Mr Geoff Lang
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17 December 2013

Dear Mr Lang,

Re: Visit undertaken to the Hergest Unit on the 2, 3 and 4 December 2013

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to the Hergest Unit, Ysbyty Gwynedd on the evening of the 2nd December and all day on the 3rd and 4th December 2013. Our visit highlighted areas that are noteworthy and include:

- The way staff co-operated with the inspection process.
- The quality, variety and choice of food for patients.
- The decoration and refurbishment of the unit.
- The pro-active activities co-ordinator that resulted in a diverse range of recreational activities available for some patients.
- The psychiatric intensive care unit (PICU), Taliesin ward, seemed to be operating with far fewer issues than both Cynan and Aneurin wards.
- On the whole patients felt that they have had a positive experience and commented positively about staff.

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Our visit also highlighted a number of issues. It is of concern that several of these were highlighted in our previous report, following our visit in August 2012. For ease of reference we have identified the outstanding issues, from our August 2012 visit, within the table below.

All of the issues detailed must be addressed as a matter of urgency. We provided a verbal overview of our concerns to your senior management team at the end of our visit on 4 December 2013. A summary of these is set out below:

Issue of concern
1. Relationships between some responsible clinicians (RC) and some nursing staff was very poor with staff not talking to each other. In addition, some nursing staff were not talking to other nursing staff. The lack of communication and behaviour amongst professionals is unacceptable and must be resolved. 2. A lack of engagement in the change process of medical, nursing and occupational therapy (OT) staff was having a detrimental effect on the operation of the unit. Staff must engage in the change process to ensure the best possible outcomes for the patient group. 3. A number of staff interviewed during our visit stated that the morale at the unit was low. Strategies for improving staff morale must be identified and implemented. 4. There was a lack of training in some key areas across all wards, specifically fire safety and basic life support. The percentage of staff having received fire safety training was Aneurin 4%; Cynan 8% and Taliesin 0%. The figures for staff receiving basic life support was Aneurin 52%; Cynan 28% and Taliesin 52%. All staff must receive regular and relevant training. 5. A lack of regular staff supervision was identified, specifically on Cynan ward. The figure of staff having received supervision on this ward was 0%. An effective supervision system must be implemented for all staff. 6. Managers do not feel empowered to initiate change and bring leadership to the unit. The reasons behind this must be fully explored and strategies to resolve this must be implemented. (Identified in August 2012) 7. There were 2.5 equivalent full time OTs available on the Hergest unit, however, a substantial amount of this time appeared to be taken up with the assessment process. The reality of this was that only 5 hours of direct contact with patients per week was taking place. More face to face sessions with patients must be facilitated. (Identified in August 2102) 8. A distinct lack of recreational and occupational activities provided by the OT service was observed and this was also confirmed by patient and staff

feedback. A range of meaningful recreational and occupational activities must be made available for all patients. A clear exception to this was the work undertaken by the activities co-ordinator that was having a positive impact upon the social and recreational activities available for patients.

9. All patients on Taliesin ward (PICU) have an OT assessment between 4-7 days after arrival on the ward. At the time of our visit, everyone assessed on Taliesin ward by OT was recommended as not requiring OT and therefore patients on Taliesin ward were not having any OT input. We identified at least patient who it appeared may have benefited from some OT input. This area must be reviewed. (Identified in August 2102)

10. Some patient admissions may be inappropriate and some admissions appear to have complex physical needs. During our visit a number of patients were admitted to the unit and discharged within a very short space of time A review of admissions to the ward is required to ensure they are appropriate. (Identified in August 2102)

11. The range of conditions that patients were experiencing was very diverse including; drug and alcohol dependency and elderly patients suffering from anxiety and depression. A review of the admission criteria to the ward needs to be urgently undertaken. (Identified in August 2102)

12. There was a lack of robust governance and clinical audit processes in place. A robust process of governance and clinical audit processes must be implemented.

13. There was confusion regarding the on-call rota for senior staff when we arrived on Monday 2 December 2013. A clear and robust system of on-call to be implemented.

14. A review of the seclusion room on Taliesin ward is urgently required. The room had a WC and wash hand basin within it and there is a lack of privacy and dignity as windows in the nurse's station look directly onto the WC within the room. In addition, the room has areas, that a patient could potentially not be visible to staff, and this is a significant risk to both patients and staff. (Identified in August 2102)

15. The environment does not promote privacy and dignity for the patient group. There are multi occupancy rooms and the bathrooms are shared between the patients on that ward. There were limited designated male and female facilities. An urgent review of the environment is required. (Identified in August 2102)

16. Significant issues with care documentation were identified and included:
    a. Risks had been identified, but no care plan was in place to address the risk.

b. Evaluation of section 17 leave not always documented.
c. Issues with a lack of care plans for non compliance of medication.

17. Patient information was displayed on whiteboards in the nurses station's and was clearly visible for fellow patients and visitors to see. Patient information must be protected.

18. The electroconvulsive therapy (ECT) suite was last used to provide treatment in August 2013 and following confirmation from staff it became evident that this is only used 2 or 3 times each year. With the ECT suite used so infrequently, we asked the board members, during the feedback meeting, how they can ensure and confirm that staff demonstrate an acceptable level of competence and knowledge to undertake ECT treatment. Therefore the use of the ECT suite must be evaluated.

19. A review of the staffing must be undertaken. Section 17 leave has been affected because of staff shortages. Staffing numbers must be adequate for the patient group and the facilitating of Section 17 leave. (Identified in August 2102)

20. A number of issues were identified in the clinic room on Aneurin ward. These included:
    a. Issues with the controlled drug register. Specifically, wrong dates entered on the charts.
    b. Staff had signed the medication charts prior to any medication given/received by the patient.
    c. There were no signatures for some medication administration.
    d. There were drugs in the cupboard for patients who had been discharged from the hospital.

    (Identified in August 2102)

21. There was no hand/alcohol sanitizer on the wards and/or on the entrance to the wards.

HIW require immediate assurance on the patient safety issues identified within this letter particularly on points, 4, 10, 11, 12, 13, 14, 16, 18, 19, 20 and 21. In addition, the Health Board are required to submit a detailed action plan by Friday 3 January 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 Health Board are 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 Dr Peter Higson, Chair, Dr Paul Birch, the Acting Medical Director, Mrs Angela Hopkins, Director of Nursing, Midwifery and Patient Services and Mrs Anne-Marie Rowlands the Assistant Director of Nursing

Yours sincerely

Mr John Powell
Head of Regulation

cc – Dr Peter Higson, Chair, Betsi Cadwalader Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

Dr Paul Birch, Acting Medical Director, Betsi Cadwalader Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

Mrs Angela Hopkins, Director of Nursing, Midwifery and Patient Services, Betsi Cadwalader Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

Mrs Anne-Marie Rowlands, Assistant Director of Nursing, Betsi Cadwalader Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

Ms Janet Davies, Patient Safety Adviser & Head of CGSDU, Welsh Government, Cathays Park, Cardiff, CF10 3NQ

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