Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health / Learning Disability Inspection (Unannounced)

Princess of Wales Hospital: Ward 14 & PICU: ABMU

16 - 18 November 2015

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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. We do this by:

- Monitoring compliance with the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards
- Assessing compliance, 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.

3. Context and description of service

Healthcare Inspectorate Wales (HIW) undertook an unannounced, follow up visit to Princess of Wales hospital, Bridgend on the evening of 16 November and all day on the 17 and 18 November 2015. We inspected Ward 14 and the Psychiatric Intensive Care Unit (PICU). As part of this visit we did an environmental visit only on Ward 15 (assessment ward) and 21 (functional mental illness, older persons).

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 at the time of our visit was a 19 bed mixed gender adult psychiatric admissions ward.

PICU was an eight bedded mixed gender adult psychiatric intensive care ward. The ward was locked and staff confirmed there was a locked door policy which they adhere too.

During our inspection we reviewed progress of the recommendations made during our previous visit in December 2014. In addition 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 peer reviewer, one lay reviewer and two members of HIW staff.

4. Summary

Our November 2015 visit to Ward 14 and PICU at the Princess of Wales Hospital was a follow-up visit, focusing primarily on the issues we identified in December 2014. It was pleasing to note that considerable improvement had been made to address the matters identified in December 2014. One issue in particular was the environment. Windows had been replaced on the PICU which now prevented items being passed through and a curtain had been fitted to the shower room to limit privacy and dignity issues that could arise because the door opens onto the communal lounge/dining area. We did identified further areas on both Ward 14 and PICU that require attention and these are listed under the ward environment section of this report.

Staffing levels were commented upon as satisfactory by the staff we spoke to and there was a clear procedure in place for additional staff to be called upon should they be required. The recruitment of staff had improved both in terms of the recruitment time and the establishment level.

Staff spoke highly of their colleagues and team working and we observed positive interactions between staff and patients on all wards, particularly de-escalation skills on PICU.

We identified that personal alarms were rarely worn by staff on Ward 14 and PICU. Issues regarding the number of alarms and the maintenance of them were still evident following our visit in December 2014. Staff described some areas of the wards as not being in direct sight of the nursing office and that corridors were not alarmed. Therefore not wearing alarms poses a risk to patient and staff safety. Occupational therapy (OT) provided a range of activities and therapies for patients. There was limited OT provision for PICU which was identified in December 2014.

There were no visible activity timetables displayed at ward level and although patients had their own individual plan, these were stored in the patients' file. Patients who actively sought OT support were provided with it; however, some patients told us they were bored. OT needs to be more proactive to engage patients who are not actively seeking OT support in order to encourage them to be involved in the activities and therapies that are available. Some issues identified in December 2014 regarding food were still evident, particularly the continuing failure of not allowing patients to make their own menu choices. The food served at the hospital was commented upon favourably by the majority of patients we spoke to and they had access to water and hot drinks.

Access and input from dieticians was an area of concern, with staff telling us there was little input for those patients requiring this service. It is essential that any patient requiring specific dietetic advice is provided with it.

Improvements were noted regarding the monitoring of professional registrations, with systems in place to ensure staff compliance. Some areas of mandatory training had high percentages of compliance and staff spoke of the opportunities to undertake additional training.

There was a process in place for staff to receive an annual performance development review (PDR) and systems to monitor progress were reviewed. It was evident that the majority of staff required a PDR in the near future. Although staff said they were receiving informal supervision, there was no system of regular, documented supervision for staff. As this area was identified in our previous visit it is essential that staff are mentored, supervised and supported in the delivery of their role.

Immediate life support training is required for all staff as this had the lowest compliance percentage across both wards. Also completion rates for Mental Capacity Act and Deprivation of Liberty Safeguards training needs to be improved.

5. Findings

Core Standards

Ward environment

Psychiatric Intensive Care Unit (PICU)

During our previous visit in December 2014, we identified issues on the psychiatric intensive care unit (PICU) regarding the windows. In particular, we identified windows which did not open and others that opened wide enough to allow items to be passed through. It was pleasing to note that the windows on the PICU had been replaced and could be opened safely and securely by the patient group.

The PICU had been extended to accommodate three extra beds as a result of ward closures at Cefn Coed Hospital. The extended area had a blind spot in the corridor and would benefit from having a mirror to reflect an image of any persons who may use this area as a hiding place. In addition, in one of the new bedrooms observations were made difficult for staff because the bed and main area of the bedroom was not in view from the viewing panel. As a result, staff told us they had to go into the room to observe the patient which could on occasions disrupt the patient's sleep.

The PICU is a locked ward and can be accessed via its own entrance or via Ward 14. All the patient and staff areas are situated on the ground floor, with a seclusion room and bathroom situated near the entrance to the ward. An open plan living and dining area occupies the middle of the ward and patient bedrooms are mainly located at the end of the ward.

The showering facility that opened directly onto the lounge had been fitted with an additional privacy curtain on the inside of the door to improve privacy and dignity as far as possible without relocating the shower room. Staff maintenance of patients privacy and dignity is essential in this area of the ward, particularly as the PICU is a mixed gender ward.

An enclosed court yard garden provided outside space for the patient group. It was accessible from the lounge/dining area and contained a shelter for patients who smoked. The main door to the garden could not be locked and during our visit, some staff said they would prefer the door to be locked after midnight. However other staff said that open access could provide a welcome space for patients during the night when they felt unwell.

This door should be lockable as part of security checks. Although staff did suggest that there was no exit from the court yard (not necessarily an absconding risk) the court yard was overlooked by a number of windows at

ground level and above. Furthermore, if staff are called to an area away from the unlocked door, a patient could be out in the courtyard unobserved.

The nurse's office door to the courtyard area was not locked on the evening of the inspection, therefore patients could have gained unauthorised access to the nurses office. This could lead to a serious compromise of safety. If staff were called to an incident a patient could gain access to items of potential harm, confidential materials or lock themselves in the office. Other doors to staff only areas were also open or wedged open.

The PICU kitchen provided staff with facilities and equipment to serve the patient group with their meals, hot and cold drinks as well as snacks. There had been the addition of a serving hatch, which was more suitable to provide meals from than the kitchen door.

A quiet lounge with TV, DVD, hi-fi system and book shelf provided an extra space for patients. A number of patient notice and information boards were located on the ward that included information in Welsh, charity and mental health organisation information as well as how to make complaints. A notice board displaying pictures of all staff members provided patients with the identity of staff, which was a positive initiative.

At the time of our visit we noted the ward was bright, airy and clean. The furniture and fittings were in a good state of repair. The clock in the seclusion room required changing because it was an hour fast, this was corrected during the inspection.

Ward 14

Ward 14 is a locked acute admission ward for both male and female patients. At the time of our visit, the ward had 19 beds; one additional bedroom had been de-commissioned due to a fire. The bedrooms were a mix of single and double occupancy rooms and four-bedded dormitories. The lay out of the ward identified that new admissions or patients on nursing observations would require a bedroom closer to the nursing office. However, staff felt that this could not always be done due to patient choice and timing of acute admissions. There were two bedrooms which had en-suite facilities and the ward had gender specific toilet and showering conveniences for those patients without en-suite rooms. Throughout the ward we noted good, clear bilingual signage on the doors.

All patient and staff areas were on the ground floor. The dining room and kitchen were located near the entrance to the ward and had sufficient seating for the patient group. Access to the outside courtyard was opposite the dining room and it was pleasing to note that the area had been improved with areas of artificial grass. The courtyard was open from 6am to midnight every day.

The area was clean and a designated area was available for patients who smoked.

A number of patient notice and information boards were located on the ward that included information in Welsh, charity and mental health organisation information as well as how to make complaints. A notice board displaying pictures of all staff members provided patients with the identity of staff, which was a positive initiative.

Bedrooms and bathrooms were located along the corridor. Bedrooms had single beds and wardrobes and chest of drawers to store their personal items. None of the bedroom doors could be locked by the patient group and this can be an issue for female patients who may feel vulnerable on a mixed ward.

Halfway down the ward, a corridor led to a patient activity area. The facilities available were a male and female lounge and an OT/communal lounge. At the time of our visit, there was seating for up to six patients in the female lounge; however there was no TV because it had been recently pulled down by a patient. There was a hi-fi system in the female lounge that patients could use. We also noted that there was broken cabinet and a damaged telephone point with cable hanging from the wall. The male lounge did have a TV and seating for up to five people.

The communal lounge/OT room was a large space with a number of bookcases and cabinets containing books, puzzles and art and craft materials. Tables and chairs provided space for patients to participate in art and craft activities. Relaxed seating/sofas provided patients the opportunity to watch TV. The room had a radio, DVD player and a chalk board. A payphone was located in the ward corridor which patients were able to use.

The ward is 'L' shaped and the lounges, pod[2] and activity room are some distance from the nursing office and the corridors were not alarmed.

Ward 14 was bright, clean and uncluttered. Throughout the ward there were a number of pictures on the walls. The sluice room door was cracked and damaged and we noted damage to the wall before the entrance to the gym area.

The gym which was shared by patients from Ward 14 and PICU was well equipped with cardio machines and weights. A table tennis and pool table were available. The room was slightly cluttered with chairs stacked up and generally untidy. There were limited staff trained to provide gym instruction.

[2] The Pod is a room in which staff store some patient items and can be used as a small meeting room.

Ward 15 and 21

As part of our evening visit we undertook an environmental visit to Ward 15 and 21, both older person wards.

Ward 15 at the time of our visit had 12 patients. Some patients were in the end stage of dementia and they required palliative care. Some of the patient group could be aggressive, many were doubly incontinent and some required assistance with feeding. Staffing levels were satisfactory for the number of patients on the ward.

The ward was well decorated, very clean and the maintenance was satisfactory. There were pictures and photographs on the walls. There were four single bedrooms, one double and three dormitories. There was a lounge, dining area and conservatory all with adequate seating in a good state of repair.

At the time of our visit, the garden area was closed in order to construct a sensory garden.

Patients did not have single gender quiet lounges and staff told us that some female patients felt intimidated by the male patients. There was a quiet area where patients could see their relatives.

Most patients during our visit lacked the capacity to use the telephone. The two patients who were able to do so used the office telephone to maintain contact with family and friends. There was no payphone on the ward.

There were no en-suite bedrooms, however patients had access to single gender bath/shower rooms.

Staff felt that there was insufficient storage space, particularly for mattresses which were being stored on the ward.

The ward was not designed originally for this patient group; therefore some features were not suitable for patients with dementia and could be hazardous. In particular, the chairs and flooring in the lounge were the same colour and the floor to ceiling pillars in the lounge were unprotected. Staff reported that patients sometimes walked into them.

We observed a good rapport between staff and patients. Staff said that having 12 patients on the ward resulted in staff giving them more time for activities. Some patients had ‘life story’ books and there were board games and DVDs available. Patients liked beauty activities the most and a hair dresser visited each week.

Ward 21 is located on the second floor. The logistics of the ward were not ideal because staff had to take patients downstairs to use the garden area, which had no seating for patients to use.

On the ward, patients had access to a lounge area which had a TV. The ward was clean and functional. Bedrooms were a mixture of two single bedrooms, double rooms and four-bedded bays.

The ward was 'L' shaped which led to an isolated corridor that was not visible to nursing staff. Staff told us that they try to accommodate low risk patients in this area but it was not always possible.

Staff told us that the patient mix (organic and functional mental illness) has been difficult to manage and that they felt there was not a specific patient diagnosis for the ward. Staff felt as a result of the mixed diagnosis of patients that there have been a number of volatile patients placed on the ward and that this had contributed to assaults on staff. At the time of our visit there were two agency staff sat with two patients on one-to-one nursing observations. There were a number of patients on 'falls alarms' and one qualified nurse on duty with two regular Healthcare Assistants.

Staff did not have designated staff toilet or changing room available on the ward and had to use the visitors' toilet just off the ward.

Recommendations

A review of the extended area on the PICU is required to ensure the safe monitoring and observation of the patient group by staff.

A review of the courtyard door is required to ensure it can be locked to protect patients and staff.

Open and wedged opened doors to the nurses office and other staff only areas needs to be reviewed to ensure the safety of staff and information contained in these rooms.

The female lounge on Ward 14 requires attention to ensure broken furniture and phone sockets are removed and/or fixed.

The sluice room door on Ward 14 needs to be repaired or replaced.

Damaged walls on Ward 14 need to be repaired, specifically the wall before the entrance to the gym.

Safety

During our previous visit we highlighted concerns regarding staffing levels, particularly during the night shift and whether staff were aware of what to do if

additional staff was required. We observed on the evening of the 16th November 2015 that staffing numbers on Ward 14 were three staff, consisting of two registered nurses and one healthcare assistant providing care to 15 patients. Although staffing numbers on Ward 14 had not increased since our previous visit, staff told us that any patient on an observation would have an additional member of staff to cover the observation. In addition, none of the staff we spoke to raised concerns regarding staffing levels during the night shift and all staff said if extra staff were required they knew how to arrange this.

On the PICU we observed two registered nurses and two healthcare assistants providing care for eight patients. As the ward had increased their bed numbers, staffing levels had been increased also. Student nurses were on placement which was a positive aspect to future recruitment.

The seclusion room had been reviewed and a bathroom next to the seclusion room was available for patients to use. A clock had been added to the room, however at the time of our visit it was an hour in front and required to be changed before any patient was admitted to the seclusion room.

The personal alarm system for staff on both Ward 14 and PICU were not fully operational and this was identified in the previous visit. Staff told us that there was a shortage of alarms on Ward 14 and that some were not working. In addition, we identified some complacency amongst staff regarding the risks posed by patients on both wards, despite staff telling us that they risk assessed daily. With some staff identifying areas on Ward 14 as being isolated, especially the OT/lounge area it is recommended that a review of the use of personal alarms is undertaken to ensure the safety of both patients and staff.

On arrival at the PICU none of the staff were wearing an alarm and staff did not automatically provide visitors or student nurses with an alarm. Staff did not appear to react in a coordinated manner when an alarm was accidentally set off.

We noted there had been no improvements made regarding the nurse call system, with the majority of bedrooms and patient lounges and corridors on Ward 14 without an alarm system. With very few staff wearing personal alarms and areas with no or difficult to reach call bells, it is recommended that a review of patient and staff safety be undertaken.

During our evening visit we noted a number of OT items being stored in the stairwell of a fire exit on Ward 14. This could have impeded patients exiting from Ward 14 and upstairs from Ward 21. This was immediately raised with staff and items were removed during the inspection. It is essential that fire

exits are kept clear and all staff remain vigilant in order to keep the wards safe.

A fire extinguisher attached to a wall on Ward 14 could easily be removed and misused. It is recommended that this is reviewed to ensure possible misuse is mitigated.

Recommendations

A review of the provision of and use by staff of personal alarms is required to ensure there are sufficient numbers for staff and visitors and the safety of both patients and staff is not compromised.

A review of the nurse call alarm system is required to ensure accessibility and availability for everyone.

The security of fire extinguishers need to be reviewed to ensure possible misuse is mitigated.

The multi-disciplinary team

All the staff we spoke to commented positively on multi disciplinary team (MDT) working, citing a number of disciplines present at meetings, including a pharmacist. Staff told us no particular discipline dominates the MDT discussions and everyone is respectful to each other, working in a professional and collaborative way.

Staff told us that care co-ordinators no longer attend MDT meetings on Ward 14 and ward rounds had been replaced with ward reviews. Nursing staff were not regularly included in ward reviews which staff said posed difficulties in managing patient expectations because they had not been part of the review and therefore not fully aware of what was discussed and agreed.

Staff told us that meetings take place on a regular basis. Apart from the daily handover meetings, a number of patient focused meetings take place which MDT members attended.

Recommendations

A review of why care co-ordinators no longer participate in MDT meetings on Ward 14 and how information regarding their patients is communicated to them is required.

A review of the current practice of replacing ward rounds with patient reviews with only the Consultant/Doctors and Psychologist undermines the nursing contribution toward patient care. The review against the Care and Treatment

Plan and daily assessment of risk is part of the nursing process and requires collaborative implementation. The new format needs to ensure that the non participation of nursing staff does not compromise patient outcomes and that communication does not become fragmented.

Privacy and dignity

All the patients we spoke to told us they felt safe and felt their dignity and privacy was respected. Bedrooms on Ward 14 were a mix of single rooms, two bedded rooms and four bedded dormitories. The patients we spoke to who were sharing rooms expressed the most dissatisfaction regarding this stating they would prefer a single room. Shared rooms had curtains between beds to provide privacy and staff told us that they would use meeting rooms for private conversations with patients.

Patients told us that they could meet with family and friends on the ward and patients were also able to use their own mobile phones to make phone calls.

From our previous visit we noted a curtain had been fitted inside the door of the PICU shower room to help maintain a person's dignity because the room opened up onto the communal lounge.

Patient therapies and activities

The majority of patients we spoke to told us they did not have enough things to do and that they had not been asked what they would like to do. Patients said they felt bored and that there was only one TV on Ward 14. Weekends were described as boring by patients and staff said there were no scheduled activities at weekends. Where possible, nursing and healthcare assistants will arrange and deliver activities.

During weekdays Occupational Therapy staff provided a number of activities and therapies including art and crafts, beauty, relaxation and gym sessions. An OT kitchen was available off the wards. During our visit we observed patients leaving Ward 14 to undertake leave and off-site activities but very little activity was observed on the ward.

Discussions with OT staff confirmed that at the time of our visit one full time OT and one OT Assistant were due to be appointed. Unlike Ward 14, there was no daily OT input on PICU and patients were not receiving a schedule of meaningful activities. OT were providing advice/assessment on an ad-hoc basis. All patient admissions were screened based on the Model of Human

Occupation (MOHO)[3] and recorded assessments resulted in individual plans for the patients.

During our visit it was observed that those patients who actively sought OT support were provided with it. For those patients requiring more encouragement and who stated they were bored more proactive input from OT to engage in activities and therapies is needed.

Visits from family and friends were encouraged and welcomed. Patients could use their own mobile phones to maintain contact with relatives and payphone facilities were also available.

All patients had access to an outside area and told us they had somewhere to go if they required time alone. Staff told us of the arrangements in place to ensure the wellbeing of patients including access to a GP and other healthcare services.

Recommendations

The timely recruitment of one full time occupational therapist and one occupational therapist assistant is required to maintain a continuous therapeutic environment, specifically for the PICU.

A review of how patients are engaged to participate in activities/therapies is required, with consideration given to generic activity timetables and patients having access to a personal timetable.

Food and nutrition

The majority of the patients we spoke to commented favourably regarding the food served at the hospital. Patients were offered four meals a day: breakfast, lunch, tea and supper.

A weekly menu was in operation at the time of our visit and patients told us they had a choice of meals. During our visit we did not observe any patients making their own food choices from the weekly menu, nor was a menu on display. Staff told us that they would make food choices on behalf of the patients.

This system of staff choosing food on behalf of the patient group was inconsistent because some staff ordered all the same food, therefore not

[3] MOHO provides a framework (or model) for occupational therapists to understand how to use daily activities therapeutically to support people's health. It seeks to explain how meaningful daily activities are motivated, patterned, and performed. For more information visit http://www.cade.uic.edu/moho/default.aspx

providing variety. This issue was raised during our previous visit and we could not evidence that the ward managers and staff were encouraging patient choice as stated in the action plan, therefore patient choice was being compromised and needs to be reviewed.

Some staff we spoke to said they thought the food was sometimes bland and unappetising, with the same foods being served on the same day every week. All the staff and patients we spoke to said the portion size was satisfactory with enough food served to the patient group.

Patients had unlimited access to water and squash. Hot drinks were provided at set times and on demand if possible. Fruit and snacks were stored in the ward kitchens and patients could request these from staff.

Access to dieticians was an area of concern, with little or no input for those patients requiring this service. Staff told us that ward 14 were receiving a weekly two hour telephone consultation. A review of the provision of dietetics[4] is required to ensure all mental health services are provided with specialist advice when required.

Recommendations

Patients should be encouraged to choose their own meals from the menu provided.

Healthy nutrition and hydration promotion from dietetics should be available. Information on maintaining a healthy weight or preventing excess weight gain is important for people on certain medications.

A review of the provision of dietetics is required to ensure all mental health services are provided with specialist advice/assessments when required.

Training

We reviewed a total of ten staff files from both PICU and Ward 14 which highlighted a lack of consistency. Half of the files we reviewed had a Personal File Checklist attached, although one was not fully completed. There were no dividers used to separate specific information therefore making the files difficult to follow and messy. One file we reviewed had paperwork confirming the employee had retired, however the employee was working part time, but there was no record of this on file.

There were files with no references and no file notes to confirm the reasons for this. Some files had application forms, offer letter and contracts while other files had only some of this information, therefore it was difficult to

[4] Dietetics is

evidence that applicants had been appointed through an open process. A standard approach needs to be applied across all staff files to ensure evidence of the appointment is consistent.

It was positive to see recruitment on Ward 14 and PICU was bringing establishment levels up to their required levels. We also noted the acuity project that was on-going at the time of our visit and how this would feed into the recruitment process to ensure sufficient staffing levels for patient needs.

The process of recruiting staff had significantly improved, with processes being reduced from several months to several weeks.

It was pleasing to note that a system to monitor professional registration renewals was in place and regular monitoring was taking place to ensure staff compliance.

The majority of staff told us that they had or were due an annual performance development review (PDR) and we noted that systems had been put in place to monitor this area. The data provided for Ward 14 did highlight a number of gaps with only seven staff out of 22 with a current PDR in place. The data for PICU staff showed that 13 out of 29 staff were scheduled for their first PDR in 2016.

We had no evidence that a process of formal supervision had been implemented for all staff on Ward 14 or PICU. Staff told us that they had received informal supervision, however there was nothing in place that documented or evidenced this. Occupational Therapy staff were receiving monthly, documented supervision which they found supportive. A programme of regular and documented supervision needs to be put in place for all staff.

The programme of mandatory training had been updated to include Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training as recommended from our previous visit, however completion rates need to be improved. Compliance rates for Mental Capacity Act training on PICU were 66% and 76% on Ward 14. DoLs training on PICU had 69% compliance and Ward 14 had 76%. Compared to the other training modules, these two areas were significantly lower and need to be improved. It is recommended that Mental Health Act 1983 training is added to the mandatory list to ensure consistency of knowledge and application.

Immediate life support training is required as a priority, with PICU having a 62% compliance and Ward 14 with 44% compliance, the lowest training completion figures for both wards. In addition to this, some staff had not received training in this area since 2013 despite the training being a yearly requirement. Specific training on risk assessment and management was not fully in place.

It was pleasing to note the PICU had achieved 97% in hand washing training and control of substances hazardous to health (COSHH) and Ward 14 had achieved 96% compliance in violence and aggression and fire training. Staff spoke of good opportunities available to undertake additional training in addition to the mandatory list.

Recommendations

A review of staff files is required to ensure consistency is applied to the information contained on file and that the paperwork is relevant and can be followed in a coherent way.

Annual performance development reviews (PDR) need to be completed for all staff.

A system of regular and documented supervision needs to be implemented for all staff.

Training for all staff in immediate life support needs to take place as a matter of priority.

Completion rates for some areas of staff mandatory training needs to be reviewed and improved, specifically for Deprivation of Liberty Safeguards and the Mental Capacity Act.

Mental Health Act 1983 training needs to be added to the mandatory training list to ensure consistency of knowledge and application.

Risk assessment training needs to be a priority for staff.

Application of the Mental Health Act

We reviewed the statutory detention documents held at Princess of Wales following up on the issues identified in our previous inspection.

While reviewing the patient files we found incomplete sets of statutory documentation within the files on the ward. The ward staff retrieved copies of missing documentation at the time of the inspection to verify the compliance with the Act. However, a set of statutory documentation should be present in each patient's file so that staff are able to easily refer to the documentation as required.

The issue regarding lack of ethnicity listed within the patient notes identified in the previous inspection had appeared to be addressed in the sample of records reviewed; ethnicity was listed in each case.

Recommendations

A process must be in place to maintain a copy of statutory mental health documentation on patients' files.

Monitoring the Mental Health Measure

We reviewed the care and treatment planning documentation for two patients at the Princess of Wales, PICU and identified the following observations:

- One set of patient notes had a good frequency of review in place and the prescription card was followed.
- There was good evidence on one patient's file of physical pain risk assessments in place.
- One patient's file had no dates of review evident and a lack of signatures.
- Risk management plans require specific detail in correlation with risk behaviour.
- Medication titration physical observations were generally maintained, however clozaril titration chart had vital signs documented as well as on NEWS chart. The NEWS chart needs to be scored to identify any action triggered.

Recommendation

All the areas identified must be addressed, including ensuring dates of review and signatures are completed where applicable; risk management plans require specific detail in correlation with risk behaviour and the NEWS chart needs to be scored to identify any action triggered.

6. Next Steps

The health board is required to complete an Improvement Plan (Appendix A) to address the key findings from the inspection and submit its 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, Ward 14 and PICU 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
Health Board: Abertawe Bro Morganwwg University Health Board
Practice: Princess of Wales – Ward 14 & PICU
Date of Inspection: 16th - 18th November 2015

Page Number	Recommendation	Health Board Action	Responsible Officer	Additional Evidence	Timescale
13	A review of the extended area on the PICU is required to ensure the safe monitoring and observation of the patient group by staff.	In terms of the extended area with the PICU and the 'blind spot' identified in the corridor. A panoramic, 90 degree acrylic security mirror has now been installed to provide supervisory capability and ease of monitoring for any unseen areas.	Ward Manager, PICU	➢ Mirror Installed.	Complete
		In regards to comments in the report relating to observations made difficult from the viewing panel in one of the new bedrooms (Bedroom 7). The security mirror (installed as part of the ward upgrade), in the ceiling space adjacent to the bed, provides a clear image of the patient that can be viewed from the bedroom door vision panel. Moreover, the Ward Manager has advised that patients nursed in this area have been assessed as a lower risk. It is accepted however that a visual check is not enough to verify a patient is sleeping in any of the bedroom areas and more direct confirmation would be necessary.	Nursing Staff, PICU	➢ Mirror Installed. ➢ Hourly observation form completed, dated and signed. ➢ Safe and Supportive Observations Policy ➢ Quality Assurance Check (twice monthly) ➢ CID123: Safe and Supportive Observation and Engagement of Patient at Risk Policy	Complete

13	A review of the courtyard door is required to ensure it can be locked to protect patients and staff.	In response to the comments in the feedback report, the courtyard security has been refreshed by the PICU Ward Manager. As a result, the main door leading into the courtyard is now of a key operated, lockable design	Ward Manager, PICU	➢ Door lock installed and can be secured on the judgment of the Nurse on Duty.	Complete
13	Open and wedged opened doors to the nurses office and other staff only areas need to be reviewed to ensure the safety of staff and information contained in these rooms.	In terms of the adjacent ward office doors remaining held open, the Ward Manager has advised that this provides a more welcoming environment for patients when approaching staff, which can help avoid any behavioural disturbance. Should the office area be unoccupied at any time then both office doors are locked. The Ward Manager has added that no patient identifiable material is on display.	Ward Manager, PICU	➢ The nursing office door that leads into the courtyard area is now locked ➢ Quality Assurance Check ➢ Lockable mobile filing case has been ordered ➢ Patient At A Glance (PSAG) board has a confidential roller blind installed.	Complete
13	The female lounge on Ward 14 requires attention to ensure broken furniture and phone sockets are removed and/or fixed.	The Ward Manager has advised that the item of furniture appeared to have been broken on the day of the visit and was immediately removed and disposed of.	Ward Manager, Ward 14	➢ The damaged telephone network point has been repaired ➢ A new television has been installed within the Female Lounge on Ward 14.	Complete
13	The sluice room door on Ward 14 needs to be repaired or replaced.	A works request has been submitted to the Estates Helpdesk to either replace or repair the damaged sluice room door on Ward 14.	Estates Manager, Princess of Wales Hospital	➢ Door repaired	Complete
13	Damaged walls on Ward 14 need to be repaired, specifically the wall before the entrance to the gym.	A works request has been submitted to the Estates Helpdesk to carry out the necessary wall and door frame repairs on Ward 14, adjacent to the gym entrance.	Estates Manager, Princess of Wales Hospital	➢ Damaged wall now repaired	Complete

15	A review of personal alarms for staff is required to ensure there are sufficient numbers for staff and visitors and the safety of both patients and staff is not compromised.	The wearing of personal alarms for ward staff is compulsory and these are issued at the beginning of each shift and signed for by the recipient. Moreover, new alarm units have been procured for Ward 14 which are of a more compact design, housed in a tough ABS plastic case. These have been tested on the ward as suitable as they have a loud, 140 decibel siren on activation. In terms of the PICU Ward, an infra red wireless alarm system is in situ. For both wards additional alarm units have been procured for visitors.	Ward Manager, Ward 14 Ward Manager, PICU	➢ Quality Assurance Check. ➢ Personal Alarm Operational Checklist. ➢ An observational audit was conducted on Ward 14 by the Clinical Service Manager on the 25th January 2016, whereby those ward staff challenged had a personal alarm in their possession. ➢ A Quality Assurance Check and personal alarm checklist was completed on the 28th January 2016	Complete.
				➢ Personal safety audit to be conducted in Ward areas	Personal Safety Advisor – February 2016
15	A review of the nurse call alarm system is required to ensure accessibility and availability for everyone.	As highlighted at the 2014 Health Inspectorate Wales visit to Ward 14, the Clinical Service Manager has advised that the current nurse call system is appropriate for the needs of the adult clinical environment, as the majority of patients nursed on the ward are mobile. In addition, by night, staff are positioned at the top of the main ward corridor to assist with observations.	Ward Manager, Ward 14	➢ Patients assessed as a lower risk are nursed in bedrooms which have an external nurse call (bedrooms 4 to 7), which are located nearer to the main ward office. ➢ Patients cared in bed will be allocated a bedroom with an accessible, internal nurse call button ➢ Quality Assurance Check	Complete.

15	The fire extinguisher on Ward 14 needs to be reviewed to ensure possible misuse is mitigated.	Suitable double fire cabinets have been procured with Advanced Fire Technologies.	Assistant General Manager	➢ (Purchase Order number 91511708).	5th February 2016
15	A review of why care co-ordinators no longer participate in MDT meetings on Ward 14 and how information regarding their patients is communicated to them is required.	The Ward Manager and Clinical Service Manager have reported that communication with the multi disciplinary team, which includes the care coordinators, has significantly improved. The appointment of a dedicated Ward Clerk has assisted with this process. As part of service improvement, ward rounds have now been replaced by individual patient reviews, with invites sent to all relevant professionals, to include the Care Coordinator. Multi Disciplinary Meetings are held on a regular basis and all relevant inpatient and community staff are invited and their attendance documented.	Ward Manager, Ward 14 Clinical Service Manager	➢ The Chair of the Patient Review Meeting documents the attendance list and the Clinical Service Manager (CSM) has stated that the Care Coordinator's clearly record their reviews within the patient health record. ➢ Care and Treatment Plan (CTP) Audit Tool ➢ Weekly multi-professional discharge planning meetings	Complete.
15	A review of the current practice of replacing ward rounds with patient reviews to ensure that the non participation of nursing staff does not compromise patient outcomes	As described in the above, it is mandatory for nursing staff to attend ward reviews.	Ward Manager, Ward 14 Clinical Service Manager	➢ Nursing staff attend	Complete.
16	Plan and daily assessment of risk is part of the nursing process and requires collaborative implementation. The new form needs to ensure that the non participation of nursing staff does not compromise patient outcomes and that communication does not become fragmented	As outlined above. New ways of working has been in place since the beginning of 2015. Nursing staff attend patient reviews.	Ward Manager, Ward 14 Clinical Service Manager	➢ Daily planning meetings in place which document and discuss prevalent issues concerning patient care and risk	Complete.

17	The timely recruitment of one full time occupational therapist and one occupational therapist assistant is required to maintain a continuous therapeutic environment, specifically for the PICU.	A rotational full time Occupational Therapist is now in place for Ward 14.	Lead Occupational Therapist	➢ Individual in post	Complete
		In terms of the PICU Ward, appointment to the recent advertisement of Occupational Therapy Technician has been unsuccessful. As a consequence, the Clinical Service Manager has agreed to review the requirements of the post with the Service Manager at the January Adult Service Group Meeting, with a view to extend the role to a full time Activity Coordinator role prior to re advertisement.	Clinical Service Manager	➢ A plan to review the Job Description and Personnel Specification was agreed at the Clinical Service Manager's meeting on the 28th January 2016	March 2016
17	A review of how patients are engaged to participate in activities/therapies is required, with consideration given to generic activity timetables and patients having access to a personal timetable.	In terms of Ward 14, the Ward Manager has advised that a recent meeting has been held with the Groundwork Wales Charity to introduce a gardening club as part of horticultural therapy for patients. The ward also has an association with the Assisted Recovery in the Community (ARC) service, whereby patients can take part in community activities or access educational and employment services. Whilst it is acknowledged that currently there is a lack of Occupational Therapy support on the ward, individualised activities are provided by the Health Care Support Workers, under the direction of registered nursing staff. Both the Ward 14 and PICU Ward Managers have advised that whilst some generic activities are in place, for example a weekly quiz, board games, baking and cooking, a more individualised recovery approach with activities is encouraged, in line with the individual care and treatment plan. This is in preference to a pre-planned timetable of activities.	Ward Manager, Ward 14 Ward Manager, PICU	➢ Upgraded gymnasium in PICU ➢ Over the Christmas period trips were arranged to the Swansea Winter Wonderland event, together with excursions to the cinema, bowling and swimming. ➢ The PICU Ward now has its own vehicle for the use of transporting patients to community based activities. ➢ White Board Activity planner to be visible on ward and to be completed daily ➢ Both wards participate in the Bridgend County Borough Council 'Just Ask' Scheme	Complete

18	Patients should be encouraged to choose their own meals from the menu provided.	An All Wales Menu Framework is in operation on Ward 14 and PICU, in line with the General Hospital. This currently consists of 18 soups, 38 main course items and 42 desserts, snacks and accompaniments. Menus are sent to the ward on a weekly basis whereby patients are encouraged to participate in food choice	Ward Manager, Ward 14 Ward Manager, PICU	➢ Food Quality Questionnaires	Complete
		Meetings have been held recently with the Hospital Catering Liaison Officer to pursue the option of providing daily menus.	Ward Manager, Ward 14	➢ Ward Manager to update at the next Ward/Team Meeting on the 5th Feb 2016. Catering to be added to the agenda	February 2016
		A new finger food buffet has been introduced by the Catering Department.	Catering Services Manager	➢ Available.	Complete
18	A review of the provision of dietetics is required to ensure all mental health services are provided with specialist advice when required.	A 0.8 whole time equivalent (WTE) Dietician has been appointed for the Delivery Unit. Nonetheless, the Service Manager for Adult Services has advised that there are plans to progress additional funding for this role via the Dietetic Steering Group, so that the provision can extend to all localities.	Service Manager	➢ In the Bridgend area, nutritional support dietary telephone advice is available. ➢ A Tier 3 Team is available for patients who have an eating disorder. ➢ Nursing staff undertake nutritional assessment as part of physical patient health screening. ➢ Dietetic steering group held 28th January 2016	Some limitations with this provision. Further progress to be undertaken via the Dietetic Steering Group. Review March 2016
20	A review of staff files is required to ensure consistency is applied to the information contained on file and that the paperwork is relevant and can be followed in a coherent way.	The Clinical Service Manager has reviewed all ward based staff files to ensure these are in a consistent format and will also combine with files currently held with them.	Clinical Service Manager	➢ An electronic drive has been created for the shared storage of documents.	Complete

20	Annual performance development reviews (PDR) need to be completed for all staff.	The importance of conducting performance development reviews for staff (PDR) is part of the NHS Outcomes Framework and compliance is routinely monitored by the Health Board.	Ward Manager, Ward 14 Ward Manager, PICU	➢ Both the Ward 14 and PICU Ward Managers have provided a schedule for their staff to achieve PDR compliance by the end of 2016. ➢ KSF & PDR Policy and Procedure ➢ Performance Statement ➢ Care Indicators	For review March 2016
20	A system of regular and documented supervision needs to be implemented for all staff.	It is acknowledged that a refresh is necessary on the implementation of regular and documented clinical supervision for staff. The Clinical Service Manager has advised that whilst management supervision is provided and documented, clinical supervision is held more on an informal basis.	Service Manager	➢ Practice Governance and Supervision Policy ➢ A database of supervisors is available	For review March 2016
20	Training for all staff in immediate life support needs to take place as a matter of priority.	The difficulties in accessing immediate life support (ILS) training remain and this has been raised at a Health Board level and is recorded within the Risk Register for the Delivery Unit.	Service Manager	➢ The PICU Ward has allocated training places for their qualified staff up to the end of April 2016 ➢ Ward 14 Manager has contacted the ILS training for information on further dates for their staff ➢ In terms of unregistered staff, basic life support is available (BLS) and this can be delivered at ward level.	For review April 2016

20	Completion rates for some areas of mandatory training need to be reviewed and improved, specifically for Deprivation of Liberty Safeguards and Mental Capacity Act.		Ward Manager, PICU	➢ The PICU Ward Manager has advised that their staff have now completed the Level 1 & 2 training via the e learning package.	Complete
			Ward Manager Ward 14	➢ The Manager for Ward 14 has advised that there is an expectation that their staff will be compliant in Level 1 & 2 by the end of February 2016	For review February 2016
		In terms of the both wards, training places for Level 3 will be booked throughout the year.	Ward Manager PICU Ward Manager Ward 14	➢ Care Indicators ➢ Audit of local training records. ➢ Fortnightly Ward/Team Manager Meetings	For review April 2016.
20	Mental Health Act 1983 training needs to be added to the mandatory training list to ensure consistency of knowledge and application.	Colleagues from the Mental Health Act Department offer 'drop in' sessions to update staff as necessary as coordinated by the Ward Managers .	Mental Health Act Manager	➢ Update Session provided December 2015	Complete
			Service Manager	➢ To be reviewed via the next Professional Nurse Forum (PNF) and Mental Health Legislative Committee	For review March 2016
21	A process must be in place to maintain a copy of statutory mental health documentation on patients' files.	Following the establishment of a health record documentation task and finish group, a Mental Health specific clinical record was introduced in order to ensure availability of comprehensive, accurate and timely information to clinicians. This includes a dedicated section relating to Mental Health Act documentation.	Ward Manager PICU Ward Manager Ward 14	➢ Ward based audit	Complete

22	All the areas identified must be addressed, including ensuring dates of review and signatures are completed where applicable; risk management plans require specific detail in correlation with risk behaviour and the NEWS chart needs to be scored to identify any action triggered.	The Ward Managers for Ward 14 and PICU advised that the Clinical Leads on each ward are monitoring all patient documentation to ensure these are compliant and relevant, in line with. In addition, the Ward Managers have advised that they will ensure that the observations on the Clozapine Titration Chart correspond with the NEWS chart. This will be monitored via the local ward audits.	Ward Manager PICU Ward Manager Ward 14	➢ The All Wales Mental Health Measure Part 2 Audit Tool ➢ Clozapine Policy & Treatment Guidelines	Complete.