Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health/ Learning Disability Inspection (Unannounced)

Betsi Cadwaladr University Health Board: Heddfan Unit, Clywedog, Dyfrdwy, Gwanwyn, Hydref & Treweryn Wards

15 and 16 April 2015

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1. Introduction

Our mental health and learning disability inspections cover both independent hospitals and mental health services provided by the National Health Service (NHS). Inspection visits are a key aspect of our assessment of the quality and safety of mental health and learning disability services in Wales.

During our visits Healthcare Inspectorate Wales (HIW) ensures that the interests of the patients are monitored and settings fulfil their responsibilities by:

- Monitoring the compliance with the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards
- Complying, as applicable, with the Welsh Government's National Minimum Standards in line with the requirements of the Care Standards Act 2000 and the Independent Health Care (Wales) Regulations 2011.

The focus of HIW's mental health and learning disability inspections is to ensure that individuals accessing such services are:

- Safe
- Cared for in a therapeutic, homely environment
- In receipt of appropriate care and treatment from staff who are appropriately trained
- Encouraged to input into their care and treatment plan
- Supported to be as independent as possible
- Allowed and encouraged to make choice
- Given access to a range of activities that encourage them to reach their full potential
- Able to access independent advocates and are supported to raise concerns and complaints
- Supported to maintain relationships with family and friends where they wish to do so.

2. Methodology

The inspection model HIW uses to deliver the mental health and learning disability inspections includes:

- Comprehensive interviews and discussions with patients, relatives, advocates and a cross section of staff, including the responsible clinician, occupational therapists, psychologists, educationalists and nursing staff
- Interviews with senior staff including board members where possible
- Examination of care documentation including the multi–disciplinary team documentation
- Scrutiny of key policies and procedures
- Observation of the environment
- Scrutiny of the conditions of registration for the independent sector
- Examination of staff files including training records
- Scrutiny of recreational and social activities
- Scrutiny of the documentation for patients detained under the Mental Health Act 1983
- Consideration of the implementation of the Welsh Measure (2010)[1]
- Examination of restraint, complaints, concerns and Protection of Vulnerable Adults referral records
- An overview of the storage, administration, ordering and recording of drugs including controlled drugs
- Consideration of the quality of food
- Implementation of Deprivation of Liberty Safeguards (DOLS).

[1] The Measure is primary legislation made by the National Assembly for Wales; amongst other matters it makes provision in relation to assessment, care planning and coordination within secondary mental health services.

HIW uses a range of expert and lay reviewers for the inspection process, including a reviewer with extensive experience of monitoring compliance with the Mental Health Act 1983. These inspections capture a snapshot of the standards of care patients receive.

3. Context and description of service

Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to the Heddfan Unit, Wrexham on the evening of 15 April and all day on the 16 April 2015. We inspected all five wards, Clywedog, Dyfrdwy, Gwanwyn, Hydref and Treweryn the Psychiatric Intensive Care Unit (PICU).[2]

The Heddfan Unit is a specialised mental health hospital situated within the grounds of Wrexham Maelor Hospital run by Betsi Cadwaladr University Health Board (BCUHB) and provides a comprehensive range of acute health services including older persons and psychiatric intensive care services (PICU).

Clywedog and Dyfrdwy were both acute, mixed gender wards, each having 18 beds. Gwanwyn and Hydref were both older persons mental health assessment wards. Gwanwyn Ward cared for patients with organic illness and Hydref Ward cared for patients with functional illness. Both wards could accommodate up to 14 patients each. Treweryn Ward was an eight bedded mixed gender PICU.

All the wards were locked and access to the wards was via a key fob system.

During our inspection we reviewed patient records, interviewed patients and staff, reviewed the environment of care and observed staff-patient interactions.

HIW's review team comprised of one Mental Health Act Reviewer, one lay reviewer, two members of HIW staff and two newly appointed reviewers shadowing the team.

[2] A psychiatric intensive care unit (PICU) provides care and treatment for people experiencing the most acute phase of a mental illness. A PICU is a safe, secure and low stimulus ward environment.

4. Summary

Our inspection at the Heddfan unit took place across five wards. We found significant scope for improvement but were also pleased to reflect some positive findings.

HIW noted that staff engaged positively with the inspection process and we observed good team working at ward level, with strong leadership and supportive management on the acute and PICU wards. Most importantly, patients were generally very complimentary about staff attitudes and approach.

We were pleased to learn of the good links the unit had with third sector organisations and the advocacy service was proactive to assist with patient needs.

It was extremely disappointing however to note the catalogue of maintenance issues we identified and the impact these were having upon patients and staff in a relatively new building. Apart from the wider maintenance issues including various roof leaks and electric cabling issues, an accumulation of minor issues, including broken washing machines, provision of hot water, broken irons and broken ward intercom phones were placing unnecessary pressure on staff and patients. We are pleased that following our feedback meeting and immediate assurance letter to the health board an action plan has been put in place to address the numerous issues identified.

Although staffing levels were satisfactory at the time of our visit, we were concerned about the amount of time nursing staff were spending performing non-nursing tasks that was taking them away from patient care and the ward. Nurses were expected to clean metal kitchen surfaces and appliances because the remit of domestic staff was not to clean these. Portering tasks and pharmacy collections were also taking nurses away from the ward. Nursing staff clearly need to concentrate on nursing care first and foremost and it is important other services within the hospital support nursing staff and undertake these duties.

Nursing stations at Heddfan were open plan, with some displaying patient information. Staff had no rooms to make private phone calls regarding patient care and all paper and computer work was completed in view of individuals on the ward, particulary on Clywedog and Dyfrdwy wards. It is important that patient information is confidentially maintained.

Some of the practices we observed on some wards were unacceptable and require immediate improvement. In particular, the dirty utility rooms on some wards contained cabinets storing sterile materials and equipment. The clean

clothes of a patient was drying in one utility room, tins of paint and brushes and a urine sample were all observed. Efforts by some staff was made to change this during our visit which we note as positive, however these rooms should not have been used and observed in this condition.

The completion of daily checking sheets and other records were noted to have gaps, with some not completed for several weeks and months. Such information included resuscitation equipment, fridge and food temperatures and Control of Substances Hazardous to Health (COSHH).

There were gaps identified in staff mandatory training that require immediate action and also supervision and appraisals need some attention, especially for those staff members who had not received any training and supervision for some time.

We identified areas for improvement in relation to patients' care and treatment plans and occupancy levels for beds need to be effectively managed to prevent existing patients being unable to return from leave. Staff confirmed that on occasions there had been too many patients for the ward; in particular staff told us that the day before our visit they had two patients for the same bed.

The administration of the Mental Health Act was very good and particularly positive regarding the approved mental health professional (AMHP) reports. In addition, the practice of referring all patients who lacked capacity to the Independent Mental Health Advocacy (IMHA) was noted as good practice.

5. Findings

Core Standards

Ward environment

Clywedog Ward is an 18 bedded acute ward for both male and female patients. The ward provided 18 single en-suite bedrooms which were split between male and female areas. The ward offered an open plan communal space in which a TV, chairs and tables were located. The seating provided appeared formal with upright chairs, there were no sofas, settees or comfy chairs suitable for relaxing. An open plan dining area was situated opposite the lounge area which only had 13 chairs available, making it impossible for all patients to dine together. At the time of our visit the ward had 18 patients. We were told that patients would sit by the tables in the lounge area to eat their food if necessary.

A payphone was situated in the open plan communal area, near the TV. There was no specific seating provided for the telephone's use and private conversations would have been difficult to have due to the location of the telephone.

A second lounge, called the male lounge was available for patients to use, however the room was unwelcoming with no pictures on the wall. There was seating available for up to six patients. A few books and TV with game console was available. The room required redecoration due to paint flaking on the walls and cables from the TV provided hazards/ligature points.

Clywedog Ward had their own ward kitchen in which patients were allowed in with staff to make drinks and snacks. Restrictions were in place because of the utensils and equipment stored in the kitchen. Shelving provided storage for items including tea bags, sugar, cups, and a toaster, microwave and fridge were also available. Staff confirmed that patient meals are prepared and brought over from the main hospital. Staff on Clywedog ward had to go and collect the food trolley from the collection point within the building and serve patients the food. In addition, staff on the ward had to wash the dishes and return the trolley to the collection point.

We identified some maintenance issues which we were told had been reported a considerable time ago and which at the time of our visit had not been repaired. Such issues included the light in the Disposal Room not working which meant staff had no light in this room posing a health and safety risk to them.

The storage facilities on this ward were not ideal and rooms including the Patients Store were being used to store additional items because space was

limited. Apart from patient items, the room was storing additional food items including boxes of cereals, staff lockers, lost property and Christmas decorations.

The Dirty Utility at the time of our visit had patients' clothes drying in the room and a cupboard storing sterile materials. There was no bin in the room to dispose of waste and it was unacceptable to have a room for waste disposal storing the items we observed.

Tryweryn Ward is an eight bedded psychiatric intensive care unit (PICU) for both male and female patients. The ward provided six en-suite bedrooms and a de-stimulation area with two single beds. The ward had an open plan communal area along with the nursing station, which allowed good observation of patients.

The Dirty Utility had a pot of urine on the draining board which staff said had been there from the day shift staff. When we questioned staff about this practice a nurse disposed of the item. Tins of paint, rollers and paint brushes were stored under the sink and paint was splattered around the sink which was dirty and dusty. Sterile materials were also stored in the dirty utility room which was unacceptable.

Maintenance issues were identified including the entrance door to the ward which was boarded up and had been for the past three to five weeks. The door handle on the Disposal Room was missing and had been for some time. As a result anyone could open this room which had hazards inside that could be fatal to patients.

The ward kitchen had shelves on which food items were stored. The sink was full of dirty water where staff had washed dishes. Staff told us that they clean all metal surfaces because domestic staff were not allowed.

An art room provided materials for patients to use, however the furniture within the room was light-weight and easy for patients to lift and cause damage.

An outside courtyard provided patients with an opportunity to get some fresh air, however at the time of our visit the garden was not appropriately cleaned and maintained, with cigarette ends and packets littering the floor. Brightly painted benches were not bolted to the floor and provided patients with an opportunity to up turn them on their ends and climb onto a protruding roof space to abscond.

Dyfrdwy Ward is an 18 bedded acute ward for both male and female patients. The ward provided 18 single en-suite bedrooms which were split between male and female areas. Dyfrdwy Ward was a mirror image of Clywedog ward

and both wards shared an activities area that had facilities for arts and crafts, a dart board, pool and table tennis table and activity room which contained computers.

Dyfrdwy Ward displayed a good range of patient information including advocacy services, 'Putting Things Right', spiritual wellbeing, Age Cymru and HAFAL. A patient forum notice board was also displayed which included some activity information.

The garden area was poorly maintained with overgrown grass, litter on the floor and bins overflowing with rubbish, dog mess was even observed in the garden area which we were told was from visitors dogs. The issue of dog excrement had been raised as an issue of concern to HIW on a separate occasion and the continued presence of dog mess during our visit in the hospital gardens was improper. The whole garden area was unacceptable and not fit for patients to use and enjoy.

The ward had its own list of maintenance issues that were taking time to address. Staff confirmed that shower rooms were flooding when used and the washing machines in the laundry room were frequently breaking down and at the time of our visit were not working.

Gwanwyn Ward is a 14 bedded older person's ward for both male and female patients with a diagnosis of an organic mental illness. The ward provided 12 single en-suite rooms and one double room with two beds. The ward had a large communal area with chairs and a TV. Notice boards were displayed with information about staffing and the date, which was three days out of date. Information about patients' rights and the mental health review process was also displayed and out of date.

Two garden areas could be accessed from the communal area and they both had rubber flooring and seating. The patient payphone was broken but staff confirmed that the ward phone could be used.

The dining room was bright and airy and pictorial menus were displayed on the wall. At the time of our visit there were four tables and 10 chairs available, enough to provide seating for the number of patients on the ward.

There was no nurse call alarm system in the assisted bathroom or on the wards. Considerable maintenance issues were observed on Gwanwyn including closed rooms because of problems with damp. As a result an unpleasant smell of damp lingered within areas of the ward.

Directly above Gwanwyn was located Hydref Ward, a 14 bedded male and female ward for patients with a functional mental illness. The accommodation was the same as on Gwanwyn Ward, 12 single rooms and one double which

were all en-suite. Patients had access to a roof garden, which required maintenance. For those patients who wanted to smoke they needed to be escorted downstairs and outside.

Maintenance issues on Hydref Ward were also identified including leaks, rising floors and noisy doors because they did not have soft door closures.

The lounge area had ample seating and a TV, newspapers, books and DVDs were available for patients to use. A working payphone was also available for patients to maintain contact with family and friends. The ward had an attractive dining area with sufficient chairs and tables, and a therapy/relaxation room and arts and crafts room were situated on the ward.

It was very disappointing to have observed so many maintenance issues across the whole of the Heddfan unit. The building is approximately five years old and if the issues are not addressed as a matter of urgency the building will fall into further disrepair. Following our feedback meeting, we issued an immediate concerns letter to the health board, citing maintenance as one of our concerns. The health board has provided an action plan to tackle the issues identified.

Recommendations

The catalogue of maintenance issues and more complex repairs and replacements requires urgent attention. The maintenance action plan submitted in response to HIWs immediate assurance letter needs to be updated regularly to ensure the building is safe for patients and staff.

A review of the furniture across all wards is required to ensure there is sufficient seating in all patient areas including dining room and it is suitable for the patient group so it can not be easily lifted to cause harm and damage.

Outside spaces and gardens require attention to ensure they are suitable for the patient group. They need to be kept to an acceptable standard, free of litter and dog mess so they can be used appropriately.

An investigation is required to determine how and why dog mess is being observed in the hospital gardens and what measures will be put in place to stop this issue.

The dirty utility rooms require attention to ensure no sterile materials and equipment; patient items or decorating items are stored in them. Any procedures undertaken which result in specimens being taken, need to be disposed of once they have finished.

A ligature risk assessment needs to be undertaken to identify potential ligature points/issues across all wards.

Safety

When HIW arrived at the Heddfan unit on the evening of 15th April, there was a significant level of confusion and absence of an effective on call system. Staff were able to make contact with the bronze on call however it was difficult to escalate above this. An effective on call system must be established to ensure any emergency/situation can be dealt with by the most appropriate persons.

Some areas within the wards had no or inappropriately placed alarm/nurse call systems. Dyfrdwy ward had no alarm system on the ward or in the assisted bathroom and shower room. On Clywedog ward the alarm call in the disabled toilet was situated six inches from the floor, making it impossible to use if someone was sitting on the toilet and required assistance.

There were numerous examples of essential audits and other record sheets not being completed. The daily record for checking resuscitation equipment on Clywedog ward had not been completed on several occasions including March 3, 4, 5, 9 and 10 and April 4, 5 and 15. The medication fridge temperature was not recorded. There were no food hygiene protocols being followed, specifically no fridge or food temperatures had been recorded. Monthly quality checks had not been completed since September 2014. On Tryweryn ward the Control of Substances Hazardous to Health (COSHH) file had not been updated since July 2013. Not recording important data could have a significant impact on the health and safety of everyone and it is important that any checks that have to be made are recorded.

Numerous maintenance issues were identified which posed potential hazards for staff and patients. The light in the disposal room on Clywedog ward was not working; rooms on the older persons ward were closed due to damp and structural works and in some corridors, roof tiles were missing, exposing electric cables. The security/access intercom system for out of hours and weekend use was not working. Staff could not see who was buzzing the main entrance door because the intercom phone was broken; therefore staff had to go off the ward to check. The PICU ward had damaged doors that would enable a patient to easily access rooms that shouldn't be accessed without a staff presence.

Nursing staff were routinely expected to perform non-nursing tasks as a result of a lack of porters at the Heddfan unit. This situation resulted in nursing staff leaving the ward for considerable periods of time in order to undertake pharmacy collections and laundry collecting, storing and moving. Although

staffing levels at the time of our visit were satisfactory, taking staff away from the ward to undertake these tasks left wards short of staff.

Staff on Clywedog and Dyfrdwy wards told us of their frustrations regarding the system in place regarding mealtimes. Apart from collecting food trolleys, staff were expected to serve food, wash dishes and return the empty food trolley to the collection point in the Heddfan unit so they can be returned to the main building. Staff told us that this took them away from their nursing duties and is an area that requires attention.

Occupancy levels for beds must be effectively managed to prevent existing patients being unable to return from leave. Staff confirmed that on occasions there had been too many patients for the ward; in particular staff told us that the day before our visit there were two patients for the same bed.

It was pleasing to note that wards had gained AIMS[3] accreditation and the unit was working towards STAR[4] wards and Safewards[5].

Recommendations

A review of the on-call system is required to ensure an effective on-call system is in operation and established to enable staff to contact the correct person in any circumstance.

A review of all nurse/alarm call systems to be undertaken to ensure they are appropriately placed and included in the assisted shower/bathroom.

All required audits and checks need to be undertaken on a regular basis to ensure the safety of the wards for everyone.

A review of the tasks undertaken by the nursing staff is required to ensure their skills and time is not taken up with duties that could be supported by other staff disciplines within the hospital, including

[3] Accreditation for Inpatient Mental Health Services (AIMS) - AIMS is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. Accreditation assures staff, service users and carers, commissioners and regulators of the quality of the service being provided. www.rcpsych.ac.uk/AIMS

[4] Star Wards is a motivational initiative that was founded by a service user and it focuses upon implementing practical ideas that make the best use of time and skills by both staff and patients. The initiative aims to recognise and build upon good practice, promote the quality of the service users experience and support the autonomy of the service user. www.starwards.org.uk

[5] Safewards is a project designed to reduce rates of conflict and containment in adult in-patient mental health settings. The work is part of a major initiative led by Len Bowers, Professor of Psychiatric Nursing at King's College London and the Institute of Psychiatry. www.safewards.net

cleaning certain kitchen surfaces, washing dishes and portering duties such as pharmacy collections.

Occupancy levels for beds must be effectively managed and monitored to prevent existing patients being unable to return from leave.

The multi-disciplinary team

During our visit we observed good team working at ward level, with strong leadership and supportive management observed on the acute and PICU wards. All the staff spoke of working in a professional and collaborative way. On the whole staff felt respected within their teams and that their professional views were valued. Some staff told us that some consultants ask nursing staff for contributions while others did not. As a result, when consultants made decisions without regard to other professions point of view communication can fall down.

Heddfan unit did not have a psychology service and staff said this was a big gap in the service provision for patients. There had been a post advertised but recruitment had been unsuccessful. Occupational Therapists (OT) support the entire Heddfan unit by undertaking patient assessments which result in patient plans to deliver specific therapies and practice sessions. At the time of our visit OT were involved in many initiatives and undertaking lots of work including anxiety, dementia, personality disorder, psychosis and depression.

The delivery of therapeutic activity was undertaken by OT staff, activity nurses and nursing staff. Staff told us of their dilemma whereby with the current staffing levels do they provide a quality service for some patients or dilute their services and provide a basic service for all patients. Staff said a small increase in staffing levels would make a huge difference in their provision. Staff told us that the joining of the two services, elderly and adult had enhanced the service and enabled OT to move towards using standardised documentation and services across all mental health provision.

Recommendation

The provision of a permanent psychologist/s for the Heddfan unit would enhance the service provision and outcomes for patients.

A review of the Occupational Therapy service is required to ensure the Heddfan unit has sufficient numbers and capacity to provide and undertake a comprehensive OT programme for all patients.

Privacy and dignity

The patients we spoke to all said they felt safe at the hospital and were generally very complimentary about staff attitudes and approach. Each patient had their own en-suite bedroom that they could lock and all the patients we spoke to confirmed staff knock on their bedroom door before entering, therefore feeling their privacy and dignity was respected.

Not all the patients we spoke to were shown around the ward and had an explanation of what was going to happen upon admission. It is recommended that all new admissions are provided with orientation to the ward in order to help patients settle in more effectively.

All the patients confirmed they could make phone calls in private and there were facilities for patients to meet with family and friends in private. We noted some payphones were situated in an open plan patient area and this would be difficult for patients to have private conversations due to the location.

Not all the patients had a named nurse that they could meet with in private to discuss their care and treatment and it is essential all patients are provided with a named nurse upon admission.

Vision panels on patient bedroom doors on some wards were left in the open position. This made it very easy to observe the patients in their bedrooms and this could cause embarrassment regarding their privacy, dignity and respect. In addition, patients were unable to operate the vision panels from inside their bedrooms to their preferred position. Staff seemed to have no concerns with this practice and it is recommended that vision panels are set to the closed position, enabling the patient to choose whether it is open or closed.

All wards had open plan nursing stations, two of which had patient information clearly displayed. Staff told us they struggled with supplying confidential information by telephone because of this. All telephone conversations, computer and paperwork were undertaken in view of everyone on the ward which was a compromise to patients' privacy and dignity.

Recommendation

All new admissions should receive orientation to the ward to help them settle in.

All patients should be allocated a named nurse in order for them to be able to discuss their care and treatment with a designated nurse.

All vision panels should be set to the position of closed to respect patients' privacy and dignity. All vision panels should have controls on

the inside of a patient's room to enable them full control of their personal space.

A review of all open plan nursing stations is required because the current set up was compromising patient's privacy, dignity and respect.

Patient therapies and activities

Staff told us the range of activities and facilities at the Heddfan unit for patients were good, including a gym, pool table and table tennis, darts, arts and crafts, and board games. During evening and weekends staff organise bowling, cinema nights and walking groups.

Half of the patients we spoke to said they had enough things to do on their wards and all patients said they had been asked what they would like to do. One of the patients who told us they didn't have enough activities to do confirmed that the activity nurses were not on the ward the week of our visit.

Our observations on Gwanwyn ward highlighted a lack of structured activities taking place. There was a lack of orientation to the day and this was further complicated by the fact that the reality orientation board for patients was displaying the date of 12/04/2015, three days out of date.

Patients told us that they had somewhere to go for peace and quiet and time alone. They were able to go outside for fresh air and opportunities for trips out were available. Visits from their friends and family were welcomed and encouraged.

Although patients were encouraged to attend to their own laundry, the facilities on Dyfrdwy ward were broken and had been for the past three months. Patients said the washing machine was not working and they had to use a machine on another ward. In addition, patients said the irons were also not working. To enable patients to attend their laundry, it is recommended that facilities are suitable for industrial usage and not domestic because it was evident they were not suitable for the amount of time they were being used for.

The advocacy service was available to all patients throughout the Heddfan unit and feedback obtained was very good. Advocacy information was displayed at ward level and staff told us they had a good relationship with the service. Advocates would visit at least weekly and also when required, including for ward rounds. Staff confirmed all patients were automatically referred to the IMHA service, who then will attend or phone the patient and introduce themselves and their service.

The knowledge among the patients we spoke to regarding advocacy was generally good, with the majority of patients knowing about the service and how to contact them. One patient told us that not a lot of the other patients were aware of the advocacy service but they helped to "spread the word". Minutes from the patient forum, Unllais in March 2015 showed a patient was informed about the service and a leaflet provided. It was good to note that the patient forum minutes had a specific advocacy section which enabled wards to ensure all patients are reminded and where necessary provided with information.

Heddfan unit had good links with third sector organisations including KIM's (Knowledge Inspiration Motivation) Café and Hafal. In addition the monthly patients' forum provided opportunities for patients to have their say regarding issues that affect them.

Recommendation

A review of the structure of the patients' day on Gwanwyn ward is required, specifically to the orientation board and information.

Laundry facilities need to be repaired and/or replaced to enable patients to attend their own laundry.

General healthcare

All the patients we spoke to knew why they were in hospital and staff had discussed options with them regarding their care. All the patients could tell us who their Responsible Clinician/Psychiatrist was, however not all patients knew their named nurse or care coordinator.

The majority of patients felt staff listened to them when discussing their treatment and all the patients we spoke to knew what medication they took and why. Patients were generally happy with all the care and treatment they had received.

Food and nutrition

All the patients we spoke to said they enjoyed the meals served at Heddfan stating the food was better than it had been and was served hot. The patients told us they had a choice of meal and the portion size was sufficient. The patients' forum minutes for March 2015, specifically the comments from Clwyedog and Tryweryn wards reiterated the feedback we received. Comments in the minutes from Dyfrdwy ward patients were not so complimentary. Patients mentioned that depending on what staff members

were working, the variety and meal size changed. Remarks about choice and a lack of condiments were also noted.

Patients requiring drinks and snacks outside of set meals times were provided with them and the majority of patients said they could buy and store their own food. At the time of our visit, staff on an acute ward had to use a hot water flask because the kettle was not working, this was another maintenance issue that caused frustration amongst the staff.

The staff we spoke to had differing views regarding the food served, with the majority saying the food could be better and that on occasions the food served was poor, overcooked and mushy. One member of staff said the meat served can be chewy and older persons on the ward would struggle with this. Staff said the variety of food was not good, especially for long stay patients and more choice was required.

There were dietician services available for the Heddfan site and patients were weighed regularly as part of their health checks.

We observed a meal time on one of the older persons wards and noted staff assisting patients with their meals. Patients were offered a choice of meal and the portion sizes were satisfactory. We observed a patient not engaging in the mealtime and the member of staff was observed to offer alternatives and encourage the patient with different drinks.

Food was delivered from the main hospital site to Heddfan ward. Staff from each ward had to collect the food trolley, transport it to the ward and serve the food.

Recommendations

The facilities used by patients to make hot drinks needs to be repaired or replaced.

Training

We reviewed 10 staff files across two wards and identified lots of inconsistencies in the information contained on each file. Some files had evidence of contracts while others had nothing; some staff files contained one reference while others reviewed had no or two references on file.

All pre-employment checks are undertaken by Human Resources (HR) and once all checks are complete, the information is sent to Ward Managers to ensure it is updated on files. Some staff files reviewed contained a personal file checklist which HR completed to evidence that specific stages of pre-employment checks had been received and finalised. However, some

checklists were incomplete, therefore it was impossible to determine and evidence that the employee was recruited through an open process. One file in particular had a checklist confirming yes to an appointment letter, proof of identification and documents, Disclosure Barring Service (DBS) check and occupational health clearance. However, there was no information for references, interview notes, contract, and local induction.

In addition, the files we reviewed did not evidence that those staff with professional registrations including nurses had an up to date registration. All the files we reviewed contained old copies of registration confirmation. When this issue was discussed with staff we were informed that staff check websites for confirmation, however there was no system in place to evidence this.

All the files reviewed had evidence that supervision takes place and the majority of staff we spoke to confirmed this, with sessions taking place every 4 to 6 weeks. However, 4 out of 10 files we reviewed did not have a supervision record on file since 2014. Staff told us that lots of informal supervision takes place but we had no evidence of what this was and how often it occurred.

An appraisal system was also in place for staff and 5 out of 10 files we reviewed had an appraisal on file dated 2014. Two files had appraisals dated 2015, two files with appraisals dated 2013 and one file had no information on appraisals. It is essential all staff receive an annual appraisal.

It was unfortunate that we were only able to obtain mandatory training statistics from the one ward, despite requesting the information from another ward. The statistics we did review highlighted significant gaps despite having confirmation that the data was up to date. The majority of mandatory training courses listed had a 0% compliance rate. Those courses with compliance data showed limited take up of the course, highlighting a significant deficit in staff skills and knowledge. Staff's knowledge in areas including food hygiene, Mental Health Capacity Act awareness and suicide awareness was at 0%. Other areas including fire safety was 21% compliance (6 staff), infection control 25% compliance (7 staff) and manual handling at 36% compliance (10 staff).

There were some areas with better figures; however it is recommended all staff achieve 100% in their mandatory training to ensure they can provide safe and effective care for the patient group and themselves. Restrictive Physical Intervention (RPI) training had 54% compliance, but some staff admitted to working without having up to date training in this area. It was also said that staff without updated RPI training would and had been involved in patient restraints.

Staff told us that on occasions training courses had been cancelled last minute due to low numbers on the course and/or staffing levels on the ward. These situations impacts on staff achieving full compliance in relation to their training and where possible should be avoided. In addition, staff told us that training opportunities outside of the mandatory list could be better, with some staff requesting training in the Mental Health (Wales) Measure 2010 which at the time of visiting had not been arranged.

Recommendations

An audit of all staff files is required to ensure all information contained is consistent with BCUHBs recruitment and retention policies. In addition, consideration needs to be given to the layout of staff files to provide improved accessibility to information.

A system to evidence all those staff that requires a current professional registration is required.

All staff require regular and documented supervision, especially those staff that have had no supervision since 2014.

All staff require an annual appraisal and immediate attention must be given to those staff members who have not received an appraisal since 2013.

A review of mandatory training is required to ensure all staff are up to date in order to deliver competent patient care.

All staff must have up to date RPI training to ensure everyone's safety when on duty.

Training gaps were identified, including the Mental Health (Wales) Measure and these need to be arranged and provided for staff as soon as possible.

Governance

It was identified that the health board had an issue with a significant number of RC vacancies, with some psychiatrist posts across the health board left vacant. Discussions with the Clinical Director confirmed the health board is aware of the issue and is working to address the issue.

Recommendation

The health board must review the psychiatrist shortage and clearly demonstrate how workforce pressures will be addressed and managed.

Application of the Mental Health Act

We reviewed the statutory detention documents of six of the detained patients being cared for on two of the wards. The following noteworthy issues were identified:

- The files reviewed were easy to access and in date order
- It was noted that the Approved Mental Health Professional (AMHP) reports were comprehensive and particularly helpful to ward staff
- Assessment of capacity documentation was thoroughly completed

The following points were identified and need to be included in your action plan:

- It was identified that a patient had been removed a distance from their home and it was difficult for family to visit.
- Difficulties to service and manage tribunals was compromised by frequent changes of the RCs.

Monitoring the Mental Health Measure

We reviewed care planning documentation on Dyfrdwy ward and we noted the following observations:

- There was a lack of weight monitoring and nutritional assessments on the files reviewed
- There was a lack of evidence of physical health checks on the files reviewed some included completed checks by doctors but none undertaken by nursing staff were available
- One file had two next of kin details documented although the file stated the patient did not want information shared
- •The care plans reviewed were generic and lacked any individualisation
- Some unnecessary assessments were identified on file
- One file reviewed had documents which were partially or not completed, specifically the Care and Treatment Plan (CTP) review form. The form was not effectively completed because it could not be identified who attended the identity of the carer or if a carers assessment had been undertaken.
- It was unclear if patients had been provided or offered a copy of their plan
- The property of a patient did not appear to have been checked effectively because the patient brought in a knife with which they self harmed with.

Recommendation

All the areas identified, including weight and nutritional assessments, physical checks, next of kin details, lack of individualised care plans, unnecessary assessments, partially and not completed documents and property checklists need to be addressed.

6. Next Steps

The Health Board is required to complete an Improvement Plan (Appendix A) to address the key findings from the inspection. It should submit the Improvement Plan to HIW within two weeks of the publication of this report.

The Health Board's Improvement Plan should clearly state when and how the findings identified at the Princess of Wales Hospital will be addressed, including timescales.

The Health Board's Improvement Plan, once agreed, will be published on the Healthcare Inspectorate Wales website and will be evaluated as part of the on-going mental health/learning disability inspection process.

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Action Plan

Recommendation	Health Board Action	Responsible person	Timescale
The catalogue of maintenance issues and more complex repairs and replacements requires urgent attention. The maintenance action plan submitted in response to HIWs immediate assurance letter needs to be updated regularly to ensure the building is safe for patients and staff.	A full action plan was drawn up following the visit. The action plan is being monitored both in the Estates Directorate and within the Mental Health and Learning Disabilities Divisional Estates meeting. The plan was last updated on June 5th 2015. A copy of this has been circulated to managers. 13 actions were identified. Seven actions are completed, 3 actions are partially completed and two items have been identified as latent defects which are being agreed for action by the builder.	Director of Estates	Ongoing As per action plan
A review of the furniture across all wards is required to ensure there is sufficient seating in all patient areas including dining room and it is suitable for the patient group so it can not be easily lifted to cause harm and damage.	A review of seating in dining areas and sitting areas is underway and requests for replacement furniture, in line with the recommendation, will be made.	Locality Manager / Matrons	31 July 2015
Outside spaces and gardens require attention to ensure they are suitable for the patient group. They need to be kept to an acceptable standard, free of litter and dog mess so they can be used appropriately.	This is addressed in the estates action plan as above.	Director of Estates	Ongoing
An investigation is required to determine how and why dog mess is being observed in the hospital grounds and what measures will be put in place to stop this issue	The grounds surrounding the Heddfan Unit are open to the public. Family of patients are allowed to bring dogs to visit as this is recognised as being beneficial to some patients. Notices are to be displayed on entrances to gardens to request that visitors with dogs must remove any excreta.	Matrons/ Ward Managers	19th June 2015
The dirty utility rooms require attention to ensure no sterile materials and equipment; patient items or decorating items are stored in them. Any procedures undertaken which result in	All areas will be checked to ensure that only appropriate equipment is stored there. All inappropriate items will be removed. The Matrons will monitor compliance on daily visits to wards.	Locality Manager / Matrons	30 June 2015

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Action Plan

specimens being taken, need to be disposed of once they have finished.			

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Action Plan

A ligature risk assessment needs to be undertaken to identify potential ligature points/issues across all wards.	A full ligature assessment of all buildings providing inpatient mental health care in North Wales has been undertaken by an external advisory company. These actions have been reviewed by the Senior Management Team. The programme of work has been agreed as having a high level of priority and work is underway to secure funding to ensure corrective action is undertaken. Local areas have been requested to produce plans in order to ensure risks are mitigated whilst the work is undertaken in order of priority. This work is being monitored locally and by Senior managers in the Division.	Director of MHLD & Director of Estates	Assessment completed by external May 2015  Anti Ligature Audit - Hedfan Unit Wrexhan
A review of the on-call system is required to ensure an effective on-call system is in operation and established to enable staff to contact the correct person in any circumstances.	The On Call system is in place there was a misunderstanding regarding the Silver On Call by switchboard. The switchboard has been made aware that Silver covers all services including the Mental Health and Learning Disability Division.	Business Manager - Safety	Completed
A review of all nurse/alarm call systems to be undertaken to ensure they are appropriately placed and included in the assisted shower/bathroom.	Matrons have been asked to undertake a review of alarm systems and ensure wards undertake any necessary corrective action to ensure patients have access to an a call system.	Matrons	30 June 2015
All required audits and checks need to be undertaken on a regular basis to ensure the safety of the wards for everyone.	Matrons have been requested to undertake weekly spot checks. This item is included in a programme of service reviews planned across all service areas in a rolling programme. The first visit was undertaken on 4th June 2015.	Matrons / Locality Managers / Senior Management Team Review Group	Commencing 1st June 2015
Occupancy levels for beds must be effectively managed and monitored to prevent existing	From April 2015, daily Bed Management meetings have taken place which monitors bed usage across North	Locality Manager &	Commencing 1st April 2015

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Action Plan

patients being unable to return from leave.	Wales. The Divisional General Manager is setting up working groups across the Division in order to identify patient flow and appropriate use of beds. This will feed into the review of the admission, transfer and discharge policy with an aim that all admissions are purposeful admissions.	Matrons/ Divisional General Manager	
A review of the tasks undertaken by the nursing staff is required to ensure their skills and time is not taken up with duties that could be supported by other staff disciplines within the hospital, including cleaning certain kitchen surfaces, washing dishes and portering duties such as pharmacy collections.	The current guidelines do not specify that nurses have to clean stainless steel surfaces. The guidelines are under review in 2015 as part of normal review process. The Strategic Food Safety Group is looking at the management of ward based kitchen. A key policy document will shortly be going out for consultation. It has already been agreed that the ward/departmental manager will carry full accountability for the implementation and monitoring of the policy requirements including weekly checklists, record keeping, and proactive escalation action logs for reported issues. A tool will accompany the policy document and will clearly outline who is responsible for which piece of cleaning and maintenance. The Ward Manager will retain accountability for ensuring the standards are consistently met. There will be a significant amount of cross working between the Strategic Infection Prevention Group, chaired by Director of Nursing, Strategic Food Safety Group, the Strategic Cleanliness Group and the Food and Hydration Committee to ensure we have a clear line of sight on all food hygiene and safety issues. Provision of Housekeepers on all wards will be reviewed and put in place where required.	Assistant Director of Infection Prevention / Locality Managers / Matrons / Ward Managers Head of Portering	Groups are meeting May 2015. Draft amended document to be ready by 31st August 2015. Ratification of document and implementation by January 31st 2016. Reviewed by 31st July 2015. Meeting between Locality Mnagers and

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	Pharmacy collection will be discussed and action agreed with the Head of portering.		portering dept by 31st July 2015
The provision of a permanent psychologist/s for the Heddfan unit would enhance the service provision and outcomes for patients.	Despite previous attempts to recruit to the psychology post, this had been unsuccessful. This post has now been recruited to.	Head of Psychology	31 August 2015
A review of the Occupational Therapy service is required to ensure the Heddfan unit has sufficient numbers and capacity to provide and undertake a comprehensive OT programme for all patients.	A report by the lead Occupational Therapist to be presented to the Senior Management Team to identify deficits in provision and suggested restructure.	Head OT	31 July 2015
All new admissions should receive orientation to the ward to help them settle in.	Ward staff will ensure that all new patients receive an appropriate orientation to the ward and routines.	Matrons	30 June 2015
All patients should be allocated a named nurse in order for them to be able to discuss their care and treatment with a designated nurse	Ward Managers reminded of requirement to have a named nurse for every patient.	Matrons	30 June 2015
All vision panels should be set to the position of closed to respect patients privacy and dignity. All vision panels should have controls on the inside of a patients room to enable them full control of their personal space.	This is included in Estates Action Plan. Spot checks for compliance will be carried out.	Director of Estates Ward Managers / Matrons	Dates in estates action plan
A review of all open plan nursing stations is required because the current set up was compromising patient's privacy, dignity and respect.	There are adequate facilities for confidential meetings and discussions, for example the Ward Manager's office, meeting rooms, patient's own bedrooms. Ward staff will be reminded that nursing stations are not suitable for storage of confidential information, or confidential discussions. There are secure white boards being introduced in all ward areas.	Ward Managers / Matrons / Locality Managers	30 June 2015
A review of the structure of the patients' day on Gwanwyn ward is required, specifically to the	Ward staff will be reminded of the need to ensure the orientation board is use appropriately. A review of the way	Ward Managers	31 July 2015

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orientation board and information.	the day is structured will also be undertaken.	Matrons	
Laundry facilities need to be repaired and/or replaced to enable patients to attend their own laundry.	New washing machines to be ordered	Ward Managers	30 June 2015
The facilities used by patients to make hot drinks needs to be repaired or replaced.	New equipment has been approved for order with immediate effect.	Ward Manager	30 June 2015
An audit of all staff files is required to ensure all information contained is consistent with BCUHBs recruitment and retention policies. In addition, consideration needs to be given to the layout of staff files to provide improved accessibility to information.	Staff have been reminded of the standard for personal files as per BCUHB policy. Compliance will be monitored through audit of the standard as part of a programme of service reviews planned across all areas. The first visit was undertaken on 4th June 2015. Any necessary corrective action will be undertaken.	Divisional General Manager / Locality Managers	31 August 2015
A system to evidence all those staff that requires a current professional registration is required.	Information is currently gathered using ESR. Evidence has been provided to inspectors of the system. Managers will be advised of the correct application of the system and its management.	Divisional Head of Nursing	30 June 2015
All staff require regular and documented supervision, especially those staff that have had no supervision since 2014.	All staff will be informed of the requirement to adhere to divisional Supervision Policy. Information is gathered using ESR this is newly introduced and will monitor and remind of requirement as outlined in policy. Supervision compliance will be monitored and progress reviewed in Locality Operational meetings.	Ward Managers / Matrons / Locality Managers	Information to current staff by 31 July 2015
All staff require an annual appraisal and immediate attention must be given to those staff members who have not received an appraisal since 2013.	Information is gathered using ESR this is newly introduced and will monitor and remind of requirement. PADR compliance to be monitored and progress reviewed in Locality Operational meetings.	Ward Managers / Matrons / Locality Managers	To commence 31 May 2015
A review of mandatory training is required to ensure all staff are up to date in order to deliver competent patient care.	The recently implemented system of ESR has the functionality to alert managers and individual staff to when their mandatory training compliance is due to expire.	Locality Managers / Divisional	To commence 31 May 2015

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	Locality Managers receive reports monthly. Compliance will be monitored monthly as part of the performance framework. There is a long term project to identify local training needs and to take a tier approach to mandatory training. This will include a review of structures and training support roles. Recording of information related to training continues to be reviewed. The Tier one requirements of the BCUHB policy has been updated on the local record.	Head of Nursing	
All staff must have up to date RPI training to ensure everyone's safety when on duty.	As action point above		
Training gaps were identified, including the Mental Health (Wales) Measure and these need to be arranged and provided for staff as soon as possible.	There is a programme of training of staff at all levels related to the Mental Health Measure. This training includes the Mental Health Measure for Care Coordinators, Mental Health Measure for Administrators and Quality Management in Care and Treatment Planning.	MHM Lead / Divisional Head of Nursing	Programme was in place by 31st May 2015 continues to be delivered
The health board must review the psychiatrist shortage and clearly demonstrate how workforce pressures will be addressed and managed.	Work is underway in order to look at a long term programme of recruitment across the Division. In the interim, locum psychiatrists are being utilised in the most effective way in order to ensure services are safe.	Divisional Clinical Director	Plan to be reported to SMT by 31st July 2015
It was identified that a patient had been removed a distance from their home and it was difficult for family to visit.	The daily divisional bed management meetings give consideration to the movement of patients between units and the appropriate location of patients related to their family and home. At times however, it may be necessary for a patient to be in a bed some distance from home due to clinical need. This will be monitored on a daily basis.	Matrons / Locality Managers	Meetings commenced 1 April 2015
Difficulties to service and manage tribunals was compromised by frequent changes of the RCs.	Existing medical staff and locum psychiatrists are being utilised in the most effective way in order to ensure	Divisional Clinical	31st August 2015

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	services are safe.	Director	
All the areas identified, including weight and nutritional assessments, physical checks, next of kin details, lack of individualised care plans, unnecessary assessments, partially and not completed documents and property checklists need to be addressed.	An audit and review of patient records will be undertaken. Compliance will be tracked through a programme of service reviews planned across all service areas in a rolling programme. The first visit was undertaken on 4th June 2015.	Ward Managers / Matrons / Locality Managers	Baseline audit to be undertaken by 30 June 2015.