Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health/ Learning Disability Inspection (Unannounced)

Abertawe Bro Morgannwg University Health Board: Princess of Wales Hospital, Ward 14 and PICU

1-3 December 2014

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Contents

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 plans
- Supported to be as independent as possible
- Allowed and encouraged to make choices
- 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).

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[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 Princess of Wales hospital, Bridgend on the evening of 1 December and all day on the 2 and 3 December 2014. We inspected Ward 14 and the Psychiatric Intensive Care Unit (PICU)[2]

The Princess of Wales hospital is a district general hospital run by Abertawe Bro Morgannwg University Health Board (ABMUHB) and provides a comprehensive range of acute health services including inpatient, outpatient and day services.

Ward 14 is a 20 bed mixed gender adult psychiatric admissions ward. During our visit there were 20 patients being cared for on the ward, 13 of which were detained under the Mental Health Act 1983 (the Act).

The ward was locked and staff confirmed that there was a locked door policy in place.

PICU was a five bedded mixed gender adult psychiatric intensive care ward. At the time of the visit there were four detained patents allocated to the ward, all of whom were male. The ward was locked and staff confirmed there was a locked door policy which they adhere too.

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 and two members of HIW staff.

[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 separate to the rest of an inpatient unit.

4. Summary

Our visit to Ward 14 and the psychiatric intensive care unit (PICU) at the Princess of Wales Hospital, Bridgend highlighted some noteworthy areas of practice. In particular the standard of cleanliness across both wards throughout our visit was very good. The environment in general was satisfactory and in a good state of repair. However, the environment of care on the PICU ward required further modification due to the fact that windows on this ward could open wide enough for objects to be passed through. In addition the area used as a seclusion room was not fit for purpose and the use of this room requires review.

Low levels of staffing was an issue, particularly on the night of our arrival, and this had the potential to compromise patient safety if there was an incident, with no additional staff available to provide support. We were concerned to learn the amount of time it was taking to recruit people into vacant posts, and this area of concern required urgent attention. In spite of low staffing numbers, the staff we met during our visit were a very committed group and the positive way in which staff engaged with the inspection process was noted.

A review of the care and treatment plans highlighted very good detail in the area of discharge and aftercare planning. There were areas within the care and treatment plans that required attention and these issues are highlighted in the General Healthcare section of our report.

The data presented to us during the visit evidenced poor rates of staff training in some areas. These included fire training, infection control, Deprivation of Liberty Safeguards (DOLS) and the Mental Capacity Act. There was no evidence of staff supervision taking place for nursing and support worker staff. Staff files had also been removed from Ward 14 and no electronic systems were in place, therefore we were unable to inspect employment and training information fully.

There was a regular advocacy service available to all patients on both wards. This service was well regarded by patients and it was good to see this practice in place to further support patients' welfare.

The multi disciplinary team (MDT) on the PICU ward was working well, with staff confirming that all disciplines had equal status and input in relation to patients' care and treatment. Unfortunately staff told us that the MDT process on Ward 14 was not effective, citing various reasons for its ineffectiveness. However a new ward manager had recently started on Ward 14 and during our

visit a meeting took place to discuss the MDT issues and find a way of improving the MDT process.

There were a lack of a nurse call alarm system in the bedrooms on Ward 14 and the personal alarm system for staff was not fully operational, with three out of six alarms not working because they were awaiting batteries. The safety of staff and patients is paramount and these areas required urgent attention.

5. Findings

Core Standards

Ward Environment

Ward 14

Ward 14 is a locked 20 bedded acute admission ward for both male and female patients. The ward had mainly dormitory style rooms, providing up to four beds per dormitory. There were also a few single occupancy rooms available. Designated male and female shower and toilet facilities were available. The ward offered two lounges, a dining room and an activity room for patient use.

The environment was clean, bright and airy. The furniture and appliances on the ward were in good working condition. The ward had its own outside space for patients to use which included a smoking shelter.

Psychiatric Intensive Care Unit (PICU)

The PICU is a five bedded mixed sex ward with an available seclusion room (the suitability of this room is discussed later in this report). The ward was bright, airy and very clean. A court yard garden was accessible from the lounge area which was also used as a smoking area. The furniture and fittings were in a good state of repair. A pay phone was available for patients use and the ward had a quiet lounge and activities room for patients use.

Some windows on the ward did not open therefore no access to fresh air was available. In contrast, some windows on the ward opened enough to allow items to be passed through them.

The shower and toilet facilities open directly onto the lounge area compromising privacy and dignity, especially if the ward has both sexes residing.

Recommendation

The environment of care on the PICU ward requires attention, specifically the windows.

Safety

The staffing levels across both the wards we visited were a concern with insufficient numbers being identified. During our night visit, Ward 14 had two registered nurses and one healthcare support worker on duty for twenty

patients. One registered nurse was dealing with a section 136 admission, the healthcare support worker was on a 1:1 patient observation and the other registered nurse was administering drugs. As a result of these activities there was no staff available to observe the remaining patients on the ward.

On the PICU ward there was one registered nurse and one healthcare support worker on duty for three patients. It was unclear how the PICU ward staff would have coped if a major problem occurred, such as a restraint or admission. Ward 14 was also seriously understaffed and they would not have been able to offer support to the PICU ward, therefore safety of patients and staff may be compromised when staffing levels are so low.

The seclusion room on the PICU ward was not fit for purpose. The room had blind spots meaning that staff would be unable to see patients in certain areas, there was no clock to enable orientation and there was no direct access to a bathroom. A review of this room is required.

The personal alarm system for staff on Ward 14 was not fully operational. Three out of six alarms were not working because they required batteries. It is essential staff have access to working alarms to ensure safety for themselves and patients.

There was a lack of a nurse call system in the majority of the bedrooms on Ward 14. A nurse call system must be provided for all patient areas including bedrooms. The nurse call on PICU lounge was situated on the wall which would be difficult to reach if in crisis.

Recommendation

The health board is required to undertake a staffing review to ensure patient and staff safety on all wards is not compromised because of low staff numbers.

Regular maintenance of the staff personal alarms is required to ensure they are working.

A review of the nurse call alarm system is required to ensure that this is accessible and available for patients to use.

The multi-disciplinary team

Discussions with staff highlighted a contrast between both wards regarding their multi disciplinary team (MDT) working. Staff told us of the good working relationships on the PICU ward, enabling the MDT group to work well. We were told that all staff work well together, making sure that any plan put in place

works. However, there was currently no occupational therapist attending MDT meetings on the PICU ward. Care coordinators were invited to attend meetings and all members have equal input into discussions.

Concerns were raised by staff regarding the MDT meetings for Ward 14. At the time of our visit the MDT was not working well and the reason cited to us for this was due to relationship issues between some of the clinical disciplines. Staff told us that professional views were not always valued resulting in the team not working professionally and collaboratively for patient outcomes. A new ward manager had recently started and a meeting had taken place to resolve the issues affecting MDT. It is essential that all issues are dealt with promptly and MDT is conducted in a professional and inclusive manner.

Recommendation

Multi disciplinary team meetings require attendance and input from all disciplines.

The outcome of the meeting regarding relationship issues between some of the clinical disciplines requires immediate action in order to improve patient outcomes.

Privacy and dignity

Issues regarding a lack of privacy and dignity were identified from our visit. The dormitory style bedrooms on Ward 14 did not provide the patients with an acceptable degree of privacy. Curtains are used to separate each bed, however, any conversations between staff and patient can be heard by other patients.

On the PICU ward, toilet and shower facilities are unisex and the shower opens directly onto the lounge area resulting in dignity issues for patients.

Recommendation

The areas identified in this section require urgent review. No patients should have their privacy and dignity compromised. Regular scrutiny is required to ensure improvement in this area is promoted and effective.

Patient therapies and activities

Discussions with staff and patients highlighted mixed views about the therapies and activities taking place on both wards. Some staff and patients spoke favourably of the activities on offer, stating patients regularly participate in activities, including watching DVDs, reading books, exercising in the multi gym

and playing pool and various other games. Although no activity timetable was seen on the wards at the time of our visit, we were told that occupational therapists meet with patients and a patient specific timetable is developed. At the time of our visit a knitting group was taking place, however the patients attending and participating in the group were from another ward. Patients from Ward 14 were encouraged to take part, however, no patients participated in the session.

Staff spoke of their commitment to help and support patients back into the community. Patients with section 17 leave were involved in walks outside the hospital, swimming and shopping. The PICU ward had recently acquired a vehicle that will enable patients to attend social and recreational activities.

The PICU ward had no occupational therapist available and the vacant post was awaiting recruitment. Any assistance in the meantime was obtained from Ward 14's activities co-ordinator. Weekends were generally more relaxed than the weekdays because no occupational therapy or activity coordinators work. Our review team were informed that staff at ward level will facilitate visits and activities during these times.

Both wards have two full days of psychology input per week and an occupational therapist is available on Ward 14. These disciplines provide a range of therapies and interventions for patients including stress control, anxiety management and smoking cessation. However, staff felt that because of poor staffing levels, the amount of time available to them to maintain a continuous therapeutic environment was difficult due to the workload.

A lack of budget, space and storage resulted in negative comments being received. With only a small amount of petty cash available, materials and resources were very limited. At the time of our visit, the male lounge was without a TV. Patients had to use the female lounge to watch TV. With no budget available, staff could not confirm when the TV would be replaced. In addition, some therapies can only take place in lounge areas due to the lack of space.

Recommendation

The allocation of occupational therapy across all wards is required to ensure patients participate in activities and receive therapies that will assist in their recovery

The health board should review the budget allocation for occupational therapy so that necessary equipment can be obtained.

Food and nutrition

Feedback from patients and staff regarding food was mixed. Patients on the PICU ward were mostly satisfied with the food provision, while feedback from others stated the food lacked variety and needs improvement.

Patients with specific dietary requirements are provided with food that meets their needs. Staff told us that the kitchen was supportive of requests for variations from the menu, and that salads and bowls of fruit can be provided.

If a patient requires a drink or snack outside of the set mealtimes they are provided with it. Tea and coffee can be requested by patients, and staff make these drinks for them. Water and squash are available at any time and wards keep fruit and bread to make toast on the ward. If sandwiches are left over from a mealtime they are kept in the ward fridge for patients to eat at a later time.

Patients and staff said the food lacked variety, with similar foods being served on a regular basis. Staff commented on the lack of variety of meals for patients who stay on the ward for longer lengths of time

Menus are sent to each ward on a weekly basis and staff told us that they make choices on behalf of the patients. The first time a patient decides what they eat is when the food arrives on the ward at that particular mealtime. Consideration should be given to allowing patients to make their own meal choices at an earlier stage.

Portion sizes were generally commented upon favourably, but staff did state that food recently sent to the ward was insufficient and that they had to request additional meals.

Recommendation

A review of the food provided to patients is required to ensure sufficient quantity and variety is available.

Where possible, patients should be encouraged to choose their own meals from menus provided.

Training

A review of staff files on the PICU ward identified that the files kept at ward level did not contain employment information, specifically evidence of an application form, job description and references. We were informed that this information is kept by the clinical services manager who was unavailable at the

time of our visit. Therefore we are unable to comment on this area, however, future visits will ensure a review of employment files.

The system in place for renewing disclosure barring service (DBS) checks for existing employees was not evidenced. We were told due to financial constraints the health board will only regularly renew those staff working with children. Any new member of staff, or any staff moving post, will have a DBS check. However, staff who remain in a role for a length of time do not have a new DBS on a regular basis. This practice needs to be reviewed and the health board needs to provide assurances that all staff caring for mental health patients have the necessary checks in place.

Psychology and occupational therapy staff receive monthly documented supervision and the staff we spoke to commented that they find this supportive. A review of systems and files found that there was no evidence of a formal documented supervision in place for nursing and support worker staff. Some nursing staff stated they had informal supervision, but there was no documented evidence that this had taken place. Staff stated they would like to receive more regular supervision.

The majority of staff commented on receiving an annual appraisal. However, we found no evidence of any systems in place that could evidence when an employee last had an appraisal and when their next one was due.

The spreadsheet in place to monitor NMC professional registration renewals on the PICU ward was blank for the majority of staff listed. Those staff members who had a date for renewal had long expired. The ward manager explained that his sheet was not up to date and that a database kept by the clinical services manager is circulated to him so that he can confirm appropriate registration. No evidence was produced to confirm all nursing staff had an up to date NMC registration, although the ward manager did verbally confirm they did. It is essential that one system is used to evidence professional registrations and that the necessary staff have access to the system at all times. The duplicate system in operation at the time of our visit did not satisfy us that NMC renewals were effectively managed.

A mandatory training programme was in place for all staff. It was pleasing to note that the majority of staff were up to date in this area. A few exceptions were identified and reassurance is required to ensure staff are booked on and complete their necessary training. Staff we spoke to had varying degrees of knowledge and understanding regarding the Mental Health (Wales) Measure 2010, Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards. It is recommended the health board reviews staff knowledge and

understanding in this area and provide training for staff to ensure consistency of knowledge and application.

Ward 14 had no files or systems in place to document and evidence any of the standards we were reviewing. At the time of our visit we were told that the staff files had been taken off the ward to be updated. It is recommended that these files remain on site and that staff are given time and support to ensure files are correct and up to date.

Recommendation

If staff files are to be kept by the Clinical Services Manager it is necessary that access to the files is available by ward managers and other senior personnel at all times.

Too many systems were in place for the recording and monitoring of professional registration, which resulted in inaccurate data. One system should be in place to record and monitor data.

Regular staff supervision needs to be implemented, recorded and embedded for all staff.

The health board to review staff knowledge and understanding in relation to the Mental Health (Wales) Measure, Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards. Training should be provided to staff as necessary to ensure consistency of knowledge and application.

The Health Board to provide assurance to HIW that all staff working with a vulnerable patient group are provided with all the necessary checks to support robust safeguarding procedures.

The Health Board needs to review the procedure of allowing staff files to be taken off site for updating.

Governance

Our visit highlighted concerns regarding the governance arrangements and audit processes of Abertawe Bro Morganwwg University Health Board, specifically in relation to staffing and communication. The report highlights our concerns regarding the number of staff on duty at the time of our visit. To ensure patient and staff safety, the Board must have in place robust arrangements for the proactive and responsive reporting and escalation of concerns regarding staffing levels. It was evident from discussions with staff that a general consensus exists on the wards regarding the maximum number

of staff who will be deployed and the process of obtaining extra staff if required. Although this was refuted by senior management, a gap in communication and clarity of information has resulted in shifts being staffed with dangerously low numbers. Clear operational guidance must be made clear to all staff and necessary policies and protocols updated and circulated.

A particular concern identified from our visit related to the recruitment of new staff. We were told that the process for recruiting to vacant posts was taking over four months. This timeframe is unacceptable considering the deficits of staff identified during our visit. The health board should review the recruitment process and identify the reasons for such unacceptable delays. There is a need for the health board to move to a more proactive approach to manage and monitor the time taken to recruit staff. The health board should develop a strategy for addressing this issue and take action to fully communicate and deliver recruitment plans.

Recommendation

The board should develop robust arrangements for the proactive and responsive reporting and escalation of concerns regarding staffing levels.

A strategy for the service needs to be developed and the board must take action to fully communicate and deliver service and workforce plans.

Application of the Mental Health Act

We reviewed the statutory detention documents of three of the detained patients being cared for on two of the wards at the time of our visit and three of the mental health administrators' files. The following noteworthy issues were identified:

- Good and supportive relationships between the Mental Health Act administrators and ward staff
- Consent to treatment, CO2 and CO3 certificates, included notes on appropriate completion
- Comments made on patients in general hospitals that were detained under the Mental Health Act 1983 were informative in terms of how to safeguard the patients interest.
- There was comprehensive information for GPs on patients admitted with their section details and medication prescribed.

It was pleasing to note that the files examined were generally consistent with each other. The ward notes were, however, in the main file and many did not have a strong and easily identified section to allow for ease of reference. These section papers are legal papers and should be stored so that trained staff caring for the patients can clearly assure themselves of the legality of the patient's detention.

Some forms at ward level did not identify patients' ethnicity.

Mental Health Act 1983 training had not been carried out during the last year, possibly due to the shortage of trained staff. A new manager had been appointed who will ensure the training takes place.

Managers should recognise the need for scanning material so that full legal papers are available. At the time of our visit, staff had to leave the ward to scan legal documents. This was a poor use of nurses' time and staff told us that having access to a scanner at ward level would be beneficial.

Monitoring the Mental Health Measure

We reviewed care planning documentation on the PICU ward and we noted the following issues:

- Risk assessment outcomes were not transferred into care and treatment plans
- A lack of evidence of medication regime being discussed with patients
- The lack of a structured index in terms of where information is stored in each file

Recommendation

All the issues identified in this section require attention and need to be addressed as a matter of urgency. Specifically, risk assessment outcomes transferred into care and treatment plans; evidence of medication regimes being discussed with patients and a structured index in each file to state where information is stored.

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.

Appendix A

Mental Health/ Learning Disability: Improvement Plan

Hospital: Abertawe Bro Morgannwg

Ward/ Department: Ward 14 and PICU

Date of Inspection: 1 – 3 December 2014

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
8	The environment of care on the PICU ward requires attention, specifically the windows.	A maintenance improvement plan addressing the issues raised within the HIW report is attached (Appendix 1)	General Manager	31st March 2015
9	The health board is required to undertake a staffing review to ensure patient and staff safety on all wards is not compromised because of low numbers.	We can advise that levels of patient acuity are regularly assessed alongside established risk assessment protocols to ensure that safe and sufficient staff levels are maintained. As acuity rises, more resources will be allocated to provide safe care. As a consequence, current assessment has led to an increase by 1 member of male staffing by night on PICU ward. Moreover and with	Adult Services Manager	Completed

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		immediate effect, the Mental Health Directorate has determined that by night, additional staff will be provided for any high level special observations on both Ward 14 and PICU and not from existing resources.		
		In connection with the medium to longer term plans, the modernisation of services for individuals with challenging behaviour, linked to the decommissioning program for Cefn Coed Hospital, will result in the centralisation of the staffing resource, with an enhanced PICU unit at the Princess of Wales Hospital. As a direct result of this development, we are able to advise that the staffing levels on PICU will then be 4 whole time equivalents on duty at night.	Adult Services Manager	31st March 2015
		The Mental Health Adult Services Manager has advised that they will be undertaking a Directorate-wide review of nursing establishments within the Acute Inpatient service, throughout the Mental Health Directorate.	Adult Services Manager	31st March 2015
		Full Directorate Wide reviews have identified that currently Adult Services Benchmarked staffing levels for the NHS are midpoint across the 66 organisations within the audit. The MH Directorate is also participating in a National Pilot	Head of Nursing	31st May 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		on behalf of CNO's Office regarding Nursing Acuity and Workload within in-patient services as a whole. This work is being led through the All Wales Senior Nurse Advisory Group. Report submitted to ABMU Health Board Nursing & Midwifery Board. Paper to CNO being prepared by All Wales Senior Nurse Advisory Group (AWSNAG) for March / April meeting for national decision making.		
9	Regular maintenance of the staff personal alarms is required to ensure they are working.	A maintenance improvement plan addressing the issues raised within the HIW report is attached **(Appendix 1)**	General Manager	31st March 2015
9	A review of the nurse call alarm system is required to ensure that this is accessible and available for patients to use.	A maintenance improvement plan addressing the issues raised within the HIW report is attached **(Appendix 1)**	General Manager	31st March 2015
10	Multi disciplinary team meetings require an attendance and input from all necessary disciplines.	Following the appointment of a new Ward Manager for Ward 14, a robust process to ensure effective Multi disciplinary team (MDT) working has been introduced. This process has received commitment from all clinical disciplines and non-compliance will be escalated to senior managers.	Ward Manager	Completed
10	The outcome of the meeting regarding relationship issues between some of the	These recommendations will be encompassed within the action points detailed above	Ward Manager	Complete

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
	clinical disciplines requires immediate action in order to improve patient outcomes.			
10	The areas identified in this section require an urgent review. No patients should have their privacy and dignity compromised. Regular scrutiny is required to ensure improvement in this area is promoted and effective.	In regards to Ward 14, staff will always strive towards patient confidentiality and will access rooms for sole occupancy on the ward when discussing matters of a sensitive or confidential nature. This will again be reinforced by the new Ward Manager In regards to the PICU ward, a shower privacy curtain is to be installed on the inside of sanitary cubicle door.	Ward Manager	Complete
11	The allocation of occupational therapy across all wards is required to ensure patients participate in activities and receive therapies that will assist in their recovery	Both Ward 14 and PICU have access to Occupational Therapy provision. The two Occupational Therapists work across both Ward 14 and the Home Treatment Team to provide input to patients, with some support grade hours to deliver specific therapeutic input. The Occupational therapy input specifically for PICU is from a support worker grade staff member, under supervision. This post has now been recruited to. Occupational Therapy activities are specific to an individual's assessed needs, and individual	Ward Manager	Complete

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		programmes are devised with the patient. This practice is in preference to fitting people into pre-planned sessions/timetable. The Therapists work closely with staff on the ward to support a general culture of activity, and ensure that this is meaningful to the patients and reflects their preferences and functional abilities.		
11	The health board should review the budget allocation for occupational therapy so that necessary equipment can be obtained.	Whilst patient activity equipment is authorised by the General Manager, the resource resources set aside for these items will be reviewed.	General Manager	31st March 2015
11	Fluid balance charts to be appropriately completed. (linked to recommendation in section 5.3 Monitoring the Mental Health Measure)	The Mental Health Directorate conducts quality assurance audits via the senior nurse, which monitors compliance with care and treatment planning (CTP). The Head of Nursing has commissioned a series of POINT reviews for all inpatient areas .Following the verbal feedback from the HIW visiting team, an immediate review was undertaken by a Senior Nurse with the Ward Team. Both the Ward Manager and Clinical Lead addressed these issues and informed staff of the need to complete the risk assessment in full, totalling the amount of fluids and ensuring this information informs the individual's plan of care. The Clinical Development Nurse also attended	Adult Services Manager	Completed

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		the ward to provide additional information and support to the Ward Manager on fluid, nutrition and oral hygiene and associated record keeping. The initial review was documented reported back to Head of Nursing and followed up as appropriate. The Mental Health Adult Services Manager has advised that a senior nurse, independent to the ward team, will be conducting a series of audits to ensure all actions are suitable addressed on a regular basis		
12	A review of the food provided to patients is required to ensure sufficient quantity and variety is available.	The Catering Services Manager for the Princess of Wales Hospital has acknowledged that whilst some menu recurrences maybe evident for those longer stay patients, an All Wales Menu Framework is in operation. This currently consists of 18 soups, 38 main course items and 42 desserts, snacks and accompaniments .Moreover, food quality questionnaires are reviewed on a monthly basis, with the results cascaded to the Health Board's Quality Assurance Manager. In addition, a food tasting group is in situ across all the hospital sites, with invites extended to representatives from mental health services.	Ward Manager	31st March 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		This matter was discussed further with both Hotel Services and Directorate representatives at the next scheduled Coity Clinic Support Services Meeting.		
12	Where possible, patients should be encouraged to choose their own meals from menus provided	The Ward Manager will reinforce the need for ward staff to ensure that meals are ordered in advance to ensure that patient choice is not compromised.	Ward Manager	Completed
14	If staff files are to be kept by the Clinical Services Manager it is necessary that access to the files is available by ward managers and other senior personnel at all times.	All personnel files are now held at ward level and managed by the Ward Manager	Ward Manager	Completed
14	Too many systems were in place for the recording and monitoring of professional registration, which resulted in inaccurate data. One system should be in place to record and monitor data.	The Clinical Service Manager has now introduced a robust system for the recording and monitoring of professional registration.	Clinical Service Manager	Completed
14	Regular staff supervision needs to be implemented, recorded and embedded for all staff.	The MH Directorate Policy of Practice Supervision & Governance **(Appendix 2)** is not fully embedded in all areas across the	Ward Manager PICU and Ward 14	31st March 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
		Directorate. Following the recent introduction of the HB Clinical Supervision Policy the Head of Nursing via the Professional Nursing Forum has highlighted the need to rejuvenate and implement this practice fully across the Directorate. A full database of supervisors is in place; with many staff making use of the process but not all. Additional efforts are being made to ensure full uptake is embedded in practice. The Ward Managers of both Ward 14 & PICU are implementing regular clinical supervision for their ward staff, which is in addition to the Health Board's Personal Development Review Procedure, and a documented record held.		
14	The health board to review staff knowledge and understanding in relation to the Mental Health (Wales) Measure, Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards. Training should be provided to staff as necessary to ensure consistency of knowledge and application.	The Mental Health Directorate has a training plan that is reviewed on an annual basis. An integral part of this plan is the ongoing training in relation to these criteria. The delivery of the Mental Health Capacity Act and Deprivation of Liberty Standards is a statutory requirement and the adequacy of the training will be further reviewed especially in light of recent legislative changes. Compliance in this area is also monitored on a monthly basis by the Health Board, using the nursing care	Adult Services Manager	1st May 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
14	The Health Board to provide assurance to HIW that all staff working with a vulnerable patient group are provided with all the necessary checks to support robust safeguarding procedures.	All newly appointed staff or those moving to a different role within the HB are required to undertake a satisfactory DBS check as a condition of offer of employment. All staff are required as part of their contract of employment to declare any issues or concerns regarding their conduct or behaviour both inside or outside of their work, to their line manager immediately. Failure to do so would be managed in line with the HB Disciplinary Policy and could result in disciplinary action, up to and including dismissal. The Health Board is committed to following NHS Wales policy regarding the three year renewal of DBS checks. This commitment is being managed on an all Wales basis due to the scale of the exercise and burden there would be on DBS services if there was no coordinated approach across NHS Wales and the costs associated with the renewal process. We are aware plans are being drawn up regarding this matter and will of course fully comply with any final decision on how this issue is resolved.	Current Practice All Wales	To be confirmed, awaiting update on All Wales basis

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14	The Health Board needs to review the procedure of allowing staff files to be taken off site for updating.	As previously highlighted, all personnel records are to be kept at ward level	Ward Manager	Completed
15	The board should develop robust arrangements for the proactive and responsive reporting and escalation of concerns regarding staffing levels.	The Health Board's Datix Incident Reporting System allows staff to raise immediate concerns should staffing levels fall below the required standard. The Ward Manager is able to escalate such issues via the Directorate Senior Managers as concerns around this area and additional temporary staff are allocated should this be required. The Mental Health Directorate fully endorse and promote the HB's Values & Behaviour Framework and as such seek to communicate and respond to all staff concerns related to patient care in a variety of methods whether verbal or written. Support is provided on a 24/7 basis with senior on-call out of office hours contact if required.	Service Manager	Completed
15	A strategy for the service needs to be developed and the board must take action to fully communicate and deliver service and workforce plans.	The Health Board, via the Directors of Nursing and Patient Experience and Human Resources, are conducting a review and refresh of the workforce plan. The Mental Health Directorate via the Head of Nursing is actively involved in this process.	Director of Nursing and Patient Experience	For review 30th April 2014

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16	The ward notes for the Mental Health Act were in the main file and many did not have a strong and easily identified part. These section papers are legal papers and should be stored as such so that trained staff caring for the patients can clearly assure themselves of the legality of the patients detention.	The Mental Health Directorate, following the establishment of a health record documentation task and finish group, has now introduced a Directorate wide Mental Health specific clinical record in order to ensure availability of comprehensive, accurate and timely information to clinicians.	Service Managers	Completed
16	Some Mental Health Act forms at ward level did not identify patients ethnicity.	Ward based staff have been reminded to be mindful of the ethnic background of all patients and to suitably record.	Ward Manager	Completed
16	Mental Health Act 1983 training had not been carried out during the last year, possibly due to the shortage of trained staff.	The Ward Managers for both PICU and Ward 14 have liaised with the Mental Health Act Manager on this training provision for ward staff	Ward Managers PICU and Ward 14	31st March 2015
16	Managers should recognise the need for scanning Mental Health Act material so that full legal papers are available. Presently staff have to leave the ward to ensure this.	Image scanners have been ordered for both Ward 14 and PICU	Assistant General Manager	31st March 2015
16	All the issues identified in this section require attention and need to be addressed as a matter of urgency. Specifically, risk	The Mental Health Directorate conducts quality assurance audits via the senior nurse, which monitors compliance with care and treatment		

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	assessment outcomes transferred into care and treatment plans; evidence of medication regimes being discussed with patients and a structured index in each file to state where information is stored.	planning (CTP). The Head of Nursing has commissioned a series of POINT reviews for all inpatient areas .Following the verbal feedback from the HIW visiting team, an immediate review was undertaken by a Senior Nurse with the Ward Team. Both the Ward Manager and Clinical Lead addressed these issues and informed staff of the need to complete the risk assessment in full, totalling the amount of fluids and ensuring this information informs the individual's plan of care. The Clinical Development Nurse also attended the ward to provide additional information and support to the Ward Manager on fluid, nutrition and oral hygiene and associated record keeping. The initial review was documented reported back to Head of Nursing and followed up as appropriate. The Mental Health Adult Services Manager has advised that a senior nurse, independent to the ward team, will be conducting a series of audits to ensure all actions are suitable addressed on a regular basis		