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17 February 2014

Dear Mr Torrington,

Re: Visit undertaken to Ty Gwyn Hall on the 10 and 11 February 2014

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to Ty Gwyn Hall independent hospital on the 10th and 11th February 2014. Our visit highlighted areas that are noteworthy and include:

- The good interaction observed between the manager and patients and support staff and patients. However, it was difficult to comment on registered nurses interaction with patients because they appeared too busy undertaking a variety of tasks including; dispensing medication and completion of a range of paperwork.
- The refurbishment of some areas within the hospital, particularly the occupational therapy area and entrance.
- The standard of cleanliness throughout the hospital was very good.
- The range of information available for patients was informative and wide ranging.
- Feedback from patients about the staff and manger was very positive.
- There was good support mechanisms in place for the patient pathway.

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- The quality of the reporting of incidents to the clinical governance meeting was very good.

- The Mental Health Act (MHA) administrator had recently completed her training and had developed systems for auditing the use of the Act and feeding information to the clinical governance group.

- There was a good focus on patient rights which were well documented and evidenced.

- The psychology input for behavioural management was very positive.

Our visit also highlighted a number of issues. We provided a verbal overview of our concerns to your registered manager at the end of our visit on 11 February 2014. A summary of these, which include regulatory breaches is set out below:

Issue of concern	Regulation
1. During our visit we identified a number of occasions when there were clearly insufficient staffing and this did not exclusively consider the days of our visit. A review of staffing numbers must be urgently undertaken and the registered provider must ensure adequate numbers of staff are provided. During our visit there was insufficient numbers of staff and this included cover for leave taken on Pentwyn unit, resulting in a patient not having recreational leave. In addition, this maybe hindering the development and supervision element of the staff nurse role.	Regulation 20 (1) (a)
2. There was no documented induction process available for agency staff. A written induction must be undertaken for all agency staff.	Regulation 20 (1) (b) & 20 (2) (a)
3. There was a lack of available information on agency staff to reassure the registered provider that agency workers had the necessary checks in place and a satisfactory knowledge and experience of the patient group. The registered provider must ensure that all agency staff have the necessary checks in place and have the appropriate level of experience and knowledge for the patient group.	Regulation 21 (2) (a) (b) (c) (d)
4. The availability of the responsible clinician (RC) must be improved. During our visit several patients complained about the lack of access to the RC. The RC must be pro-active in seeing patients.	Regulation 15 (1) (a) & (b)
5. There was a lack of an effective advocacy system/process available. Patient access to	Regulation 19 (2) (a) (b) (i) & (e)

independent advocacy must be improved.	
6. Pentwyn ward had only 2 out of 12 corridor lights working. Routine maintenance must be undertaken in a timelier manner. *During the feedback meeting we were advised that this issue has been raised with the maintenance team and specific parts for the light fittings need to be ordered.*	Regulation 26 (2) (b)
7. Some staff had not received regular supervision for a period of time. A system of supervision for all staff must be implemented.	Regulation 20 (2) (a)
8. We reviewed patient care records and the following was identified: a. Care plans for patients A (Ty Gwyn) and B (Pentwyn) were not evaluated in line with identified timescales. b. There was a lack of discharge plans on file for patients A; C and B. c. Patient A's (Ty Gwyn) care plan stated *'bloods to be taken routinely'* but this was not defined. d. Patient A (Ty Gwyn) declined routine blood test on 28/01/2014. There was no update in the care records to confirm when these were subsequently done. The areas identified in relation to care plans must be addressed.	Regulation 15 (1) (a) (b) & (c)
9. The electronic system used for recording patient information was difficult to navigate and would benefit from additional tabs to cover specific areas, e.g. multi disciplinary team notes (MDT) etc.	Regulation 23 (1) (a) (i) (ii) (3) (a)
10. There was no structured educational programme in place for patients. Considering the patient group and rehabilitative model there was a lack of basic literacy and numeracy assessment and training. A structured educational programme must be introduced.	Regulation 15 (1) (a) (b) & (c)
11. The treatment room was examined and the following areas were identified: a. A range of medication was being stored in the medicines cupboard for disposal. Timely disposal of medication is required.	Regulation 15 (5) (a) & (b)

12. Registered nurses (RN) would benefit from a developmental programme defining their role. A programme for developmental of RN's to be formulated and implemented.	Regulation 20 (1) (a) & (2) (a) & (b)

You are required to submit a detailed action plan to HIW by **10th March 2014** setting out the action you intend to take to address each of the above issues. The action plan should set out timescales and details of who will be responsible for taking the action forward. When the plan has been agreed by HIW as being appropriate you will be required to provide monthly progress updates.

On receipt of this letter the registered provider is required to comment on the factual accuracy of the issues detailed and on receipt of your action plan, a copy of this management letter, accompanied by your action plan will be published on our website.

We may undertake a further visit to ensure that the above issues have been properly addressed and we will undertake more frequent visits if we have concerns that necessary action is not being taken forward in a timely manner.

Please do not hesitate to contact me should you wish to discuss the content of this letter.

A copy of this letter is being sent to Mr Shaun Cooper, Manager at Ty Gwyn Hall Hospital.

Yours sincerely

Mr John Powell
Head of Regulation

cc – Mr Shaun Cooper, Ty Gwyn Hall, Llantillio Pertholey, Abergavenny, Gwent NP7 6NY