Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health/ Learning Disability Inspection (Unannounced)

Ysbyty Gwynedd: Hergest Unit: Betsi Cadwaladr UHB

6 - 8 January 2016

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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 plan
- 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).

[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 visit to the Hergest Unit on the evening of 6 January and all day on the 7 and 8 January 2016. We inspected all three wards, Aneurin, Cynan and Taliesin the Psychiatric Intensive Care Unit (PICU)[2]

The Hergest Unit is a specialised mental health hospital situated within the grounds of Ysbyty Gwynedd Hospital run by Betsi Cadwaladr University Health Board (BCUHB) and provides a comprehensive range of acute mental health services including psychiatric intensive care services (PICU).

Aneurin and Cynan are both acute wards, each having 16 beds. Aneurin accommodates female patients and Cynan ward male patients. Taliesin is a six bedded PICU.

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 peer 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.

4. Summary

Our January 2016 visit to the Hergest Unit at Ysbyty Gwynedd was a follow-up visit, focusing primarily on the issues that HIW identified in May 2014. It was pleasing to note that considerable improvements had been made to address some of the matters we identified in our previous visit as well as other improvements. These included:

- the intensive care suite (ICS) had been modified with a separate en-suite facility which provided improved privacy and dignity for patients using this facility.
- Patient information displayed on whiteboards in the nurses' office was covered up when not in use. This improvement enabled patient information to be visually protected from visitors and other patients.
- Mandatory training for staff had improved considerably with higher compliance rates across all wards. We did however identify some areas in which improvement needed to be made and this is listed under the Training section of the report.
- A system was in place for staff to receive regular and documented supervision, with the majority of staff confirming that this takes place on an on-going basis.
- The achievement of AIMS[3] in 2015 reflects improvements made at the Unit.
- Staff morale had improved and was generally good across all wards, however, some frustrations were identified which the health board need to consider and act upon (see Governance section)

[3] AIMS - Accreditation for Inpatient Mental Health Services. AIMS is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. Accreditation assures staff, service users and carers, commissioners and regulators of the quality of the service being provided. www.rcpsych.ac.uk/AIMS

- Advocacy services were spoken highly of by both patients and staff and the independent patient forum was a very positive initiative
- Patients and staff spoke favourably of the food served at the unit in relation to the quality, choice and portions of food served.

In addition to the improvements noted, we also identified good practices which we have continued to observe during our visits to the unit. These were specifically the receptive way staff engaged with the inspection programme and the number of positive staff and patient interactions we observed throughout our visit.

Despite the good practice identified, we also found significant scope for improvement in a number of areas. Following our visit we issued an immediate assurance letter to the health board regarding concerns that could potentially pose a risk to the safety of patients. The purpose of this letter was to seek assurance from the health board of the actions they have and will undertake to mitigate the risks. The areas we have identified for improvement are documented in Appendix A, but a summary of the main issues include:

- A considerable pressure on in-patient beds with the number of patients exceeding the 16 available beds, on both Aneurin and Cynan wards. Frequently a 17th and 18th bed are provided on the wards to accommodate additional patients. Existing patients could also be moved around the wards. This situation is very unsettling for patients and creates difficulties for staff.
- Issues regarding staffing were identified, specifically on Aneurin ward. We identified that on a number of occasions there was only one registered nurse on the ward and sometimes they were the 'bleep'[4] holder for the whole unit. A significant number of occasions were identified when staff had not been taking breaks due to the demanding workload and nature of the ward. Some staff had accumulated

[4] Bleep holder holds the bleep for communication purposes. The bleep holder will be used to contact members of the team for emergency and urgent calls and respond to Section 136 admissions.

significant time owed to them due to staff shortages and the need to work overtime.

- A number of vacancies across the unit including medical, nursing and support staff
- A ligature risk assessment had identified significant safety issues across the three wards. Numerous ligature risks were identified which included beds, door closures and bathroom pull cords. It was identified that new beds had been ordered in August 2015 and at the time of our visit had not arrived. The outstanding actions from the ligature risk assessments, which are undated need to be addressed and completed as a matter of urgency.
- The admission criteria for the Unit needs to be reviewed to ensure that patients can be cared for appropriately. A number of patients had been recently admitted with a more organic type of illness e.g. dementia and these patients require specific care for their individual needs.
- A number of sets of patient documentation were examined on Aneurin ward and some significant issues were identified in relation to the care and treatment of a patient who had recently fallen.
- Environmental issues were identified that need to be addressed and include water temperatures that were too hot in some areas and too cold in others. Windows that inappropriately screwed shut and could not be opened. In addition the nurse call systems did not meet the guidance documented and initiated by the health board on the Risk of Falls Pathway.

5. Findings

Core Standards

Ward environment

The Hergest unit is a self contained building situated in the grounds of Ysbyty Gwynedd. The unit has its own entrance and reception. The unit is single storey with three operational wards and a number of offices for staff.

On entering the reception area, doors lead to a number of areas and wards, including Taliesin ward, a psychiatric intensive care unit (PICU) and two acute wards Cynan for male patients and Aneurin for female patients.

Taliesin ward is a six bedded PICU for both male and female patients. The ward is locked with access to the ward via a key fob system for staff and an intercom system for visitors. The ward provided six single bedrooms which contained a wardrobe for patients to store personal belongings. Patients on the ward had access to shared gender specific toilet and showering facilities. The observation panels in the bedroom doors could only be operated from the outside.

Taliesin ward had a shared lounge with enough seating for the number of patients the ward can accommodate. A TV was fitted to a wall and there were some books on the window sill. There were two tables in the lounge and some pictures on the wall. Taliesin ward did not have any single gender lounges.

The dining room at the time of our visit had one table and four chairs which was not enough for all patients to eat together, however there were a number of easy chairs in the room.

It was pleasing to note that following our previous visits the intensive care suite (ICS) room had been modified and improvements made to the room that included a separate en-suite facility. A clock was also visible to allow patients to orientate themselves when in this room.

Patients had access to an outdoor area. The garden was contained and used only by patients on Taliesin. The garden had seating and areas of shrubbery which made the garden area more pleasant.

A payphone was situated in an open space which did not provide privacy for anyone using it.

Not all the call bells situated in bedrooms and other patient areas were within easy reach of patients.

The ward environment was adequate for a PICU and provided low stimulus areas that this ward requires.

Aneurin (female) and Cynan (male) wards were environmental duplicates of each other. They both were 16 bedded wards with a mixture of single and dormitory style bedrooms. Each ward had shared bathroom, showering and toilet facilities. We noted that signage on the wards required updating because bathrooms had signs stating male or female areas on them instead of being specific to the gender that the ward was accommodating.

Patients in single bedrooms on Aneurin and Cynan wards could lock their bedroom doors but this could be over ridden by staff if necessary. There were no locks on the dormitory rooms. The observational panels in bedroom doors could only be operated on the outside. Therefore patients were unable to control the observation panel for key day to day activities, such as undressing.

On Aneurin ward we noted that the bathroom had two bars of soap stored on the side of the bath, which was a potential infection control issue. In the shower room a number of products were stored on the radiator, including shampoo, shower gel and air freshener. The items were not appropriate to be left in the room due to the harm they may cause an unattended patient, especially if the bathroom door was not locked. The flooring in the shower room had burn marks from a recent incident and needs to be cleaned or replaced.

At the time of our visit the water temperature in the bath on Aneurin ward was very hot and in the bathroom on Cynan ward the water was running cold. No temperatures were being regularly recorded by staff to ensure an appropriate water temperature was available. At the time of our visit, we requested evidence that these temperatures were being recorded on a regular basis but documentation was not provided.

Throughout all the wards staff told us that some windows would flap open and bang if the weather was windy. This was due in part to the lack of closures on the windows and to overcome this on some wards that windows were screwed shut. In a dormitory on Aneurin ward all three windows were screwed shut and could not be opened to allow air to circulate. In addition, the windows that could be opened on the wards had potential ligature risks.

We identified a number of nurse call bells in rooms including bathrooms and bedrooms that were not conveniently located. In a number of bathrooms, the call bell was situated opposite the toilet. Therefore if a patient required assistance then they would have difficulty accessing the nurse call system. In addition, dormitory bays had one nurse call system for three or four patients. A review of patient access to call bells is required because it is in direct contradiction to the instruction written on the ‘Risk of Falls Pathway’

document, which clearly states call bells must be in sight and reach of patients at all times.

We identified a number of ligature risks throughout all the wards, especially beds, door closures and bathroom pull cords. This needs to be addressed in accordance with the ligature risk assessments, which are undated that was undertaken.

Aneurin and Cynan wards had pictures displayed on the walls of the corridors and both wards had notice boards displaying a good range of information and leaflets in both Welsh and English.

The lounges on both wards provided easy chairs, TVs and tables. At the time of our visit, the lounge on Aneurin ward was being utilised by a number of patients who were knitting and one patient reading. There was a puzzle on the table that had been started by a patient and there were book shelves with games and books available.

Both wards had their own garden areas which were small but landscaped.

A section 136 suite was available at the Hergest unit, which provided adequate facilities for persons using the suite.

Recommendations

Water temperatures across all wards need to be checked and regularly monitored to ensure a safe and consistent temperature is maintained. This was of particular concern in the bath on Aneurin ward.

All windows across the unit need to be reviewed, specifically windows in patient bedrooms and areas to ensure they can be operated appropriately and do not present a ligature risk.

Signage across all wards needs to be updated to ensure it is appropriate to the patient group.

Patient access to call bells needs to be reviewed because it was in direct contradiction to the Falls Pathway documentation and in one dormitory there was only one call bell for up to four patients.

A review of all the required actions from the ligature risk assessments need to be undertaken as a matter of urgency.

Safety

Discussions with patients highlighted that the majority with whom we spoke said they felt safe at the Hergest Unit. Two patients who said they didn't feel safe gave examples of other patients having the potential to be violent and concerns about who could enter the dormitory bedroom because they were unable to lock the door. The majority of staff we spoke to did not identify any safety issues, however some did mention potential ligature risks in bathrooms and with beds. Staff had mitigated these risks by locking the bathroom door so patients have to request to use it, however the door on Aneurin bathroom was not locked on the evening of our inspection.

We identified issues around staffing, specifically on Aneurin ward. There had been a number of occasions when one registered nurse was on the ward and had also been the bleep holder. Therefore if they were dealing with the bleep call their ward would have been left without a nurse or would have had to borrow another registered nurse from a different ward. We also identified a significant number of occasions when staff were not taking breaks and as a result some staff had accrued a significant amount of time owing. These areas need to be reviewed to ensure patient and staff safety.

Over occupancy of beds was clearly an issue on Aneurin and Cynan wards. Frequently additional beds were put on the wards to accommodate additional patients. At the time of our visit, Aneurin ward was over capacity. There was one patient in the general hospital receiving care and treatment for a fractured hip. Their bed had been allocated to a new admission and if the patient was to return to the ward an additional bed would be required.

In addition to the above, there had been a number of occasions when the bronze on call had told staff at the Hergest to put up additional beds for new admissions. This situation has resulted in inappropriate admissions being made, with a male patient being admitted to a female ward. Staff on call were not always aware of the service provided by the Hergest unit and this needs to be reviewed and changed to ensure on call staff have knowledge of the service and where necessary gain specific advice from nursing staff at the unit to ensure admissions were appropriate.

A number of potential ligature risks were identified throughout the wards specifically beds, door closures and pull cords in bathrooms. It was pleasing to note that new beds had been ordered in August 2015, however, at the time of our visit they had not been delivered. Staff had also put measures in place to mitigate risks in patient bathrooms. All areas need to be reviewed and actioned in accordance with the ligature risk assessments.

We noted during our night visit that not all staff were wearing personal alarms on Aneurin and Cynan wards, despite the allocation of alarms to visitors. It is

important that staff safety is reviewed and personal alarms are worn by staff at all times.

The information contained on the patient board on Aneurin ward was difficult to understand. The board at the time of our visit appeared to list 20 patients when there were not 20 patients on the ward. After some scrutiny we concluded that three patients listed were not currently on the ward. One patient was on Taliesin, one patient was an inpatient in the general hospital and other was on long term community leave. Some improvements to the notice board should be made to avoid any confusion in relation to actual patient numbers.

Concerns about the patient mix was raised by some staff, stating that some patients are being admitted that staff feel were unsuitable for the unit. Not only has this resulted in some incidents, there were concerns that facilities were not available or suitable especially for patients with dementia. Some members of staff also felt they might not have the necessary knowledge and experience to nurse dementia patients.

Recommendations

The staffing issues identified need to be addressed, specifically to ensure staff take breaks and time accrued is effectively monitored and managed. The allocation of the beep needs to be reviewed to ensure no wards are left without a registered nurse.

The over occupancy of beds must be addressed as a matter of urgency.

Staff assigned to the bronze on call system need to have improved knowledge of the Hergest unit to ensure their decisions are appropriate so that staff and patient safety is not compromised because of those decisions.

A review of usage of personal alarms is required to ensure staff are allocated and use alarms when on duty.

The multi-disciplinary team

The staff we spoke to felt their team worked in a professional and collaborative way and attended regular case reviews for their patients.

Multi disciplinary team meetings (MDT) are attended by the disciplines that have been involved with that particular patients care. Staff told us that psychology were more accessible because they were based at the unit and therefore could see patients quickly. MDT meetings take place on a regular basis, however some staff did state that community teams/key workers find it difficult to attend meetings.

Some members of staff felt that their views/opinions were not valued by some members of the clinical team. All members of staff must feel valued and professional views respected by all members of the clinical team.

The number of consultants for some wards were as many as seven which meant a lot of wards rounds and pressure on nursing staff. Staff told us that they had a ward round timetable to accommodate the number of consultants for their ward, but some consultants could turn up unannounced, again putting additional pressure on nursing staff.

Staff said they regularly attended staff meetings however at the time of our visit no minutes were available for Aneurin ward. Some minutes of meetings were presented after our feedback session. It is essential that regular team meetings take place and minutes capture the discussions and outcomes to enable all staff to be aware of them. Staff had handover meetings between each shift.

Recommendations

All members of the MDT must feel part of the team and that their opinions are valued and respected within the MDT.

Privacy and dignity

Some patients had single bedrooms and other patients were in three or four bedded dormitories. Discussions with patients and staff did confirm that everyone would prefer single occupancy bedrooms. In the dormitories curtains are used to separate individual beds, however curtains do not provide privacy for patients to discuss personal matters with staff and patients complained of being disturbed by other patients.

A lack of space on the wards was commented on by both patients and staff. Patients told us that there were limited places to meet with family and friends on the wards and staff said there was not enough space for one-to-one meetings with patients.

The majority of patients we spoke to said they were shown around the ward when admitted and 50% of patients we spoke to could confirm they had a named nurse.

The patients we spoke to told us that staff respected their privacy and dignity and would knock on bedroom doors before entering. Observation panels in bedroom doors were operational from the outside only, therefore patients could not alter the panel from inside their bedrooms in order to obtain privacy.

Patients had access to phones to maintain contact with family and friends. Some patients had their own mobile phones, while others had access to a ward payphone. At the time of our visit, there was one broken telephone on Aneurin ward. The other telephone could only receive incoming calls. The payphone on Taliesin ward was situated in the corridor and did not provide any privacy for the person using it. Staff told us that patients could use the office phone if they requested.

It was pleasing to note that following previous visits, patient information displayed in nursing offices on white boards was covered when not in use, therefore protecting patient information.

Patient therapies and activities

Displayed on wards were activity timetables offering patients a range of activities between Monday and Friday. Facilities at the Hergest unit were wide ranging and included an occupational therapy (OT) kitchen, art and craft room as well as an activity room. The activity room provided patients access to games, books, table tennis, a piano, computers without internet access and a treadmill.

Despite the facilities available, the majority of patients we spoke to told us that they didn't have enough activities to do and only a few patients said they had been asked what they like to do. One patient told us that they found the days long because of limited activities and that the facilities were not being used because patients need to be escorted by staff.

Discussions with staff confirmed that patients can only use the above facilities if staff were available. At the time of our visit, use of the facilities was limited because there were no activity co-ordinators in post.

Occupational therapy staff described their process of assessment, which starts with a referral from the ward or community mental health team. OT staff undertake a baseline assessment using various standardized and non-standardized assessments. The end result is an individual plan for the patient which is documented and saved in their care plan so all staff can follow it.

OT staff told us that they run group and individual sessions for patients which might include cooking, shopping, using transport and home visits. During term time, on two evenings a week, students facilitate activities such as art, table tennis, watching films and music. On weekends, activities which have included trips out to local attractions were arranged and organised by ward based staff.

Patients who do not have Section 17 leave are more restricted in their choice of activities. Informal patients do not have these restrictions.

During our night visit we saw a group of patients knitting and crocheting and observed a positive interaction between patients and staff.

There was dedicated psychology input for the unit, however during our visit we were unable to meet with them for specific feedback. Staff confirmed that no weight, diet or smoking cessation programmes were offered to patients.

If patients required access to other services, such as a dentist, optician and/or podiatrist this would be arranged by staff. General physical health screening was carried out by staff.

Posters were visible on the wards advertising advocacy, Citizen Advice Bureau and Hafal services, they included contact details. The majority of patients we spoke to knew how to make a complaint should they need too and also knew how to contact the advocate. All the staff we spoke to told us how good these services were and how regular they attend the unit to support patients. Having external services that can support and help patients with their concerns and are well thought of by patients and staff is noteworthy.

In addition to the above, an independent patient forum run by Unllais undertakes monthly patient meetings. Patients from each ward are invited to attend the meetings to raise any suggestions and/or concerns. Minutes from the meetings are displayed on each ward and ward managers are required to respond to the any actions arising. These independent patient forum meetings are a positive initiative and an example of transparency by the Hergest unit regarding patient care.

Recommendation

The appointment of activity co-ordinators is required to ensure the provision of OT is not negatively impacted upon.

General healthcare

We identified a number of issues regarding the Frailty Project which must be addressed. These included:

- Numbers were in excess of the planned bed availability.
- Patient access to the nurse call alarm system was not available despite the health boards 'Risk of Falls Pathway' document clearly endorsing a call bell in sight and reach of patients at all times.

- Development of a group of specialist staff is required because of the patient mix evident on the wards.
- Training needs to be improved to adequately provide for this patient group.
- Flexible admissions to be considered because some patients under the age of 65 may require the service.

Recommendations

The areas identified regarding the frailty project must be addressed, specifically bed availability provision, specialist staff, staff training and admissions for patients under the age of 65.

Food and nutrition

All the patients and staff we spoke to commented favourably on the food served at the unit. Patients were offered four meals a day, including breakfast, lunch, tea and supper.

Patients were provided with menus to choose their meals from. Their choices included a vegetarian option. In addition, snacks were also available including sandwiches and/or jacket potatoes.

All the patients we spoke to said the food portions were ample and that there was good variety offered. Staff told us that patients with specific dietary needs were catered for and access to dieticians was available.

Any patient requiring a drink or snack outside of the set mealtimes was able to obtain one. Hot and cold drinks were available as was a variety of snack options stored in the ward kitchens. Patients did have the choice to order a take away on Saturdays if they wished.

Patients were weighed regularly as part of their general physical healthcare.

Training

We reviewed 10 staff files and identified some inconsistencies with the employment information contained on file. One file had a checklist which had confirmed all the pre and post employment information had been obtained including job description, application form, two references, interview notes, contract of employment and induction. However none of this information was on file. Other files reviewed had emergency contact details and certificates of

fitness while other files did not have this information. A standard approach needs to be applied across all staff files to ensure consistent employment processes.

It was pleasing to note that systems were in place to ensure that professional registrations were up to date. Ward managers check websites to ensure compliance with registrations and the e-rostering system provides a flag up system to staff when registrations are a few months from renewal.

Following on from previous visits, a much more robust and well documented system of staff supervision was in place. Discussions with staff confirmed that the majority receive regular formal supervision which is documented. A number of informal supervision sessions also take place of which staff spoke positively.

Eight out of 10 staff files reviewed had evidence that they had received a performance appraisal and development review in the last 12 months.

A programme of mandatory training was in place for staff and a system was being used to capture, record and monitor progress for each employee. An analysis of training statistics across the three wards did highlight significant improvement in compliance rates. There were a number of areas that need improvement and these need to be monitored to improve compliance. Such areas included equality training which was under 30% compliance on Taliesin and Aneurin wards. In addition health and safety training which was under 30% on Aneurin and Cynan and 10% on Taliesin ward.

There were some vacancies across the unit that need to be filled to ensure a full complement of staff. We identified a lack of activity co-ordinators across the unit and this was having a negative impact upon OT provision because their resources were being spread thinly. The recruitment of a ward clerk is required because at the time of our visit one ward clerk was being shared between all three wards. In addition, a high number of responsible clinician (RC) vacancies were still outstanding. Locum RC's were filling vacancies on a temporary basis. A review of staffing is required to ensure a full complement of staffing can be filled for the unit.

Staff told us morale was better across the whole unit, however some staff spoke of their frustration when issues take a long time to resolve. Staff dynamics were also cited as affecting morale.

We were told by staff that there was a lack of debriefing/lessons learnt sessions for staff following patient incidents and incident reports were not available following an incident. It is essential that this area is reviewed and staff attend a debriefing/lessons learnt session to ensure good practices are continually delivered and risks mitigated as much as possible.

Since our previous visit in May 2014 the Hergest unit has promoted initiatives to develop staff. Therefore it was pleasing to note that the unit had achieved AIMS.

Recommendations

A standard approach needs to be applied to all staff files to ensure that evidence of all appointments is consistent.

A review of staffing is required and recruitment to some key posts is necessary to ensure wards are operating at full complement.

Staff morale, particularly on Taliesin ward needs improvement, with a specific focus on the time frame to resolve issues and staff dynamics.

Debriefing/lessons learnt must form part of staff communication to ensure good practices are continually re-enforced and risks mitigated as far as possible.

Governance

A high number of responsible clinician (RC) vacancies throughout Betsi Cadwaladr health board continue to be unfilled. During the feedback meeting we were assured that this issue is being addressed. A recruitment strategy is required.

The demand on in-patient beds as described in the ward environment section requires urgent attention. A bed management strategy is required to deal with the issue. In addition, better knowledge and understanding of the service requirements for those staff on bronze on call needs to be addressed to ensure admissions are appropriate.

Delays in obtaining new furniture, including new beds which had been ordered in August 2015 need to be reviewed. The time lapsed is unacceptable and impacts upon ligature issues.

Despite improvements in staff morale throughout the unit there was evidence of low morale on Taliesin. Staff dynamics were cited as key factors. A review of these issues needs to be undertaken.

Recommendation

A review of the governance/audit systems and processes need to take place to ensure the health board has robust and adequate information conveyed to them.

All the areas identified must be addressed, specifically:

- A recruitment strategy to fill the high number of RC vacancies

- A bed management strategy to manage the demand of in-patient beds
- An acceptable time frame for the delivery of new furniture needs to be established
- A review of and strategy to deal with the issues on Taliesin ward regarding staff morale

Monitoring the Mental Health Measure

We reviewed the care and treatment planning documentation for six patients at the Hergest unit and identified the following observations:

- One patient had a risk of falls identified but no care plan was in place to address the risk

- The observation records for one patient who fell were missing and could not be located

- One patients self elected use of a wheelchair was not risk assessed or care planed

- The use of the Mental Health Measure documentation needs to be improved because there was a lack of detail on the files we reviewed. As a consequence further training in the use of the Measure needs to be implemented.

Recommendation

All the areas identified must be addressed, including ensuring all risk assessments are undertaken and in place for patients, observation records are maintained and are accessible. The use of the Mental Health Measure documentation needs to be improved.

Application of the Mental Health Act

We reviewed the statutory detention documents of three of the detained patients being cared for on one of the wards. The following issues were identified:

- Section 17 leave forms were in need of updating as 'to' dates had expired and recording of leave was not easy to follow.
- Section 17 leave was not being evaluated.
- Observational recording sheets did not have dates.
- The files we reviewed had evidence that patients had been read their rights and that an independent Mental Health Advocate (IMHA) had been involved. However there was no evidence on the files or audits in place to confirm that these actions were being repeated.
- The Mental Health Act administrators were not receiving hospital manager reports in time.
- Due to the number of locum doctors, MHA administrators have to continually check that the doctor is an approved clinician and section 12 accredited.

Recommendations

All the areas identified must be addressed, specifically to ensure section 17 leave and observation forms are appropriately completed and evaluated, hospital manager reports to be completed and submitted to the MHA administrators in a timely manner. Patient rights need to be read and evidenced accordingly and systems are required to ensure checks are completed promptly for locum doctors to prove their approved clinician and section 12 status.

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 Hergest Unit 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: **Betsi Cadwaladr University Health Board**
Hospital: **Ysbyty Gwynedd, Hergest Unit**
Date of Inspection: **6th – 8th January 2016**

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
1. Ward Environment				
1.1 Water temperatures across all wards need to be checked and regularly monitored to ensure a safe and consistent temperature is maintained. This was of particular concern in the bath on Aneurin ward.	1.1.1 All baths must be temperature checked using a thermometer before patients enter the water, based on best practice across the Health Board.	1.1.1 Confirmed at Senior Nurses Meeting 11th February 2016 that water temperatures are to be checked using a thermometer on all wards, and any issues should be raised immediately with the Estates Team. All thermostatic devices fitted to water outlets are checked every six months for correct functioning and adjusted accordingly by Operational Estates. Where fitted to a bath, a failsafe test is also carried out to ensure the hot water supply is automatically shut off if the cold water supply fails.	Locality Manager; Matron Estates Operations Manager – West	31st March 2016 31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	1.1.2 Health Board best practice to be identified and clear guidance provided to ward nurses on temperature range.	1.1.2 Locality Manager to discuss with Learning Disability Services Matron and develop guidance.	Locality Manager	31st March 2016
1.2 All windows across the unit need to be reviewed, specifically windows in patient bedrooms and areas to ensure they can be operated appropriately and do not present a ligature risk.	1.2 See 1.5.2	1.2 This matter has been logged on the Risk Register. A detailed external Audit has been commissioned through external Consultants. This work defined the high risk areas which in turn has necessitated the completion of RA for the management of specific clinical areas. This work was completed by the Clinical MH&LD teams. The Anti-Ligature Project Team have procured a BCUHB wide Contractor Framework to undertake the project work which is scheduled to commence on the 1st March 2016.	Locality Manager Head of Capital	To begin 1st March 2016; running until 31st March 2017. Commencing on 1st of March completion by June 2016
1.3 Signage across all wards needs to be updated to ensure it is appropriate to the patient group.	1.3 Signage review is not currently part of the Estates plan for Hergest in 2016-17, as a decision needs to be reached by	An Interim solution to signage will be agreed between local management and estates.	Matron/Locality Manager/Director of Estates	31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	the Division regarding the appropriate patient group for the Unit, which will affect any signage used.			
1.4 Patient access to call bells needs to be reviewed because it was in direct contradiction to the Falls Pathway documentation and in one dormitory there was only one call bell for up to four patients.	1.4.1 Patients assessed as being at risk of falls are given personal alarms worn on the wrist. These are in place and being used.	1.4.1 Complete	Matron	29th February 2016
	1.4.2 A wireless nurse call system will be investigated and a proposal sent to the Divisional Leadership Team for consideration.	1.4.2 Operational Estates representatives have met with the Matron to detail areas of shortfall. Costs will be obtained from Static Systems Group to provide suitable extensions to the existing system either hard wired or wireless as appropriate.	Estates Operations Manager – West	31st March 2016
	1.4.3 Floor sensors have also been purchased and were delivered 11/02/2016, to be fitted by end February 2016.	1.4.3Purchased and delivered, to be installed.	Matron	29th February 2016
1.5 A review of all the required actions from the ligature risk assessments need to be undertaken as a matter of urgency.	1.5.1 Purchase of anti-ligature beds.	1.5.1 New anti-ligature beds have now been procured and have been delivered- COMPLETE	Locality Manager	29th February 2016
	1.5.2 Review of required work to complete Anti-Ligature Project and prioritisation of same.	1.5.2 Extensive estates work regarding ligature risks have been reviewed formally in Estates sub-group and work prioritised	Head of Capital	To begin 1st March 2016 completion by June 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
		as per Anti-Ligature Project Plan which commences on 1st March 2016.		
2. Safety				
2.1 The staffing issues identified need to be addressed, specifically to ensure staff take breaks and time accrued is effectively monitored and managed. The allocation of the beep needs to be reviewed to ensure no wards are left without a registered nurse.	2.1.1 Implement a National Mental Health (Inpatient) Ward Acuity Process, and present the results of this to the Divisional Leadership Team to guide decision-making for the Unit.	2.1.1 This commenced in February 2016. Results are expected to be presented to Divisional Leadership Team in March 2016.	Locality Manager; Matron	31st March 2016
	2.1.2 Division to commence a review of the skill mix within the Unit based on results of 2.1.1, with particular regard to numbers of RMNs available in the Unit over the 24hr period.	2.1.2To commence once 2.1.1 complete.	Director of Nursing; Divisional General Manager	30th June 2016
	2.1.3 The Divisional Managers to have a system for closely monitoring e-rostering against the required staffing template. To ensure that e-rostering is fully utilised as a planner and management tool to ensure reliability and cross-cover within the Unit.	2.1.3E-roster use is currently being reviewed by Divisional Leadership Team.	Interim CRES Programme Manager	31st August 2016
	2.1.4 The Senior Nurse / Bleep Holder role to be in addition to establishment ward staffing, not part of it.	2.1.4This is already in place and occurs only in exceptional circumstances where mitigation to manage the situation is put in place.	Locality Manager; Matron	completed

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	2.1.5 Accumulation and use of TOIL to be managed under the current Health Board policy – audits to be undertaken followed by managerial intervention where required.	2.1.5 Matron to provide monthly position statement on TOIL to Divisional General Manager as of April 2016.	Matron; Divisional General Manager	1st April 2016
	2.1.6 Division to review how shifts are managed in practice, and introduce shift workplans across all wards. Effectiveness of shift workplans to be monitored through daily escalation tool and monthly quality audit.	2.1.6 Confirmed at Senior Nurses Meeting 11th February 2016 that shift workplans are to be in use on all wards, and any changes to the workplan due to challenges or pressures should be escalated to the Matron through the Daily Escalation Tool.	Matron	1st April 2016
2.2 The over occupancy of beds must be addressed as a matter of urgency.	2.2.1 The immediate use of the daily escalation support tool will be utilised for any bed which is being required.	In use across all wards; to be reiterated and included in all Senior Nurses Meetings. It was agreed by the Divisional Leadership Team on 15 February 2016 that to ensure the safest environment with appropriate staffing levels in the current accommodation, Hergest will operate 2 x 16 bed wards (plus PICU).	Locality Manager; Matron	1st April 2016 Completed
	2.2.2 Divisional Leadership Team	2.2.2 See above	Divisional	Completed

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	has provided definitive operational guidance regarding the management of finite bed numbers in the Hergest Unit (see above).		Leadership Team	
	2.2.3 The guidance document will set out bed management guidelines to staff and managers with regard to bed pressures and escalation when required.	The Hergest Operational Policy will be reviewed and revised to ensure clarity for admissions, including bed management.	Matron/Locality Manager	31st March 2016
	2.2.4 To manage capacity the Division will develop and maintain region-wide Bed Status Dashboard, accessible to Duty Nurses, Home Treatment Teams, Matrons and On-Call Managers.	2.2.4 Bed Management and Patient Flow is currently being reviewed by Divisional Leadership Team. An existing patient flow system used in acute physical health care will be considered and adapted for use in mental health care.	Interim Programme Consultant	31st August 2016
	2.2.5 Division to prescribe whole system "patient flow" protocols and apply to service, including Continuing Health Care, Delayed Transfer of Care, discharge planning milestones.	See 2.2.4	Interim Programme Consultant	31st August 2016
2.3 Staff assigned to the bronze on call system need to have improved knowledge of the Hergest unit to ensure their decisions are appropriate so that staff and patient safety is not compromised because of those	2.3 Divisional Leadership Team has provided definitive operational guidance regarding the management of finite bed numbers in the Hergest Unit.	See 2.2.2 above.	Matron/Locality Manager/ Divisional General Manager	31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
decisions.	The revised Operational Policy document will set out bed management guidelines to staff and managers with regard to bed pressures and escalation when required.			
2.4 A review of usage of personal alarms is required to ensure staff are allocated and use alarms when on duty.	2.4 Personal alarms are available in sufficient numbers for staff and should be in use on wards.	2.4 In use across all wards; to be reiterated and included in all Senior Nurses Meetings.	Locality Manager; Matron	Complete
3. The Multi-Disciplinary Team				
3.1 All members of the MDT must feel part of the team and that their opinions are valued and respected within the MDT.	3.1 Staff engagement exercise to be completed for West Locality to understand specific issues and challenges to good MDT working across all specialities. Implement the use of the NHS Engagement Diagnostic Tool and the NHS Wales staff engagement resource for all leadership roles in West Locality.	3.1 Quality and Safety Lead supporting Locality Manager to begin implementation.	Locality Manager	31st August 2016
4. Patient Therapies and Activities				
4.1 The appointment of activity co-ordinators is required to ensure the provision of OT is not negatively impacted upon.	4.1 Two activity co-ordinators have been appointed and are pending employment checks. Expected to start work by April 2016.	4.1 Complete	Matron	1st April 2016
5. General Healthcare				
5.1 The areas identified regarding the frailty project must be addressed, specifically bed availability provision, specialist staff, staff training and	5.1.1 Division to consider development of complex / frail health care either within the existing ward environments or	Linked to 2.2.2 Divisional Leadership Team to explore alternative inpatient	Director of Nursing	31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
admissions for patients under the age of 65.	whether a separate ward environment would be more appropriate.	environments able to provide safe, age appropriate care for complex, frail patients.		
	5.1.2 The Division to re-establish use of the falls pathway already introducedto clinical areas. The monthly quality audit on each inpatient ward will provide a level of assurance required with daily monitoring by Ward Manager.	The monthly quality audit on each inpatient ward will provide a level of assurance required with daily monitoring by Ward Manager.Confirmed at Senior Nurses Meeting 11th February 2016 that falls pathway will be in use across all wards; to be reiterated and included in all Senior Nurses Meetings.	Locality Manager, Matron	Completed
	5.1.3 Division to investigate and procure as appropriate assistive technologies and supplementary equipment with regards to falls prevention, i.e. call systems that are ligature safe and bed sensors / alarms.	See 1.4	Matron	29th February 2016
	5.1.4 Division to commence active monitoring of the levels and complexity of patients currently under its care. To provide assurance that appropriate risk mitigations are in place.	See 2.1.1 Acuity review to be undertaken.	Locality Manager; Matron	31st March 2016
	5.1.5 A review of specialist skills required to support and meet all physical and mental health needs	See 2.1.1 To be based on results of acuity review.	Director of Nursing	31st August 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	must be undertaken across all inpatient areas of the Division.			
	5.1.6 Compliance against mandatory training to be reported in Locality Governance Meeting.	5.1.6 Report is sent to Locality Governance Meeting bi-monthly.	Divisional Training and Development Co-ordinator	29th February 2016
	5.1.7 Specialist training needs analysis to be undertaken as highlighted above.	See 5.1.5	Director of Nursing	31st August 2016
	5.1.8 Training in complex / frail health care issues to be delivered and ward "champions" identified to lead of care issues.	Training – see 5.1.5. Champion - The Locality OPMH Matron has been asked to be a visible presence on the Hergest Unit to support staff and to act as champion.	Matron; OPMH Matron	31st March 2016
6. Training				
6.1 A standard approach needs to be applied to all staff files to ensure that evidence of all appointments is consistent.	6.1 Staff file audit to be undertaken against standard guidelines of what information should be held in paper copy and what information should be on ESR.	6.1 to begin in May 2016	Locality Manager	31st May 2016
6.2 A review of staffing is required and recruitment to some key posts is necessary to ensure wards are operating at full complement.	6.2 Ward clerk has been appointed and pending employment checks. Expected to start work by April 2016.	6.2 Complete	Matron	1stApril 2016
6.3 Staff morale, particularly on Taliesin ward needs improvement, with a specific focus on the time frame to resolve issues and staff dynamics.	See 3.1 Staff engagement exercise.	3.1 Quality and Safety Lead supporting Locality Manager to begin implementation.	Locality Manager	31st August 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
6.4 Debriefing/lessons learnt must form part of staff communication to ensure good practices are continually re-enforced and risks mitigated as far as possible. There are processes in place to ensure that lessons learnt are presented to the West Governance Meeting and the Divisional Leadership Team, however cascade processes are needed to ensure information is shared with all staff in the team.	6.1 Locality Scorecard is being developed which will capture this information and provide a route for cascading through the teams.	6.2 Locality Scorecard is being developed.	Interim CRES Programme Manager	30th June 2016
7. Governance				
7.1 A review of the governance/audit systems and processes need to take place to ensure the health board has robust and adequate information conveyed to them.	7.1 Governance processes across the Division are currently being reviewed. The Division will have a formal Quality, Safety and Experience Committee to act as central hub for all governance and audit information and ensure the appropriate flow of this information up and down through the organisation.	7.1 New governance structures and processes are being developed and will be introduced over the year as processes are finalised.	Director of Nursing; Associate Director Governance	30th June 2016
7.2 All the areas identified must be addressed, specifically: 7.2.1 A recruitment strategy to fill the high number of RC vacancies	7.2.1 A recruitment plan was put to the Medical Director and Director of Workforce and Development in July 2015. The Divisional Clinical Director will continue to seek support for this plan at a Health Board level.	7.2.1 The Divisional Clinical Director will continue to seek support for this plan at Health Board level.	Divisional Clinical Director	31st December 2016
7.2.2 A bed management strategy to manage the demand of in-patient beds	7.2.2 See 2.2.4	See 2.2.4	Interim Programme Consultant	31st August 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
7.2.3 An acceptable time frame for the delivery of new furniture needs to be established	7.2.3 See 1.5.1; furniture is being delivered in February 2016.	7.2.3 New non-ligature beds have now been procured and are to be delivered on 17th February 2016.	Locality Manager	17th February 2016
7.2.4 A review of and strategy to deal with the issues on Taliesin ward regarding staff morale	7.2.4 See 3.1; staff engagement exercise.	3.1 Quality and Safety Lead supporting Locality Manager to begin implementation.	Locality Manager	31st August 2016
8. Monitoring the Mental Health Measure				
8.1 The review found that CTPs were not being appropriately updated to reflect inpatient care planning, including risk assessment, observations and Mental Health Measure documentation. There needs to be a consistent approach to management of CTPs from community and inpatient across the Division.	8.1.1 Locality Manager to discuss with colleagues in Central and East to understand how this issue is managed elsewhere.	8.1.1 Locality Manager to discuss in March.	Locality Manager	31st March 2016
	8.1.2 Results of that region-wide review to be discussed with Head of Nursing.	8.1.2 Locality Manager to present finding to Director of Nursing for consideration.	Director of Nursing	30 April 2016
	8.1.3 The Division will continue to monitor valid CTPs asa a percentage of team caseload: the standard set is 90%	8.1.3 On the 27th January 2016, the Division had achieved 85% compliance against this standard	Mental Health Measure lead: General Manager	30th June 2016
9. Application of the Mental Health Act				
9.1 Section 17 leave forms to be appropriately managed in line with the Mental Health Act.	9.1Reminder to all nursing staff regarding their responsibilities for ensuring forms are appropriately updated. Monitor appropriate updating of Section 17 leave forms through use of the monthly	The monthly quality audit on each inpatient ward will provide a level of assurance required with daily monitoring by Ward Manager.	Locality Manager, Matron	1st April 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	Quality Audit.			
9.2 Observational records should be signed and dated and filed in the patient's notes.	9.2Reminder to all nursing staff regarding their responsibilities for ensuring observational records and signed, dated and filed. Monitor quality of observational records through use of the monthly Quality Audit.	9.2 Confirmed at Senior Nurses Meeting 11th February 2016 that observational records should be signed and dated and filed in the patient's notes; to be reiterated and included in all Senior Nurses Meetings.	Locality Manager, Matron	Completed
9.3 Patients should be read their rights and offered the services of an IMHA, and this should be evident from the file. Processes already exist to ensure that this occurs at the time of a change to the patient's status; however there are currently no systems to ensure that patients are reminded of their rights or their access to an IMHA at relevant stages of their care.	9.3.1 Reminder to all nursing staff regarding their responsibilities for reminding patients of their rights and IMHA services, particularly at times when the patient's capacity is noted to have improved.	9.3.1 The monthly quality audit on each inpatient ward will provide a level of assurance required with daily monitoring by Ward Manager.	Locality Manager, Matron	1st April 2016
	9.3.2 Adapt checklist in order to provide prompts to nursing staff on reaffirming to patients their rights under s132 MHA and IMHA access at periodic intervals. This will need to apply cross-region.	9.3.2 Locality Manager to discuss with Mental Health Act Manager and Co-ordinator.	Locality Manager; Mental Health Act Manager	31 March 2016
9.4 Hospital Managers reports should be received in a timely manner.	9.4 Mental Health Act Co-ordinators to escalate any delays with Hospital Managers reports through the Daily Escalation Support Tool, to the Locality Manager or Divisional Clinical Director for action.	9.4 Mental Health Act Manager will issue reminder to all staff who prepare Hospital Managers reports that any delays will be escalated as a matter of urgency from now on.	Locality Manager; Mental Health Act Manager.	29thFebruary 2016
9.5 Robust systems should be in place	9.5.1 The Mental Health ActCo-	9.5.1 The Clinical	Mental Health	31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
to ensure that locum doctors are checked for Approved Clinician and Section 12.2 status.	ordinator must be notified immediately, via the Clinical Services Co-ordinator, of any/all changes to the senior medical workforce, including the full name of the proposed locum, and geographical area of employment to be covered.	Services Co-ordinator is integrating an alert for the Mental Health Act Co-ordinators into existing processes.	Act Manager; Business Manager	
	9.5.2 Divisional Clinical Director to write to Office of the Medical Director to request priority is given to responding to requests for approval.	9.5.2 Divisional Clinical Director to write to Office of the Medical Director	Divisional Clinical Director	29th February 2016