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7 October 2014

Dear Ms Howell,

Re: Visit undertaken to St Caradog and St Non wards, Bro Cerwyn Centre, Withybush Hospital on the 8th, 9th, 10th and 11th September 2014

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to St Caradog and St Non wards at Bro Cerwyn Centre, Haverfordwest on the 8th, 9th, 10th and 11th September 2014.

St Caradog and St Non's wards are located at Bro Cerwyn Centre, Withybush Hospital, part of Hywel Dda University Health Board. Bro Cerwyn is a psychiatric service providing health services to Mid and West Wales, consisting of two inpatient wards and a day centre.

St Caradog ward is an in-patient facility providing 16 beds, specialising in assessment and short term care and treatment for patients, usually through an acute stage of their mental illness.

St Non's ward is a 15 bedded mixed gender ward providing in-patient psychiatric assessment care and treatment for adults aged 65 and above.

Our visit highlighted areas that are noteworthy and include:

Healthcare Inspectorate Wales • Arolygiaeth Gofal Iechyd Cymru
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www.hiw.org.uk

- The majority of staff engaged with the inspection process. It was unfortunate that psychology felt they did not have time to engage[1]

- There were comprehensive patient risk profiles available
- The cleanliness of St Non's ward, at the time of our visit, was noted to be excellent. The courtyard had benefitted from staff input by them purchasing and planting flowers which made the patient outdoor space tranquil and colourful. This area was appreciated by relatives of patients who commented positively on the area

- The comprehensive, structured and documented system of staff supervision in place on St Non's ward

- All the staff files reviewed on St Non's ward during our visit had a current Personal Development Review (PDR) in place

- Staff on both wards, were on the whole, well motivated to provide the best care and treatment they could offer for patients

- Care plans in terms of the Measure[2] were compliant

- The engagement of senior management in the review process was noted to be positive and welcomed

- The Deprivation of Liberty Safeguards (DoLS) process was being followed appropriately.

Our visit also highlighted a number of issues. We provided a verbal overview of our concerns to your senior management team at the end of our visit on 11th September 2014. A summary of these is set out below:

Issue of concern
1. Staffing levels on St Caradog ward were clearly an issue. When HIW arrived on the evening of the 8th September, there were only four staff on duty. During this time there were two patients being observed by two staff and leaving insufficient staff cover for the remaining patients, including a new admission.

[1] In response to this letter, Hywel Dda health board provided HIW with a report setting out the input of psychological services into St Caradog's and St Non's wards (27th October 2014).

[2] Mental Health (Wales) Measure 2010 – The Measure is primary legislation passed by the National Assembly for Wales and has similar legal status in Wales as other UK Mental Health Acts. It sets out additional statutory requirements to improve the support available to people in Wales with mental health problems, whether they are in hospital or the community. These additional requirements are important for the assessment, care and treatment of all people with a mental health problem. www.hafal.org/hafal/pdf/April2014.pdf

Low staffing levels were having a negative impact on:

a. Nurse led activities
b. 1:1 therapeutic time for patients
c. A lack of staff supervision taking place
d. Staff morale
e. Staff complained of feeling tired.
f. Care and treatment planning.

Staffing levels must be addressed as a matter of urgency.

2. The recruitment and retention of staff was an on-going issue. Staff told us of the high number of staff that have left St Caradog ward and how nursing and care agencies have been unable to supply staff to cover. However, there were a number of newly registered nurses about to commence employment. Recruitment and retention issues must be addressed.

3. A significant number of staff had not undertaken training in:
    a. Restrictive Physical Intervention (RPI). Statistics provided showed some staff had not been trained in RPI since 2012
    b. Nearly all staff training in basic life support had expired
    c. A significant number of staff had not received up to date training in moving and handling
    d. There was also no reference to training in areas such as the Mental Health Act 1983; Mental Capacity Act; Deprivation of Liberty Safeguards (DoLS) and adult protection on St Caradog ward
    e. Many training modules were delivered via e-learning and some via different departments, which would email to confirm which staff required training. However, there was a lack of a central system on St Non's ward that held comprehensive training data for all staff. Ward managers should have an overview of their staff training and progress to ensure staff are suitably skilled and experienced.

    Training must be undertaken for all the areas identified.

4. There was no evidence, in the staff files examined, to confirm that supervision for nursing staff on St Caradog ward was taking place. All staff must receive regular and documented supervision.

5. There was no evidence on the St Caradog's staff files examined of an updated Personal Development Review (PDR). All staff must receive an annual PDR review.

6. A significant number of maintenance issues were identified on both wards:
    a. On St Caradog ward:
        i. There were bedroom windows with broken handles and therefore patients could not close their windows properly, with some complaining of a draught at night
        ii. Flooring was damaged and ripped, specifically where the clothes dryer was located
        iii. Redecoration was required, including the nurses office
        iv. Some fire doors were not fitting properly and some did not

appear to have any “seals” that would ensure the door was effective in preventing the spread of smoke, in the event of a fire

v. A cracked window pane was visible in the patient’s dining room
vi. The outside light to the garden did not work
vii. The dishwasher and clothes dryer were not working. We were informed that these have been out of action for a considerable period of time.

b. St Non’s ward had the following issues:
    i. There was no working dishwasher and clothes dryer. We were told that both machines had been out of action for over 6 months
    ii. Handrails in the toilets had been removed. As a result, patients who once could use the toilets without assistance were now relying on staff to assist them
    iii. Handrails were present in the corridors. Given the lack of handrails in toilets, this suggests inconsistency in the approach taken when assessing the risk of ligature points. It is for the Health Board to satisfy itself that its judgement in this area is consistent and sound..

All maintenance issues to be addressed.

7. The standard of food on both wards was completely unacceptable.
    a. Food was being provided by the main Withybush hospital. There were no menus provided for patients to choose their own meal. No sound reasons or rationale was provided to HIW as to why these wards were being treated differently to patients at the main Withybush hospital, where menus and choices were offered to those patients
    b. There was a repetitive serving of foods being provided to patients. Mash potato was being served to patients twice daily on St Caradog ward
    c. There was no indication of what the food was when it arrived on the ward. Therefore staff cannot tell patients what the dishes were and what ingredients they contained
    d. Food for patients on St Non’s did not always arrive by 12 noon, sometimes arriving 30 minutes to 1 hour late. Food arriving late for this patient group had a negative impact on their routines.

    All areas identified must be addressed.

8. Staff on St Caradog ward felt undervalued, disempowered, not listened too, burnt out and not able to achieve what they wanted for patients. A changing, and at times challenging ward, coupled with staff shortages, was cited as the main reasons for staff feeling this way. Staff morale must be improved.

9. There were little or no activities taking place on St Caradog ward during

our visit. Patients complained about a lack of activities and boredom. Activities must be improved for patients.

10. Arbitrary/blanket decisions specifically around the use of mobile phones on St Caradog ward was an issue. Patients told us that once their mobile phone had no charge left in their batteries there was no way to recharge their phones. This was because patients were not allowed to plug their chargers into the electric sockets on the wards. At the time of our visit, the pay phone was not working and patients had no means of maintaining contact with their family and friends. Arbitrary decisions must not be undertaken and there must be facilities for patients to make contact with family and friends.

11. St Caradog ward did not have a notice board for patient information. We were told this had been pulled down some time ago and had not been replaced. A patient notice board must be provided and relevant information displayed including advocacy details.

12. Care and treatment plans were reviewed and the following identified:
    a. There was generally a lack of evidence of patient involvement and there was a delay in reporting significant events on the DATIX system.
    b. The entry following an incident on the 8th September 2014 for patient RW lacked sufficient detail.

    Documentation issues and timeliness of reporting significant events to be addressed.

13. A review of the facilities for patients admitted under a section 136 is required. In reality this area consisted of little more than a lounge area.

14. A review of the clinic/treatment room on St Caradog ward highlighted the following observations:

    a. There was confusion amongst staff in relation to the recording of Controlled Drugs.
    b. There were patient administration records that had entries which were crossed out and over-written, making them unclear.

15. Occupancy for St Caradog ward was an issue. There have been occasions when patients had slept in lounge areas because the ward did not have sufficient bedrooms available. This practice is not acceptable and a strategy for adequately dealing with this issue must be formulated. We also noted that a high number of patients were on leave and if any of these patients required re-admission this would clearly have a significant impact upon the patient numbers and available beds. A review of the arrangements for admitting patients is required to ensure that the hospital does not have more patients than beds.

16. Some of the patient files examined contained expired section 17 leave

forms, these should be marked as cancelled so it is evident to staff which form is the most current for ease of reference.

Mental Health Act Monitoring – The Administration of the Act

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

- The files examined had good evidence of medical and administrative scrutiny

- St Non's ward was using an admission checklist which incorporated a Mental Health Act checklist in their filing system, this is considered noteworthy practice.

You are required to submit a detailed action plan to HIW by **28th October 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. 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.

Yours sincerely

Mr John Powell
Head of Regulation

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