Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Llanarth Court Hospital

Inspection date: 13, 14 and 15 May 2024
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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Llanarth Court Hospital on 13, 14 and 15 May 2024.

The following hospital wards were reviewed during this inspection:

- Awen Ward – 16 beds providing female medium secure services
- Treowen Ward – 11 beds providing male low secure services
- Deri Ward – 11 beds providing male low secure services
- Teilo Ward – 20 beds providing male low secure services
- Howell Ward – 16 beds providing male medium secure services
- Iddon Ward – 17 beds providing male medium secure services
- Woodlands – 4 beds providing locked rehabilitation services.

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

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

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 spoke with patients during our inspection. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of five questionnaires were completed by patients or their carers and five were completed by staff. Feedback and some of the comments we received appear throughout the report.

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.

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. The patient information booklet designed by one of the patients for Iddon Ward was very detailed and informative, plans were in place to replicate this booklet on all wards.

Some patients told us that improvements were required around meal provisions.

This is what we recommend the service can improve:

- Update the 'You said we did' notice board
- Improvements regarding meal provisions
- Windows on all wards require cleaning
- Décor and furniture on woodlands ward.

This is what the service did well:

- Variety of patient activities
- Patient information booklet
- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff.

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.

This is what we recommend the service can improve:

- Resuscitation and emergency equipment must be stored in an appropriate place on Awen Ward
- Updated medication management policy in clinical rooms.

This is what the service did well:

- Good standard of care planning
- Safeguarding processes.

Quality of Management and Leadership

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

We observed a committed staff team who had a good understanding of the needs of the patients at the hospital. There was dedicated and passionate leadership displayed by the hospital director and clinical lead.

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

This is what we recommend the service can improve:

- Staff vacancies.

This is what the service did well:

- Strong leadership provided to staff by the hospital director, clinical lead and multi-disciplinary team
- Mandatory training compliance was good.

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 five responses to the questionnaires; this low number needs to be borne in mind when considering these responses.

We also reviewed internal patient feedback surveys to help us form a view on the overall patient experience.

Patient comments included:

"The food is not good quality this is where I live, and I expect to have decent quality food".

"Food was better when cooked on site".

Health promotion, protection and improvement
Llanarth Court 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 gardening, woodworking, arts and crafts as well as gym based and outdoor activities.

A social club was available onsite which gave opportunities for patients to engage and relax with each other outside of the standard therapeutic timetable. A café and patient shop were also available.

The hospital director had also implemented a paid work scheme for patients at the hospital. Jobs included, recycling and gardening jobs and patients also had opportunities to help run the hospital shop. Patients would submit applications and then have interviews for the paid work. This helped to provide patients with life skills to prepare them for independent living.

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

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

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

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

Some patients had en-suite bedrooms that provided a good standard of privacy and dignity, while other patients had to access communal toilets and showers. Patients could lock their rooms, but staff could override the locks if needed. We saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering. Patients were able to personalise their rooms and store their own possessions.

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. During our tour of the hospital, we positively noted that the vision panels were closed by default to protect the privacy of patients as people passed the rooms.

Personal items were risk assessed on an individual basis for the safety of each patient. This included the use of personal mobile phones. A telephone was available at the hospital for patients to use to contact friends and family if needed, and digital devices were available for patients to use with support from staff when required.

Patient information and consent
Patient boards displayed in the hospital contained relevant information to help patients and their families understand their care. This included information such as the weekly activity timetable, healthy eating, advocacy services and how to make a complaint or raise a concern. Easy read patient information guides were also available for patients on each ward.

Registration certificates from Healthcare Inspectorate Wales and information on how to raise a complaint were on display. This information was also available in Welsh.

There were patient notice boards on all wards, containing information on ‘you said, and we did’. The information displayed on some ward boards was outdated and should contain up to date information.

The registered provider must ensure that patient information boards are up to date.

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

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

Suitable rooms were available for patients to meet staff and other healthcare professionals in private. Visiting arrangements were in place for patients to meet friends and family at the hospital where appropriate and a designated child visiting area was available away from the ward areas.

We saw that each ward had a 'who's who' board which contained a picture and some information about each staff member working on the ward. In addition, the expectation of patient behaviour was also outlined on boards.

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 (MDT). 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 which were very detailed and personalised, this helped support the hospital in being able to deliver comprehensive care to the patients.

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

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

Legal documentation relating to detained 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. We saw that the hospital had an Equality, Diversity, and Inclusion policy available to help ensure that patients' equality and diversity were respected.

Citizen engagement and feedback
There were regular patient meetings and surveys to allow patients to provide feedback on the provision of care at the hospital. Information was also available to inform relatives and carers on how to provide feedback.

There was a complaints policy and procedure in place. The policy provided a structure for dealing with all complaints within the hospital. It was evident that an independent person is assigned to investigate complaints and actions were taken in line with the registered provider's complaints policy to ensure that complaints are dealt with appropriately. We reviewed a sample of formal and informal complaints and confirmed that they had been actioned in line with the organisational complaints policy.

The hospital produces a monthly newsletter which includes items written by patients. We were provided with copies of the newsletter which included pictures of patients undertaking activities, fundraising events, and community engagement events. The hospital had made improvements on the newsletter since the last inspection and were now producing monthly newsletters which they were sharing with NHS health boards in England and Wales.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
The hospital had processes in place to manage and review risks and maintain health and safety at the hospital. The hospital provided individualised patient care that was supported by least restrictive practices, both in care planning and hospital or ward practices.

At the time of our inspection there were a number of ongoing improvements being made across the hospital site. A new medium secure unit is currently being built on the hospital grounds and is scheduled to open in December 2024.There is still some uncertainty on how the remaining wards will be used once the new unit opens and as a result some of the remaining wards looked tired and in need of updating.

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

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

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 to follow in the event of a major incident occurring at the hospital. These included events such as fire, loss of water and electricity supply and severe weather conditions.

Fire safety policies were all up to date and fire risk assessments had all been completed, however the current fire evacuation map displayed in Awen Ward had not been updated since the reconfiguration of the ward.

The registered provider must ensure that the fire evacuation map on Awen Ward is updated to reflect the new layout of the ward.

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. Cleaning equipment was stored and organised appropriately.

A range of up-to-date policies were available that detailed the various IPC procedures in place to help keep staff and patients safe. Regular audits had been completed to monitor compliance with hospital procedures. Staff compliance with mandatory IPC training was high at 95.30 per cent.

Nutrition
Patients were supported to meet their dietary needs, a dietician worked at the hospital to support staff and patients with nutritional requirements.

The hospital had changed the way in which meals are provided to patients, with meals no longer being prepared at the hospital. Most patients we spoke to told us that the meals needed improving, this was also reflected in the patient questionnaire results with most patients being dissatisfied with the way in which the food is prepared and the lack of variety. Most patients told us that the food choices were much better when the food was cooked on site.

The registered provider must review the current meal provisions and choices provided to patients and make improvement.

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

Medicines management
Overall, medicines management was safe and effective. Medication was stored securely with cupboards and medication fridges locked. However, on the first night of the inspection, medication was left unattended in the locked clinical room. This matter was brought to the attention of the hospital director and immediately resolved.

The registered provider must ensure that all staff comply with medication management.

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 policy in one clinical room was out of date.

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

It was positive to see self-medication care plans in place and three patients on one ward were responsible for caring for their own medication. This was working well and there was evidence to support that the patients were self-administering all medication as prescribed. However, on Awen Ward there was no care plan in place for one patient who was self-medicating.

The registered provider must ensure that self-medication care plans are in place for patients who are self-administering medication.

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 team of social workers who were 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 workers 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.

The Social worker ‘duty scheme’ whereby a nominated social worker was used to screen referrals and record decision making on why a referral was being made or not to the local authority was highlighted as an area of noteworthy practice during the inspection.

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.

During staff discussions, it was evident that staff were aware of the locations of ligature cutters in case of an emergency. There were up-to-date safety audits in place, including ligature point risk assessments.

The emergency drug bag was located on top of clutter in the small nursing office on Awen Ward, in addition the emergency medication was not sign posted. Both issues could impact on familiar and unfamiliar staff if this equipment was needed in an emergency.

The registered provider must ensure that emergency equipment is stored in an easily accessible and familiar place for staff and in line with how other wards store this equipment.

Oxygen cylinders were available on Awen Ward and were in date however the key used to open the valve was missing and the tubing and mask was already connected to the cylinder. Fully functional oxygen cylinders were available on other wards that Awen Ward could access in an emergency.

The registered provider must ensure that the oxygen cylinders have appropriate equipment keys and that tubing and masks are used in accordance with guidance on safe administration and supply of oxygen usage.

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 and analysed at governance meetings.

Evidence obtained during the inspection confirmed that incidents and use of physical interventions are used, and it was positive that no restraints had been recorded on Treowen ward in a two-year period. 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 ward atmosphere.

When a restraint does take place, all completed paperwork is checked and robustly supervised and any lessons learnt are disseminated to staff. The inspection team

witnessed positive redirection and de-escalation of difficult behaviours, all of which were done respectfully and in a very supportive manner.

Staff were completing observation charts in line with guidance. In addition, ward managers were monitoring and auditing the completion of observation charts, this was an area of improvement since our last inspection.

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

Participating in quality improvement activities
During our discussions with the hospital director, we were provided with numerous examples where they were reviewing the service provision and looking to develop aspects of the hospital.

At the time of our inspection there were several ongoing improvements being made across the hospital site, such as the new secure unit being built, which had brought additional challenges to the hospital. The hospital director and deputy had clearly considered the impact on patients and invested a lot of thought and time to ensure that patients were not being adversely affected by the building activity and site visitors.

The ward manager on Treowen Ward had also recently devised a standard operating procedure and risk assessment for some patients to have unsupervised access to the first floor on Treowen Ward, this demonstrated that the hospital was using least restrictive practices to promote independence amongst the patient group.

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.

On the first night of the inspection, some patient identifiable information was located in the locked visitors room on Awen Ward. This was brought to the attention of the hospital director and immediately actioned and removed.

The registered provider must ensure that no patient identifiable information is left unattended and not secure.

Records management
Patient records were being maintained electronically and were password protected to prevent unauthorised access and breaches in confidentiality. The patient records we reviewed during the inspection were well organised which made it easy to navigate through the sections. It was evident that nursing staff and MDT professionals were writing detailed and regular entries that provided up to date information on the patient and their care.

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

Mental Health Act monitoring
We reviewed the statutory detention documents of five patients 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.

It was positive to see that capacity assessments had improved since the last inspection and were easily accessible in-patient notes.

Following a review of the notes we noted that there is a record that the Second Opinion Appointed Doctor (SOAD) consulted with the Statutory Consultees, but there was no designated format on which to record the Consultees rationale for the decision made. We recommend that it would be good practice to develop a specific form for statutory consultees to record decision making following discussions with the SOAD.

The registered provider should develop a specific form for statutory consultees to record decision making following discussions with the SOAD.

The Codes of Practice for Mental Health Act were not available on some wards, it was positive to see that this was actioned during the inspection and copies were placed on all wards.

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.

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

We reviewed nine care files and found that they were kept to a good standard.

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

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

In one patient record on Teilo we noted a risk formulation was present, however this related to a different patient.

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

Management of patients' behaviours were reflected in their care plans and risk management profile, along with staff training to use skills to manage and defuse difficult situations. However, in one patients record on Awen Ward there was no Positive Behavior Support Plan (PBS) in place for the patient when there was evidence in the patients notes of escalating and changing behaviors.

The registered provider must ensure that patients PBS plans are up to date and reflect any changes in patient behaviors.

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

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 five were completed by staff.
Staff comments included:

> *"More Learning Disability training"*
>
> *"I would place a family member if need withing Llanarth Court"*
>
> *"I think we provide a really good service at Llanarth. I really enjoy working here. I feel that I receive a lot of support and can share ideas and progress in my role".*

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.

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

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

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

During our time at the hospital, we observed a positive culture with good relationships between staff who we observed working well together as a team. It was evident that staff were striving to provide high levels of care to the patient groups to expedite recovery and minimise the length of time in hospital. It was clear to see that the hospital director, deputy and ward managers had a very supportive and approachable leadership style, this was also confirmed during staff interviews. The team was a cohesive group of leaders and interviews with them demonstrated that they valued and cared for the staff and patients.

Dealing with concerns and managing incidents
There was a complaints policy and procedure in place. The policy provided a structure for dealing with all complaints at the hospital.

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.

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 Priory Healthcare to assist staff with many aspects of work and personal life including an independent counselling service.

Workforce planning, training and organisational development
We saw evidence of staff annual appraisals and supervision in staff files and staff told us that supervision takes place on a regular basis.

Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. We were told that agency staff are rarely used, however when there are shortfalls the hospital will try and use regular agency staff who were familiar with working at the hospital and the patient groups.

We were also informed about the recruitment initiatives currently being undertaken to attract new staff, as the hospital did have a number of staff nurse vacancies, however it was positive to see that the hospital was taking steps to try and fill the vacancies.

The hospital director also held separate lessons learnt and security meetings outside of the clinical governance, emphasising the importance of having these as independent meetings. Information from these meetings were also disseminated to

the staffing group and continued to be meeting agenda items within clinical governance.

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.

During staff discussions, some staff told us that they would benefit from training in Autistic Spectrum Disorder and other neurodiversity training to help them further support patients with diverse needs.

The registered provider must ensure that staff have training to deal with neurodiverse patients.

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
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Service: Llanarth Court Hospital

Date of inspection: 13 – 15 May 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 were identified on the inspection.					
2.						
3.						
4.						

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: Llanarth Court Hospital

Date of inspection:13 - 15 May 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.	Information displayed on some ward boards was outdated and should contain up to date information.	The registered provider must ensure that patient information boards are up to date.		All ward boards were immediately reviewed after inspection to ensure information was accurate and up to date. These boards will be reviewed during monthly site audits. Site in process of designing updated ward information boards, co-produced with patients.	Ross Morris delegates to Treeve Brooks	Completed
2.	Current fire evacuation map displayed in Awen	The registered provider must ensure that the fire evacuation		Evacuation plan has been updated to reflect	Ross Morris delegates to	Completed

	Ward had not been updated since the reconfiguration of the ward.	map on Awen Ward is updated to reflect the new layout of the ward.		the modification to Awen's environment.	Alexander Hore	
3.	Patients told us that the meals needed improving, this was also reflected in the patient questionnaire results with most patients being dissatisfied with the way in which the food is prepared and the lack of variety.	The registered provider must review the current meal provisions and choices provided to patients and make improvement.		Catering provision at Llanarth to be reviewed with outsourced operational board to ensure meals meet patient requirements, focusing on variety and satisfaction. Action plan in place to rectify areas of concern identified from patient surveys.	Ross Morris delegates to Alexander Hore	August 24
4.	On the first night of the inspection, medication was left unattended in the locked clinical room.	The registered provider must ensure that all staff comply with medication management.		Night Site Managers and Ward Managers will conduct regular spot checks during medication rounds to ensure compliance with medication management.	Ross Morris delegates to Treeve Brooks	August 24
5.	Medication policies in one clinical room was out of date.	The registered provider must ensure that policies in clinical room are up to date.		Medication policy has been replaced with the updated version.	Ross Morris delegates to Treeve Brooks	July 24

				Policies to be checked during scheduled monthly clinic spot checks.		
6.	On Awen Ward there was no care plan in place for one patient who was self-medicating.	The registered provider must ensure that self-medication care plans are in place for patients who are self-administering medication.		Audit to be conducted of all patient care plans who are self-medicating.	Ross Morris delegates to Treeve Brooks	August 24
7.	The emergency drug bag was located on top of clutter in the small nursing office.	The registered provider must ensure that emergency equipment is stored in an easily accessible and familiar place for staff and in line with how other wards store this equipment.		Nursing office to be de-cluttered to ensure emergency equipment is easily accessible. Weekly quality check to encompass emergency medication accessibility to prevent reoccurrence.	Ross Morris delegates to Treeve Brooks	July 24
8.	Emergency medication was not sign-posted.	The registered provider must ensure that emergency medication is sign-posted		Signs are now in place and clearly visible identifying emergency medication.	Ross Morris delegates to Treeve Brooks	July 24
9.	Oxygen cylinders were available on Awen Ward and were in date however the key used to open the valve was missing and the tubing and mask was already	The registered provider must ensure that the oxygen cylinders have appropriate equipment keys and that tubing, and masks are used in accordance with guidance on		Key has been replaced. Masks and tubes to be checked during monthly spot checks.	Ross Morris delegates to Treeve Brooks	July 24

	connected to the cylinder.	safe administration and supply of oxygen usage.				
10.	Patient identifiable information was located in the locked visitors room on Awen Ward.	The registered provider must ensure that no patient identifiable information is left unattended and not secure.		Patient identifiable information was removed during inspection. Staff across site have been reminded of the correct GPDR principles we must adhere to.	Ross Morris delegates to Treeve Brooks	July 24
11.	There was no designated format to record the Consultees rationale for the decision made.	The registered provider should develop a specific form for statutory consultees to record decision making following discussions with the SOAD.		Form has been created by site to ensure rationales can be clearly documented and stored within Carenotes.	Ross Morris delegates to Treeve Brooks	August 24
12.	In one patient record on Teilo we noted a risk formulation was present, however this related to a different patient.	The registered provider must ensure that patient records entries are completed for the correct patient.		Audit to be completed across site to ensure correct information is present.	Ross Morris delegates to Treeve Brooks	August 24
13.	In one patients record on Awen Ward there was no Positive Behavior Support Plan in place for the patient when there	The registered provider must ensure that patients PBS plans are up to date and reflect any changes in patient behaviors.		Audit to be completed across site to ensure PBS plans are timely, accurate and in place for all patients.	Ross Morris delegates to Margaret Davies	August 24

	was evidence in the patients notes of escalating and changing behaviors.			PBS are currently being reviewed across site.		
14.	Staff told us that they would benefit from training in Autistic Spectrum Disorder and other neurodiversity training to help them further support patients with diverse needs			Site currently in liaison with ASD specialist for Priory to arrange required training.	Ross Morris delegates to Lisa Green	August 24

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

Service representative

Name (print): **Ross Morris**

Job role: **Hospital Director**

Date: **09.07.2024**