	Dignity and respect	There is secure storage under every bed. Patients are aware of these cupboards and that can request a key should they wish. Same applies for their bedroom doors. There are also lockers in the nursing station should patients wish to store smaller items securely.	Site Security Manager Lee Davies Ward Manager Lisa Murphy	Completed

				This has been reinforced in community meetings.		
4.	Some patients told us that whilst they provide feedback, they don't always feel listened to.	The registered provider must ensure that feedback on issues raised by patients is provided to patients in a prompt and timely manner.	Dignity and respect	Included in patients' community meeting 'You said, we did'. Boards to reflect this. Boards have been sourced and will be put up and updated (following community and Governance meetings) on the ward as soon as they arrive	Hospital Director Vicki Wheeler Site Security Manager Lee Davies	31/07/2024
5.	The entrance gate and perimeter fencing appear currently to be restrictive.	The registered provider must review the locked gates and perimeter fencing to ensure it is reflective of the service its currently providing.	Managing risk and health and safety	Drive through gate – offers security to the hospital from external risks, Pedestrian gate will be 'failed' open allowing free access for pedestrians to come and go as they please. Patients have been asked what they feel about the gates, and	Site Security Manager Lee Davies Hospital Director Vicki Wheeler	31/07/2024

				they expressed no view as to whether they would prefer them open or closed all the time Protocol to be written and ratified at Governance		
6.	Patients told us that the lifts were often broken and sometimes it took time for the lifts to be fixed.	The registered provider must ensure that lifts when not working are fixed in a prompt and timely manner.	Managing risk and health and safety	Hydraulics are being manufactured and main lift will be upgraded. Stair lift also to be installed 12/06/2024 to ensure stairs do not need to be used by patients. Risk Assessment of Stair lift to be carried out for each patient. Staff workshop training to be carried out once stair lift installed. Local Protocol to be formulated and disseminated prior to patient use	Site Security Manager Lee Davies Britton Price lifts Acorn Lifts Lead OT Rachel Mayne	31/07/2024 12/06/2024 28/6/2024

7.	The garden was often locked and not accessible for patients to access freely without having to ask staff to unlock the garden during the day.	The registered provider must ensure that patients can access the garden areas freely during the day.	Environment	As the garden is downstairs patients require escort to ensure safety and open doors Quotes being arranged for refurbishment of garden on ward level. OTL Quote Second Quote required and requested	SSM Lee Davies HD Vicki Wheeler OTL Kingsley Build Group Ltd.	On Going 10/06/2024 30/06/2024
8.	The current restraint policy from Elysium does not make specific reference to restraint within eating disorders.	The registered provider must ensure that the current policy is updated and make specific reference to restraints within eating disorders.	Nutrition	This is evidenced in current Elysium management of violence and Aggression policy. Any patient who may require support to comply with NG feeding or management of challenging behaviour will have an STMVA care plan to support and guide the staff who have all received Safe and Therapeutic	Hospital Director Vicki Wheeler	07/06/2024

				Management of Violence and Aggression training		
9.	Patients told us that the main issues they complained about was meal provisions. Concerns had been raised that portion sizes were incorrect and the way in which food is prepared and served to patients did not assist their recovery.	The registered provider must ensure that improvements are made relating to portion sizes and meal preparations.	Nutrition	Clear phases of meal plans have been introduced and portion size incorporated in the phase. All Catering staff have spent time shadowing in a sister eating disorder service (Cotswold House) Clear direction as to meal sizes and portions is now understood by both catering and ward staff and patients	Chioma – Dietitian Site Security Manager – Lee Davies Catering staff	31/05/2024 Complete 04/04/2024 10/04/2024 Shadowing shifts
10.	During the mealtimes, we identified that staff did not engage with patients pre or post meal to provide support.	The registered provider must ensure that patients are provided with support from staff pre, and post mealtimes and that staff have adequate training to enable them to effectively	Nutrition	Further meal support training has been arranged. Full day sessions first session to be held. 11/06/2024 Further sessions will	All Staff MDT Vicki Wheeler Hospital Director	13/08/2024

		support patients during these times.		be arranged. Meal support workshop also facilitated. Staff Workshops have been arranged and are being facilitated to support staff in their engagement with the patient group and enhance skills and confidence.		
11.	Patients told us that they had raised concerns regarding incorrect portions being prepared by kitchen staff. some patients described meal plans going missing or that the kitchen has served inaccurate meals not in accordance with their plan.	The registered provider must ensure that patient meal plans and portion sizes are adhered to by kitchen staff.	Nutrition	Clear system has been developed to ensure that if any meal choices/ menus have gone missing they can easily be retrieved. Meal choices scanned and saved into folder of the Hospitals shared drive prior to being sent to the kitchen. Minimising risk of the choices going 'missing'.	Vicki Wheeler Hospital Director Lisa Murphy Ward Manager	Complete

				June 2024 – noted significant reduction in any complaints relating to the catering/ kitchen and systems		
12.	Medication policies in the clinical room was out of date.	The registered provider must ensure that policies in clinical room are up to date.	Safe and clinically effective care	No policies should be printed out as they are available on the intranet. Policy removed from clinic	Vicki Wheeler Hospital Director	Complete
13.	On the first night of the inspection there was a slight delay in staff locating the ligature cutters.	The registered provider must ensure that all staff area aware of the location of ligature cutters and that the ligature cutters are easily accessible in an emergency.	Managing risk and health and safety	All staff are aware of where ligature cutters are stored – they are on security check list which is checked twice per shift. There are also the 'Staff Questionnaire' which checks x5 per staff per months knowledge of ligature cutter's location.	Lisa Murphy – Ward Manager	Ongoing monthly audit
14.	Staff told us that they would benefit from	The registered provider must ensure that staff have	Governance and accountability	Further meal support training has been	Vicki Wheeler HD	13/08/2024

	more bespoke training related to eating disorders and patients also confirmed that they felt that staff required more specialist training.	further training which is bespoke to eating disorders.	framework	arranged. Full day sessions first session to be held. 11/06/2024 Further sessions will be arranged. Meal support workshop also facilitated. Staff Workshops have been arranged and are being facilitated to support staff in their engagement with the patient group and enhance skills and confidence. Workshops will continue for so long as staff identify they require the additional educational support and ensuring all staff have attended the workshops		
15.	We identified that copies of leave authorisation were not	The registered provider must ensure that copies of leave are provided to	Record management	Lisa Murphy to put together Primary Nurses session plan/	Lisa Murphy Ward Manger	30/06/2024

	routinely given to patients or family members who accompany patients on leave.	patients or family members whilst on leave.		check list. Patient folders / display books with their care plans and leave authorisation form and part of their PN session to ensure the most up to date are evident in their folder. Folders on order to be disseminated on arrival	Primary nurses Rebecca Woolley PA/ Lee Davies	Ongoing weekly PN sessions Complete/ Arrived 11/06/2024
16.	In one patient record we noted an entry had been inputted relating to a different patient.	The registered provider must ensure that patient records entries are completed for the correct patient.	Record management	Human error and staff will be encouraged to speak out if error made so as process to remove entry can be followed. Which would involve an IT ticket being raised and the apps team will carry out the instruction to delete the entry	Vicki Wheeler Hospital Director	On going
17.	There were some mixed responses from	The registered provider must ensure that the senior management team are	Governance and accountability	Roles and responsibilities and		

	staff regarding the visibility of the senior management team on the ward.	visible and engaged with the staffing team.	framework	expectations of different positions to be clearly clarified and shared. Blended staffing culture Rota for senior management to attend the ward every morning. Putting up a 'you said' 'we did' board for staff in the staff room.	Vicki Wheeler Hospital Director Rebecca Wooley PA	28/06/2024 Complete 11/06/2024 Complete 10/06/2024
18.	During our time at the hospital, we observed some workplace tensions and conflicting opinions on roles and responsibilities amongst the staffing group.	The registered provider must ensure that the staffing group is a cohesive and supportive staffing group who have a good level of understanding on their individual roles and have an awareness and understanding around managerial roles and	Workforce recruitment and employment practices	Review Staff handbook and include UpToDate organisational personnel pyramid organogram. Disseminate to all staff via weekly COMMS email to all staff via global email	Hospital Director Vicki Wheeler Hospital Director Vicki Wheeler	01/07/2024 April 2024 commenced - ongoing

		responsibilities.				
19.	Staff who completed the survey stated that they would benefit from leadership training and specific training related to their roles and responsibilities.	The registered provider must reflect of the staff survey and ensure that leadership training and specific training on staffing roles and responsibilities.	Workforce recruitment and employment practices	Leadership courses have been applied for by some of the nursing staff already and continue to be encouraged in supervision in ongoing appraisals	Ward Manager Lisa murphy	On going

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): Vicki Wheeler

Job role: Hospital Director

Date: 11/06/2024