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2nd June 2014

Dear Mr Lang,

Re: Visit undertaken to the Hergest Unit, Ysbyty Gwynedd on the 12, 13 and 14 May 2014

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to the Hergest Unit, Ysbyty Gwynedd on the 12, 13 and 14 May 2014. The main focus of the visit was to establish progress in addressing the issues highlighted in our earlier visit in December 2013. Our visit highlighted areas that are noteworthy and include:

- The continuing way staff engaged with the inspection process.
- The positive rapport observed between patients and staff.
- Patients generally spoke positively about the care and treatment they had received.
- The Mental Health Act (MHA) administrator clearly evidenced involvement in the process at all levels.
- The development of staff with initiatives such as AIMS[1], Star Wards[2] and Safe Wards[3].

[1] AIMS – Accreditation for Inpatient Mental Health Services. AIMS is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. Accreditation

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- The multi disciplinary team (MDT) for Taliesin ward seemed to function far more effectively than the other two wards. One reason for this maybe because the number of responsible clinicians (RC) is far less than the other wards. For example, at the time of our visit, Aneurin ward had patients accommodated with 8 different RC's. This clearly presented logistical challenges in terms of ward rounds and the competing priorities of medical staff.

We also identified some improvement in aspects highlighted in our earlier visit:

- We noted the Hergest Unit had improved in some areas since our visit in December 2013. Progress had been made to increase the number of staff and there had been a number of new staff recruited for the various wards. (point 19, December 2013 letter)

- Some progress had been made to improve the governance arrangements and included the establishment of a number of groups which take place on a weekly and monthly basis. These comprised of the Hergest Operation Group, Senior Nurse Group, Clinical Governance Group, Estates Group and a Service User/Carer Group. (point 12)

- HIW noted improvement in staff morale. Staff away days have taken place and are scheduled up to December 2014. The away days are for all staff to feed into the initiatives the unit is developing. (point 3)

- Hand/alcohol sanitizer was available on the entrance to each ward. (point 21)

Our visit also highlighted a number of issues. We provided a verbal overview of our concerns to you and your senior management team at the end of our visit on 14th May 2014. A summary of these is set out below:

Issue of concern
1. A review of the Seclusion room on Taliesin ward is urgently required. The room had a WC and wash basin within it and there was a lack of privacy and dignity as windows in the nurses' station looked directly onto the WC within the room. This issue was identified in December 2013 and August

assures staff, service users and carers, commissioners and regulators of the quality of the service being provided. www.rcpsych.ac.uk/AIMS

[2] 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

[3] 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

2012 and therefore requires more timely action.

2. Whilst it is acknowledged that there has been the creation of a frailty room on two of the wards, a frailty ward would be beneficial for this group of vulnerable adults and would enhance the care delivery to this group of patients.

3. An independent medical review of the care and treatment received by patient A on Taliesin ward is required to ensure that the patient has received and continues to receive the required level of care. There was uncertainty regarding the diagnosis of the patient and the patient was very complex and presented with very challenging behaviour. There was clearly a significant difference of medical opinion with the care and treatment of this patient.

4. Despite assurances given to HIW that the electro convulsive therapy (ECT) suite would not be used due to on-going training and staff development issues, a consultant was recommending that the Hergest ECT suite was utilised for a patient. The ECT suite must be de-commissioned with immediate effect.

5. Patient information continued to be displayed on whiteboards in the nurses' station and was clearly visible for fellow patients and visitors to see (point 17, December 2013). Patient information must be protected.

6. A review of 5 sets of care documentation was undertaken and the following observations was made:
    a. The assessment of risk for patient B (Taliesin ward) identified 'seclusion' as a risk reducing factor but there was a lack of a documented plan in terms of reducing the time in seclusion or considering alternative strategies. For example the patient being accommodated at a more secure unit until the challenging behaviour was reduced to a more manageable level.
    b. Sections on the Mental Capacity Act 2005 had not been completed for patients B, C and D (Taliesin ward).
    c. The care and treatment plan (Mental Health (Wales) Measure 2010) for patient C (Taliesin ward) was not completed.
    d. Patient C was prescribed Lithium but the side effects profile was not completed.
    e. Patient D transferred from Aneurin ward to Taliesin ward but the care and treatment plan had not been completed.
    f. There were limited care plans in place for patient D (Taliesin). Only two core/generic plans were on file, orientation and detention under section 2.
    g. The care and treatment plan for patient E, Aneurin ward was not completed.
    h. Numerous observational forms for patient E were not dated.
    i. The care plan for patient E did not define any areas of risk.
    j. The care and treatment plan for patient D, Aneurin ward was not completed. If core/generic care plans are to be utilised then they

must be fully implemented.

k. The risk reducing factors for patient D did not consider observational levels even though the patient was on 1:1. In addition, there was no description whether the 1:1 included patient use of the bathroom/WC.
l. Betsi Cadwaladr University Health Board's procedure on Therapeutic Observations for Inpatients was not being implemented. There were no observational records being used, no entries in notes and no indication that the patients could be safely given some privacy.
m. Seclusion documents did not have a start date when the seclusion continued for a significant period of time.

All of the areas identified above must be addressed.

7. A patient had been transferred from a psychiatric intensive care unit (PICU) to an acute ward by a medical practitioner who was no longer the patient's responsible clinician. This practice is totally unacceptable and a review of the transfer must be undertaken so that lessons learnt can be established.

8. The system for recording staff training was maintained at ward level and each ward had a different system in place. There was no system in place that ensured information was available for the whole of the Hergest unit. The reality of this system was that on Anuerin ward the manager was on annual leave and the training records could not be accessed. A comprehensive system for recording and identifying training that is easily accessible must be established.

9. There was a number of staff, including new staff who had not received training in Restrictive Physical Intervention (RPI). Furthermore, bank staff do not receive RPI training. As a result of this, on more than one occasion, staff from Aneurin and Cynan wards with current RPI training have had to form a team to support staff on Taliesin ward because they had insufficient staff trained in RPI. All staff must receive RPI training to ensure staff and patient safety on all three wards.

10. A review of the use of resources, both equipment and personnel is required because the excellent work of the activity co-ordinator is in danger of stalling due to a failure to maximise the use of resources. The occupational therapy (OT) craft room and materials were not being shared with the activity co-ordinator. Support from staff or another activity co-ordinator would have beneficial results for the wards to maximise the activities on offer.

11. The recommendations made in the 'Clinical Psychology Adult Acute Mental Health Service Report', dated January 2014, needs to be implemented and actioned to ensure the psychology services are available.

12. With the integration of Notes, information had not been carried over in some cases, including risk assessment/outcomes of leave. A plan for the

information to be available for Notes is required.

13. The supervision/appraisal system for medical staff needs to be embedded in their development. The review team did not have the necessary level of assurance that some medical staff had received any performance management reviews.

Mental Health Act Monitoring – The Administration of the Act

We reviewed the statutory detention documents of 6 of the detained patients being cared for on 2 of the wards at the time of our visit. The following issues were identified and need to be included in your action plan:

1. Patient F on Aneurin ward had no note on file as to whether they had been given or understood their rights under Section 132. All patients detained must be made aware of their rights under Section 132.

2. The Mental Health Act (MHA) administrator's role is being diluted due to her extended role and responsibilities to other units. A review of resources is therefore required.

You are required to submit a detailed action plan to HIW by **Monday 23rd June 2014** setting out the action you have already taken as well as that which 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 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 Dr Peter Higson, Chair, Professor Matthew Makin, 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 Cadwaladr Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

Professor Matthew Makin, Medical Director, Betsi Cadwaladr Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

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

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

Ms Janet Davies, Specialist Advisor for Quality & Patient Safety, Welsh Government, Cathays Park, Cardiff, CF10 3NQ