Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Bryntirion & Dderwen Ward, Cefn Carnau 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 Cefn Carnau Hospital, on 9,10 and 11 September 2024.

Cefn Carnau is a modern low secure hospital offering services for adults with a diagnosis of learning disability who may also present with a mental illness.

The following hospital wards were reviewed during this inspection:

- Bryntirion Ward - 11 beds providing a low secure service for female adults over the age of 18 years diagnosed with a primary diagnosis of a learning disability and who may be liable to be detained under the Mental Health Act 1983.

- Dderwen Ward – 11 beds providing a low secure service for male adults over the age of 18 years diagnosed with a primary diagnosis of a learning disability and who may be liable to be detained under the Mental Health Act 1983.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. No questionnaires were completed. 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. Overall, we found evidence that the service provided safe and effective care.

Staff were knowledgeable of each patient and strove to provide individualised care. We observed genuine kindness, warmth and respect between staff and patients. Most patients we spoke with spoke highly of staff and told us that they were treated well by staff and felt safe.

This is what we recommend the service can improve:

- Update the 'You said we did' notice board
- Retain the Sensory room for its original use rather than storage.

This is what the service did well:

- Good team working and motivated staff
- 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.

We saw a good standard of care planning which reflected the domains of the Welsh Measure. 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.

We viewed a sample of Medication Administration Records (MAR charts) on both wards and found they were being maintained to a good standard. The statutory detention documentation we saw was compliant with the Mental Health Act and Code of Practice.

This is what we recommend the service can improve:

- Update Positive Behavioural Support plans to make them more user friendly.

This is what the service did well:

- Staff interacted and engaged with patients respectfully
- Staff compliance and understanding and implementation of observation policy
- Good standard of care planning
- Safe and effective medication management.

Quality of Management and Leadership

Overall summary:
We observed a committed staff team who had a good understanding of the needs of the patients at the hospital. We found a friendly, professional and kind staff team who demonstrated a commitment to providing high quality care to patients. There was dedicated and passionate leadership displayed by staff, the ward managers and senior leadership team.

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

It was evident that the hospital had learnt from previous inspections and implemented improvements.

This is what we recommend the service can improve:

- Security of patient identifiable information.

This is what the service did well:

- Staff and patient meetings were regularly taking place
- Mandatory training compliance figures were good
- Strong leadership provided to staff by the hospital manager, clinical lead and multi-disciplinary team.

3. What we found

Quality of Patient Experience

Patient feedback
We provided HIW questionnaires to patients during the inspection to obtain their views and experience of the service provided by the hospital. We received no responses. To support our patient experience findings, we also reviewed the hospitals internal patient feedback, any complaints and other survey data, to help us gain a better understanding of the overall patient experience.

Patients we spoke with during the inspection told us they were treated well, and that staff were kind and helpful. The hospital also undertakes annual patient and family questionnaires.

Patient comments on the inspection included:

> *"Ward managers and staff are lovely"*

Health promotion, protection and improvement
Cefn Carnau had a range of facilities to support the provision of therapies and activities for patients. In addition, patients have regular access to community services for those who are authorised to leave the hospital.

We observed patients at the hospital being involved in a range of activities throughout the inspection. The Occupational Therapy (OT) staff and activities co-ordinator had a variety of activities in place, and it was clear to see that the OT department, along with the activities co-ordinator were providing some beneficial therapeutic activities for the patient group. There is a weekly activity timetable in place and activities include basketball, football, crafts and cinema club.

In addition, patients had access to an occupational therapy kitchen which they could use to prepare meals. Patients were seen using this area during the inspection.

Patients also had access to outdoor garden areas, however there were no sheltered areas to protect and allow the patients to continue using the garden during any adverse weather conditions.

The registered provider should consider installing shelters to enable the patients to use the garden area during all weathers.

Patients also had access to a sensory room, however this room appeared untidy and cluttered, and did not appear to be used for its intended purpose.

The registered provider must ensure that the sensory room is organised and tidy.

Patients were able to access GP, dental services and other physical health professionals as required.

Services are also provided by other professionals, such as physiotherapy, dietetics and speech and language therapy, in line with individual patient needs. Patient records evidenced detailed and appropriate physical health assessments and monitoring.

Health promotion leaflets and details of support organisations were available in the hospital for patients.

Dignity and respect

We found that all employees engaged with patients appropriately and treated them with dignity and respect. This included ward staff, senior management, and administration staff.

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

All bedrooms were ensuite and all had observation panels that can be opened or closed from the outside to maintain privacy. During the inspection we highlighted a privacy and dignity issue relating to a patient using the shower facilities. This issue was resolved on site and the patients care plan was updated accordingly to prevent any further issues.

We saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering. At the time of the inspection patients did not have access to their own personal keys to their bedroom areas. The hospital manager confirmed that plans are in place to ensure that patients have access to keys.

The registered provider should ensure that patients have keys for their bedrooms.

Patients were able to personalise their rooms and store their own possessions. Personal items are risk assessed on an individualised basis, to help maintain the safety of each patient. This included the use of personal mobile phones and other electronic devices. A telephone was also available for patients to use to contact friends or family if needed, and there were electronic devices available on the wards for patients to use.

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, containing information on 'you said, and we did'. The information displayed on some 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
All patients we spoke with said they felt safe and were able to speak with staff when needed. They also said they were happy at the hospital and that staff were kind and helpful. There was a clear mutual respect and strong relational security between staff and patients. Throughout the inspection, we observed staff engaging and communicating in a positive and sensitive way with patients, taking time to help them understand their care, and using appropriate language or communication styles.

We were told that some staff spoke Welsh, and that translation services can also be accessed should patients need to communicate in other languages other than English or Welsh.

For specific meetings, and where applicable, patients can receive support from external bodies to provide support and guidance, such as solicitors or patient advocacy services. With patient agreement and wherever possible, their family members or carers were included in these meetings.

During the inspection we saw many examples of patients being involved and engaged in decision making. We observed a patient meeting which takes place every month where patients are provided with opportunities to raise issues about things that matter to them or make suggestions on improvements they would like to be made at the hospital. The hospital manager attended this meeting and was very engaged and familiar with the patient group and the patients demonstrated that they were happy to escalate and have open discussions with the hospital manager.

In addition, each ward has a patient representative who attends part of the clinical governance meetings where the patient representative discusses any issues, improvements or changes that the patient group would like to make.

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. Patients told us that they enjoyed the sessions that OT and the activities co-ordinator arranged for them.

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 good arrangements in place to promote and protect patient rights.

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

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.

A multi faith room was also available for staff and patients to use.

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.

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.

The hospital has 24-hour reception coverage, and reception staff are responsible for booking visitors appointment and ensuring safety of the hospital keys and staff alarms. There were good systems in place for allocation of keys to staff, this was an area of improvement from previous inspections.

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 wards.

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.

Evidence of audits were recorded electronically, and all were up to date and fully complete at the time of the inspection.

Managing risk and health and safety
Overall, we found that appropriate systems and governance arrangements were in place which helped ensure the provisions of safe and effective care for patients. There was an electronic system in place for recording, reviewing, and monitoring patient safety incidents. Staff confirmed that de-briefs take place following incidents. The meetings we attended, and the evidence obtained during the inspection confirmed that incidents and the use of physical restraint interventions are monitored and supervised robustly.

There were nurse call points around the hospital and within patient bedrooms and bathrooms so that patients could call for help if needed. There was also a well-equipped laundry room in place for use by patients, under supervision and patients are encouraged to manage their own laundry to promote independence.

A range of up-to-date health and safety policies were in place and various risk assessments had been completed, such as ligature point risk assessments and fire risk assessments.

Infection prevention and control (IPC) and decontamination
We found suitable IPC arrangements in place at the hospital. A range of up-to-date policies were in place to support staff with infection prevention and control procedures, to maintain patient and staff safety. Regular audits had been completed to check the cleanliness of the environment and check compliance with hospital procedures.

We found that staff had access and were appropriately using Personal Protective Equipment (PPE). Staff told us that PPE was readily available and we saw that sufficient hand washing, drying, and sanitation facilities were available.

Cleaning equipment was stored safely and organised appropriately and there were suitable arrangements in place for domestic and clinical waste.

Staff compliance with mandatory IPC training was 100 percent and was being continually monitored to ensure staff remained in compliance.

Nutrition
The hospital provided patients with regular meals on the wards, making their choices from the four weekly rotational menus. Meals are cooked freshly on-site by the chef who meets regularly with the patients to establish patients preferred meal and snack choices.

Patients were supported to meet their dietary needs, and we were told that specific dietary requirements were accommodated, as appropriate.

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

Medicines management
We found suitable arrangements in place for the management of medicines and its safe and secure storage. We also saw evidence of regular temperature checks of medication fridges to maintain safe storage.

There was a controlled drugs cabinet this met the required standard. A controlled drugs book and Drugs Liable for misuse book were also available on the wards.

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

We observed several medication rounds, and saw staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

Minimal and least restrictive prescribing of medications was observed. The medication policy was up to date and kept in the clinical rooms.

Medication Administration Records (MAR Charts) reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages and their Mental Health Act legal status.

It was positive to see self-medication care plans in place and one patient was responsible for caring for their own medication. This was working well and there was evidence to support that the patient was self-administering all medication as prescribed.

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

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

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
There were regular clinical audits undertaken at the hospital and we saw evidence of regular auditing of resuscitation equipment. Staff had documented when this had occurred to ensure that the equipment was ready for use 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.

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. Staff confirmed that de-briefs take place following incidents. Meetings we attended and evidence obtained during the inspection confirmed that incidents and use of physical interventions are checked, analysed, and supervised.

Strategies were described for managing challenging behaviour to promote the safety and well-being of patients. We were told that preventative techniques were used, and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the physical restraint of patients was used, but only as a last resort.

Management of patient behaviours were reflected in their care plans and risk management profile, along with staff training to use skills to manage and diffuse difficult situations. Care plans were very clear and focussed on primary interventions. Where interventions are required care plans referred to the gender of staff and the type of physical intervention to use.

Evidence obtained during the inspection confirmed that incidents and use of physical interventions were robustly monitored. There had been an increase in physical interventions during the period of June, July and August, partly due to the complex care needs of one individual patient. A decrease was noted in September, and it was positive to see that figures around physical interventions were monitored and discussed in clinical governance.

Any physical intervention that occurred during the previous 24 hours was reported and discussed at the daily meeting and then reviewed through the hospital's clinical governance structure. In addition, a CCTV review is undertaken on physical interventions and evaluated by the reducing restrictive practice trainer who will provide debrief sessions for staff and ensure lessons learnt are shared across the organisation.

The hospital has access to an extra care area (ECA) which is used for deescalation or seclusion if needed. Seclusion packs are completed during any period of seclusion. The pack details all reviews and observations and patients also have access to a seclusion feedback form.

The seclusion suite was rarely used; however, we were told that patients would often choose to use the ECA area as a way of deescalating their own behaviours or to have time away from the ward areas.

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. Significant improvements had been made across the hospital environment since our previous inspections, and it was positive to see that the patients were very involved around what improvements they wanted to take place.

Good multi-agency relationships had been made with the local Police and local safeguarding team. Both agencies attend at the hospital to engage and educate the patient group.

The hospital manager was also focussing on a new initiative to create a racial support group for both staff and patients to raise awareness around the different cultures in the hospital, and what support can be provided to both staff and patients.

Cultural awareness days were also due to be arranged to celebrate all the different cultures of staff and patients in the hospital, with the aim of increasing knowledge, understanding and appreciation of the many diverse cultures of staff and patients 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.

On the first night of the inspection, some patient identifiable information was found in the patient treatment room. This was brought to the attention of the hospital manager 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 kept electronically. The electronic system was password protected to prevent unauthorised access and any breaches in confidentiality.

Overall, we found robust systems in place to ensure that personal information relating to patients and staff were kept securely. There was a formal information governance framework in place and staff were aware of their responsibilities in respect of accurate record keeping and maintenance of confidentiality.

Further information on our findings in relation to patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010 below.

Mental Health Act monitoring
We reviewed the statutory detention documents of four patients, and all were 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 administrators ran an efficient and effective system to support the implementation monitoring and review of the legal requirements of the Mental Health Act.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
We reviewed the Care and Treatment Plans (CTPs) of five patients. The records evidenced a fully completed and current overall physical health assessment and standardised monitoring documentation, such as NEWS and MUST. In addition, there were standardised assessments based on the individual patient needs.

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

It was positive to see that care files clearly showed patient involvement in care discussions, which were patient focussed and signed by the patient. Records also included evidence of the patient voice to reflect their views.

There was evidence that care plans are reviewed regularly by staff and updated to reflect current needs and risks. Physical health monitoring is consistently recorded in patient records. Risk management plans were good with detailed risk assessments and risk management strategy plans, these plans also evidenced physical health considerations for staff to consider when physical interventions were required. In addition, there was evidence of active planning and discharge planning for long term placements.

Positive Behavioural Support Plan (PBS) were in place for all patients, however the information contained in the PBS grab sheets contained too much information, and the language used was too formal. Staff were aware that the PBS plans needed updating and had recently attended training on how to improve PBS plans and staff were in the process of reviewing and updating PBS plans. Improvements in PBS plans will also help hospital staff to support observations and reduce incidents and help unfamiliar staff to provide more individualised care to patients.

The registered provider must ensure that PBS plan is reviewed and updated.

Quality of Management and Leadership

Staff Feedback
We invited staff to complete HIW questionnaires following the inspection to obtain their views and experiences on the service provided at the hospital. However, insufficient questionnaires were completed, although we were able to gain views and experiences from the staff we spoke with during the inspection.

Staff told us that the culture on both wards was positive, and that they would feel confident in raising a concern and knew the process of how to do so. This was confirmed in evidence we reviewed during the inspection.

Staff also told us that they enjoyed working on the wards and that they were a supportive team.

Governance and accountability framework
There was a clear organisational structure in place 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.

It was positive to see that senior staff attended when notified of the inspection team's arrival and were on hand to provide additional support.

The day-to-day management of the wards was the responsibility of the ward managers, assisted by the deputy managers.

There was clear, dedicated and passionate leadership from ward staff, who are supported by committed multidisciplinary teams and senior hospital managers. Staff were able to describe their roles and appeared knowledgeable about the care needs of most patients they were responsible for.

During our time on the wards, we observed a positive culture with good relationships between staff who we observed working well together as a team. Most staff spoke positively about the leadership at the hospital. Most staff also spoke favourably about the support from colleagues working within the hospital and reported a good team-working ethos at the hospital.

Arrangements were in place to quickly share information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helped to maintain patient safety and continuous improvement of the service provided.

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.

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

Workforce recruitment and employment practices
Staff we interviewed spoke passionately about their roles, and throughout the inspection we observed a strong cohesive team working together. Staff were able to access most documentation requested by the inspection team in a prompt and timely manner, demonstrating that there are good governance systems in place.

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 were 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 experienced ward staff. Staff showed us documentary evidence and talked us through the systems of induction in place.

We were provided with a range of policies, the majority of which were up to date, however, the consent policy was due for renewal in April 2023.

The registered provider must ensure that the consent policy is reviewed and updated.

Workforce planning, training and organisational development
The inspection team considered staff training compliance and provided with a list of staff mandatory training compliance. Training figures provided to us on the inspection indicated that overall compliance figures were 91.8 percent.

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 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 group.

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

Staff also told us that they would feel secure raising concerns about patient care or other issues at the hospital and felt confident that the hospital manager would address their concerns. A whistleblowing policy was in place to provide guidance on how staff can raise concerns.

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 during this inspection.			

Appendix B - Immediate improvement plan

Service: Cefn Carnau

Date of inspection: 9 – 11 September 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 this 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: Cefn Carnau

Date of inspection: 9 – 11 September 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 had access to outdoor garden areas, however there were no sheltered areas to protect and allow the patients to continue using the garden during any adverse weather conditions.	The registered provider should consider installing shelters to enable the patients to use the garden area during all weathers.		Shelters will be ordered for both gardens and fitted in both communal gardens	Dean Harries	13/01/2025
2.	Patients had access to a sensory room, however this room appeared untidy and cluttered and	The registered provider must ensure that the sensory room is organised and tidy.		This has been completed.	Dean Harries	04/10/2024

	appeared like it wasn't being used for its intended purpose.					
3.	At the time of the inspection patients did not have access to their own personal keys to their bedroom areas.	The registered provider should ensure that patients have keys for their bedrooms.		Keys are all on site available. MDT meetings to sign off each patient access to their bedroom key are planned. Following this process Keys will be released.	Dean Harries	04/11/2024
4.	There were patient notice boards, containing information on 'you said, and we did'. The information displayed on some boards was outdated and should contain up to date information.	The registered provider must ensure that patient information boards are up to date.		Notice board checks now form part of the Ward Rep Meeting. These will be checked every month by the Ward Manager and rep and raised in the monthly meeting.	Dean Harries	04/11/2024
5.	On the first night of the inspection, some patient identifiable information was found in the locked patient treatment room. This was brought to the attention of the	The registered provider must ensure that no patient identifiable information is left unattended and not secure.		A communication email has been developed and sent to all staff members ensuring paperwork is stored appropriately.	Dean Harries	04/10/2024

	hospital manager and immediately actioned and removed.					
6.	PBS grab sheets contained too much information, and the language used was too formal.	The registered provider must ensure that PBS plan is reviewed and updated.		PBS process is being finalised and grab sheets are being further developed.	Dean Harries	16/12/2024
7.	The consent policy was due for renewal in April 2023.	The registered provider must ensure that the consent policy is reviewed and updated.		Hospital Director has raised this to the Elysium Corporate Board for review.	Elysium Board	03/02/2025

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): Dean Harries

Job role: Hospital Director

Date: 04/10/2024