Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health Service Inspection (Unannounced)

Talygarn Ward, County Hospital

Aneurin Bevan University Health Board

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1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW completed an unannounced inspection of County Hospital mental health service within Aneurin Bevan Health Board on the evening of Sunday 15 to Tuesday 17 January 2017. The following hospital sites and wards were visited during this inspection:

- Talygarn Ward – Adult Mental Health

Our inspection team was made up of one HIW inspection managers and two clinical peer reviewers, one of whom was the nominated Mental Health Act reviewer.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act and the 2016 Mental Health Code of Practice for Wales.

Further details about our approach to inspection of NHS services can be found in Section 6.

2. Context

Talygarn Ward, County Hospital currently provides mental health services in the Pontypool area of Torfaen County Council. Talygarn Ward falls under the adult mental health directorate within Aneurin Bevan Health Board.

Talygarn is an acute mental health ward that provides admission and assessment for patients within the local authorities of Torfaen and north Monmouthshire and for the whole of Aneurin Bevan between the hours of midnight and 9am.

Talygarn Ward is a stand alone ward on the County Hospital site. The ward is located on the ground floor with the associated community mental health team located upstairs.

The ward is a mixed gender with 21 beds that comprised of two 4-bedded gender specific dormitories, two 2-bedded gender specific dormitories and nine single bedrooms. At the time of the inspection two bedrooms were in the process of being refurbished, therefore there were only 19 beds and all were full.

The staff team includes a ward manager and two deputy managers. The ward has a number or registered mental health nurses and health care support workers. The multi-disciplinary team includes three responsible clinicians who work at Talygarn Ward and their respective community localities, a psychologist who works with the in-patient and community teams and a designated ward occupational therapist.

3. Summary

Overall, we found evidence that staff at Talygarn Ward treated patients with respect to provide patients with individually focused care. However, Strategic decisions by the health board have impacted detrimentally on the day-to-day operation of Talygarn Ward.

This is what we found the service did well:

- Staff were positive about the openness of the team and the support they received from each other and the ward management.
- There was good management of medication at Talygarn Ward.
- Staff provided care to patients at Talygarn Ward in a respectful manner.
- There was positive collaboration between the in-patient and community teams.

This is what we recommend the health board could improve:

- Its model of care for out-of-hours admissions and in-patient capacity so that patients are admitted in a timely manner to their local hospital.
- The environment and facilities on the ward to improve the privacy and dignity of patients.
- The provision of personal alarms for staff to maintain the safety of staff, patients and visitors.
- The provision of mental health Senior House Officer (SHO) cover to meet the health board's SHO requirements.
- Support and facilities for ward staff to complete their mandatory training in a timely manner.

4. Findings

Quality of patient experience

Throughout our inspection we observed staff treating patients with respect and kindness. Staff made every effort to maintain patient dignity; however shared dormitory accommodation only provided a basic level of privacy for patients.

We are concerned about the undignified manner in which patients are transferred between hospitals within the health board to meet the capacity needs of the adult mental health in-patient population. The health board must review its model of care and in-patient capacity to ensure it meets the needs of its population in a timely manner.

There was positive collaborative working between the in-patient service at Talygarn Ward and the Community Mental Health Team (CMHT) that benefited the patient journey.

Dignified care

Standard 4.1 Dignified care

People's experience of healthcare is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, cultural, language and spiritual needs.

Throughout our inspection we observed staff treating patients with respect and kindness. The majority of patients we spoke with confirmed they felt their privacy and dignity was respected and spoke positively about staff on Talygarn Ward.

The ward office had a *patient status at a glance board*[1] displaying confidential information regarding each patient being cared for on the ward. There were

[1] A board that provides staff with a quick reference to essential information about the individual patients being cared for on the ward.

facilities to hide the confidential information when the boards were not in use, which we observed to be the practice of staff throughout our inspection.

The ward comprised of two 4-bedded gender specific dormitories, two 2-bedded gender specific dormitories and nine single bedrooms. The bed areas within the dormitories were separated by curtains that only provided the most basic form of privacy for patients and therefore impacted negatively on the patient experience.

Two of the single bedrooms had an en-suite toilet, sink and shower. There were three showers, a bath and additional toilets for patients on the ward.

Patients said that on the whole, staff would respect their privacy and dignity and knock on their bedroom doors before entering. The vision panels for bedroom doors for staff to undertake observations were covered by curtains on the outside of the door. Therefore patient's privacy was sufficiently maintained by the curtain when observations were not being undertaken.

Patients had access to an enclosed court yard. Despite some artwork on one of the wall/gate areas this area was rather bare and uninviting. Patients were able to smoke in this area if they wished but the area was not well maintained.

There was a lounge, dining room, a quiet room and an additional room that was being developed in to a patient area for making hot and cold drinks. The lounge and dining room were small for the number of patients that were being cared for on the ward. Throughout the inspection we saw a number of patients loitering or pacing the main corridor.

Overall the ward environment was small for 21 patients; there was limited free access to space for patients apart from the communal areas, bed areas or the outside court yard.

The ward environment appeared clean and the decoration was in a good state. However, the ward environment was bland with limited artwork or displays to break up the continuous single-coloured walls in the main corridor and communal rooms.

There was no dedicated meeting/visitor room in which patients could speak to staff or visitors in private, however patients could use the quiet room if available. There were no dedicated child friendly visiting facilities either, staff gave examples of the options available if there were any under 18s visiting patients at the hospital, however these were not wholly appropriate or reflect the guidance in the Code of Practice for Wales, paragraphs 11.15 & 11.17.

The use of mobile phones by patients was allowed, to maintain contact with family and friends. Access to mobile phones was managed on an individual patient risk basis. Patients and staff told us that ward telephones could also be used to contact relatives and there were payphones on the wards. However, one of the payphones was damaged and could not be used, the health board were unable to confirm if or when this would be repaired. Neither of the pay phones were in private areas, one was located in the entrance area of the ward which was regularly busy, the other was located in the dining room which was not always private. We recommend that the health board should consider what arrangements can be made to provide patients with a private place to make phone calls.

There were concerns about the transfer of patients from Talygarn Ward to other mental health hospitals within Aneurin Bevan and South Powys to accommodate the admission of patients. Transfers were made due to insufficient bed capacity and the health board's procedure for all patient admissions to be facilitated through Talygarn Ward between midnight and 9 am. This is detailed later in the report under **Timely Care** (*Standard 5.1 Timely Access*). However, it was evident that transferring patients to accommodate new admissions is inappropriate and impacted upon patient's dignity. Patients and staff raised their concerns regarding this process.

Improvement needed

The health board must review the dormitory accommodation and provide single bedroom accommodation.

The health board must review the visual appearance of the ward and garden area to provide appropriate decoration, pictures, etc.

The health board must ensure that there are appropriate visiting facilities available on Talygarn Ward, including child friendly facilities.

The health board must ensure that payphones are in working order and provide patients with a private area to make phone calls.

Standard 4.2 Patient information

People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them make an informed decision about the care as an equal partner.

Standard 3.2 Communicating effectively

In communicating with people health services proactively meet individual language and communication needs.

On wards there were patient notice boards which displayed advocacy information and other relevant information leaflets and posters.

Unlike other areas of the health board's mental health service the wards did not display pictures of the members of staff who worked on the wards and what their roles were.

Timely care

Standard 5.1 Timely access

All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

Talygarn Ward provided out-of-hours adult admissions (midnight to 9am) for the whole of Aneurin Bevan Health Board. In an attempt to accommodate the out-of-hour admissions Talygarn had designated two beds. Once a patient had been admitted to Talygarn Ward they would be transferred (typically the next day) to the hospital within the health board which corresponded with their area of residence or remain at Talygarn Ward if from its locality. The other hospitals include St Cadoc's (Caerleon), Ysbyty Ystrad Fawr (Caerphilly), Ysbyty Aneurin Bevan (Ebbw Vale) and Bronllys Hospital (Brecon) part of Powys Teaching Health Board.

During the out-of-hours the admission doctor would be located at Talygarn. During the first evening of our inspection we were present whilst two potential patients had been brought to Talygarn Ward for assessment. Whilst one person was being assessed by the doctor the other person was waiting within the quiet room.

There were clear bed capacity issues within the health board's adult mental health service. Speaking to staff and patients it was noted that the mental health service had developed the inappropriate practice where patients would be transferred from Talygarn Ward to other hospitals within the health board and Bronllys Hospital to ensure that there were two admission beds available.

It was evident from records that this practice had become common place, particularly between August and November 2016.

We were informed by staff that whilst they would prefer not to transfer patients, it was the necessity to do so to meet the needs of the health board's service provision. Staff stated where possible they would identify the more settled patients to be transferred. Staff would ask patients if they would mind being moved, however staff stated that some patients felt that they had little option but to comply. The assessment bed provision appears to add to the anxiety of patients on the ward in the evenings and at night.

Staff stated that they had observed a further negative impact on patient wellbeing when, on occasions, patients would become anxious during the afternoon and evening with the expectation that they may be asked to move hospital.

There were also occasions that patients had been awoken during the night and been asked to move because the ward had more patient admissions than the number of available beds.

There were occasions where patients were moving between two or three hospitals on subsequent days. We noted that one patient, over two months, had been transferred at least seven times, accumulating over 250 miles in hospital transfers.

The practice of moving patients to meet the needs of the service and not the individual patient's needs is wholly inappropriate. Despite that transfers of patients had in December 2016 decreased quite significantly, it was evident that the health board's service model was not meeting the needs of its population and requires review. Patients should not be moved across the health board to be admitted out-of hours for the benefit of the service. In no instance should a patient be transferred to another hospital to accommodate an admission due to insufficient bed numbers. The health board must review the service model that is in operation to ensure that there is timely and appropriate access to their service.

Following the inspection the health board have confirmed that there has been no requirement to move patients to other wards to create bed capacity at Talygarn during December 2016 to February 2017.

It was positive to note the collaborative working between the in-patient service at Talygarn Ward with the Community Mental Health Team (CMHT) and Home Treatment Team that were located within the same building as

Talygarn Ward. Staff from both teams spoke positively about the joint working between the teams that benefited the patient journey and care received.

Improvement needed

The health board must review the adult in-patient mental health model to ensure that there is sufficient capacity and processes to timely admit patient to their local hospital when required.

Delivery of safe and effective care

On the whole documentation in regards to the Mental Health Act and the Mental Health (Wales) Measure was completed to a good standard. However, staff did not always indicate whether there was patient and/or family involvement.

Staff provided care in a safe and effective manner; however staff did not have access to personal alarms. The health board must provide personal alarms to maintain the safety of staff, patients and visitors.

There was safe medicine management at Talygarn Ward; however the health board need to ensure that the recording and review of *As Required* medication is completed by staff.

Application of the Mental Health Act

We reviewed the statutory detention documents of five of the detained patients being cared for on Talygarn Ward. The documentation held evidenced that the detentions were compliant with the Mental Health Act (the Act). We noted the following areas of improvement:

- Section 17 Leave authorisation forms did not indicate if a patient, relative or other concerned party had received a copy of the form.
- Spent or expired Section 17 Leave authorisation forms should be marked as no longer valid; this was not always the case.

Improvement needed

The health board must ensure that Section 17 Leave forms indicate who has received a copy.

The health board must ensure that all spent or expired Section 17 Leave authorisation forms are marked as no longer valid.

Care planning and provision - Monitoring the Mental Health (Wales) Measure 2010

We reviewed three sets of Care and Treatment Plan documentation. The following observations were identified:

- Care and Treatment Plans were complete and appeared to be kept up-to-date; however they were not always signed and dated by staff and/or the patient as required under the Mental Health (Wales) Measure 2010.
- Risk assessments set out the identified risks and how to mitigate and manage them.
- The care and treatment plans identified patients' care co-ordinators.
- The care and treatment plans identified patients' nearest relatives; however it was not always clear that patients' families were involved in the care planning process or, if not, why.
- There was evidence of timely reviews of patients' Care and Treatment Plans.

Improvement needed

The health board must ensure that all Care and Treatment Plans are signed and dated by staff and the patient. Staff must indicate if patient has declined to sign.

The health board must ensure that all Care and Treatment Plans document family involvement or indicate why this has not occurred.

<u>Safe care</u>

Standard 2.1 Managing risk and promoting health and safety

People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced and prevented.

The ward was secured against unauthorised access via a locked door; staff opened the door via an intercom. Throughout the inspection the door was also secured to prevent anyone leaving the ward. At the time of the inspection there were some patients who were receiving care as an informal patient, voluntarily and not detained under the Mental Health Act. However, there was no information on display for informal patients to inform them that they were able to leave, and how to do so if they wished.

It was of concern that staff did not carry personal alarms; they had 2-way radios so that they could alert other staff if they required assistance. However, this is insufficient and staff must be provided with personal alarms so that they can easily alert colleagues, particularly if they are unable to talk.

At the time of our inspection the health board were undertaking maintenance work to replace fixtures with anti-ligature equivalents. This work was due to be completed by the end of March 2017 and would improve the environment of care for the safety of patients.

The patients we spoke to told us they felt safe at the hospital and felt that they could raise any concerns with the staff on the ward.

Incidents were recorded on the health board's electronic incident recording system. This allowed for analysis of incidents so that trends and frequencies could be reviewed. Senior staff described suitable arrangements for reporting and investigating patient safety incidents. We were told that learning from incidents that had happened on the wards were shared with the staff team. We were also told that learning form incidents was shared more widely amongst the hospital and mental health services within the health board at managers' meetings.

The ward had a defibrillator and other emergency equipment that was stored in the ward's clinic room, weekly audits were undertaken to ensure that all items were present and in date.

Improvement needed

The Health Board must ensure that informal patients are made aware of their right to leave the hospital if they wish, 2016 Code of Practice for Wales paragraph 4.22.

The Health Board must ensure that all staff working at Talygarn Ward have personal alarms.

Standard 2.5 Nutrition and hydration

People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury.

Patients on Talygarn Ward were provided with meals from the main hospital kitchen for breakfast, lunch, evening meal and supper. Patients choose their meals from the hospital menu. Patients had access to refreshments throughout the day.

The majority of the patient meals were prepared on site. Patients and staff did not have any concerns about the quality of the food provision on Talygarn

Standard 2.6 Medicines management

People receive medication for the correct reason, the right medication at the right dose and at the right time.

On the whole we found that the administration of medication to patients was managed well on Talygarn Ward. The medication trolleys were appropriately secured within the clinic rooms. All medicine cupboards were locked appropriately for the safe storing of medicines. All Controlled Drug cupboards were secure and all entries in the Controlled Drug book were signed as required by two members of staff when controlled drugs were removed from the cupboard.

Staff measured and recorded the temperature of the medication fridges daily in the clinics to ensure that medicines were being stored at the required temperature.

Staff on all wards had access to the health board's Medicine Management Policy via the health board's intranet.

On review of the Medication Admission Records (MAR Charts) we noted that the use of *As Required* medication was not always documented in the individual patient's notes. Where it had been documented, there wasn't always a record of why the *As Required* medication was necessary. It is important that nurses record when and why *As Required* medication is used in patient notes.

We also noted on the review of MAR Charts was that in some instances *As Required* medication was being regularly used. However, there was no information to evidence that the regular use had been reviewed by the multi-disciplinary team and consider whether the medication would be best prescribed as *Regular* as opposed to *As Required*, or if alternative medication would be more appropriate.

Improvement needed

The Health Board must ensure that staff record the reasoning for the use of *As Required* medication in patient notes.

The Health Board must ensure that the multi-disciplinary undertake and document reviews of regular *As Required* medication usage.

Quality of management and leadership

Talygarn Ward was managed by the ward manager who was supported by two deputy ward managers and regular support from the Senior Nurse.

Strategic decisions by the health board, particularly the out-of-hours model and the closure of another ward, have impacted detrimentally on the day-to-day operation of Talygarn Ward. The health board must review these strategic decisions to alleviate the pressure on the operation of Talygarn Ward.

At the time of our inspection the health board was unable to fulfil Senior House Officer (SHO) requirements from February 2017. The Health Board must ensure that there are appropriate arrangements in place to meet these requirements.

Governance, leadership and accountability

Health and Care Standards, Part 2 - Governance, leadership and accountability

Effective governance, leadership and accountability in keeping with the size and complexity of the health service are essential for the sustainable delivery of safe, effective person-centred care.

It was positive that throughout the inspection that the staff at Talygarn Ward were receptive to our views, findings and recommendations.

We saw very good management and leadership on the ward by the newly appointed ward manager and deputy ward managers. The staff we spoke to commented positively on multi-disciplinary team (MDT) working. Staff said the MDT work in a professional and collaborative way and individual views were sought and valued.

There was clear support to the ward staff from senior management; with the Senior Nurse regularly present on the ward. This provided guidance to those staff that were new in their roles as managers.

As stated above **(Timely Care)** the out-of-hours model (that was introduced in 2013) where by all Aneurin Bevan patients are admitted into Talygarn Ward

impacted on patient experience. There was also a significant impact in the provision of timely and dignified care for patients at Talygarn Ward (and throughout the health board) when patients were transferred across the health board to facilitate out-of-hours admissions at Talygarn Ward.

The health board in January 2017 developed a document for inpatient bed management contingency in relation to insufficient in-patient beds. Whilst this documents senior management governance around the process, the document identifies the use of temporary bed in non-bedroom areas. Whilst senior management advised HIW that these areas were safe to accommodate patients short-term, i.e. overnight and no longer than 24 hours; it is not appropriate for patients to be accommodated out-side of bedroom / dormitory areas.

In addition, in December 2015 Talygarn Ward being the locality ward for north Monmouthshire patients[2]. There were no increases in bed numbers to facilitate this change; therefore there were fewer beds to accommodate a larger catchment area.

These two decisions by the health board have impacted significantly in the provision of care on Talygarn Ward. As stated as Improvement Needed in **Timely Care** the health board must review these decisions and the current service model to ensure that the provision of inpatient mental health services meet the needs of the health board's population.

From February 2017 the health board would not have sufficient Senior House Officer (SHO) cover, with only six of the 21 mental health SHO slots being filled. At the time of our inspection the health board did not provide sufficient assurance on how the significant shortfall would be met.

During our inspection we were informed of a potential patient admission from one of Aneurin Bevan general hospital wards. The patient required specialist physical care that the team at Talygarn Ward were not trained to provide. It was evident that the ward manager was under significant pressure from

[2] In 2010 the closure of a Rholben Villa (11 beds), Maindiff Court Hospital, Abergavenny resulted Carn-y-Cefn ward, Ysybyty Aneurin Bevan in Ebbw Vale becoming the locality ward for north Monmouthshire patients. Due to clinical and staffing pressures at Carn-y-Cefn, in December 2015 Talygarn ward became the locality ward for north Monmouthshire patients.

colleagues within the general hospital to complete training so that the patient could be transferred to Talygarn Ward.

We raised our concerns with the Ward Manager and Senior Nurse that the ward staff, even after training, would not be sufficiently experienced in providing the care for the patient. We reiterated this with other senior management at the inspection feedback who provided verbal assurance that the transfer would not be occurring imminently; if a transfer did occur in future appropriate arrangements would be put in place to support Talygarn Ward staff.

We followed up our concerns with the health board through our Immediate Assurance Process by writing to the health board. The health board confirmed what arrangements would be in place to ensure that, if the patient was transferred, there would be appropriate input of physical and mental health care for the patient.

However, this incident highlighted the lack of communication between senior management and ward staff within the mental health directorate with this complex case. We were also concerned with the pressures between physical health and mental health wards within the health board that may have resulted in a patient being inappropriately transferred without the required care package being in place.

During the inspection we were unable to identify what governance arrangements were in place for managing the care of a patient with significant physical health and mental health needs. However, we were reassured by the actions and leadership of the Talygarn Ward Manager who was insistent that a patient would only be transferred to the ward when all physical health and mental health arrangements were in place.

Improvement needed

The Health Board must ensure that there are appropriate arrangements in place to meet the health board's mental health Senior House Officer (SHO) requirements.

Staff and resources

Standard 7.1 Workforce

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

Talygarn Ward had a newly appointed ward manager who had worked on the ward as a registered nurse for a number of years prior to taking up the new role. The ward manager was supported by two recently appointed deputy ward managers. It was evident that they provided leadership for the ward team.

At the time of our inspection there were five Whole Time Equivalent (WTE) nursing vacancies which had all recently been appointed to by the health board. The employees were due to take up the posts in the following couple of months due to other employment commitments. Due to the vacancies the ward had been covering shifts with the use of health board bank staff or ward staff taking additional hours.

Staff rotas identified that there were unallocated shifts in registered nurses and health care support workers each week during December 2016. Unfilled registered nurse shifts varied between five and 15 shifts per week, unfilled health care support workers varied between seven and 13 shifts per week. Staff stated that the health board's bank system had not always been able to provide sufficient staff to fulfil the rota requirements for Talygarn Ward. Therefore ward staff wither worked additional shifts or the shift would be short staffed.

On reviewing staff rotas it was evident that some members of ward staff were undertaking significant increase in hours to fulfil the staff rotas. Staff spoke of great teamwork to assist each other in ensuring shifts were not short. Whilst this is commendable to the ward staff we raised our concerns about the sustainability of staff working additional hours over long periods. The recent appointment to vacancies should ease the situation. However, the health board must ensure that they monitor the number of hours staff are working for the welfare of staff and provide support where required.

Speaking to staff they confirmed that they were supported to undertake training, with completion rates improving since the appointment of the ward manager. However, staff confirmed that they often found it difficult to complete training due to the difficulties in fulfilling staff rotas. Staff were committing their

time to undertake additional shifts to support colleagues as opposed to undertake training.

To add to the difficulties in staff completing training there was no dedicated computer access within a quiet room for to undertake training eLearning to not be disturbed; nor sufficient computers to complete eLearning on the ward.

There was newly appointed occupational therapist for Talygarn Ward. The occupational therapist had been developing the therapeutic activates for patients at Talygarn and had a clear vision of future developments with organisations within the community that would be available to patients upon discharge from hospital. The work that the occupational therapist was undertaken would benefit the patient group and support them on their patient pathway in hospital and the community. It was also positive to note that the health board were recruiting an occupational therapist technician to assist the occupational therapist and lead on suitable activities.

There was input from a psychologist who worked with the ward and the community teams. The psychologist had significant input in to patient care. The psychologist also provided support to staff by running group sessions for staff to reflect upon events, incidents and specific cases.

Improvement needed

The health board must ensure that there are suitable facilities available at Talygarn Ward to support staff to complete mandatory training.

The health board must ensure that staff have dedicated time to complete mandatory training.

5. Next steps

This inspection has resulted in the need for the health board to complete an improvement plan (Appendix A) to address the key findings from the inspection.

The improvement plan should clearly state when and how the findings identified at Talygarn Ward, County Hospital will be addressed, including timescales.

The action(s) taken by the service in response to the issues identified within the improvement plan need to be specific, measureable, achievable, realistic and timed. Overall, the plan should be detailed enough to provide HIW with sufficient assurance concerning the matters therein.

Where actions within the service improvement plan remain outstanding and/or in progress, the service should provide HIW with updates to confirm when these have been addressed.

The improvement plan, once agreed, will be evaluated and published on HIW's website.

6. Methodology

The Health and Care Standards (see figure 1) are at the core of HIW's approach to inspections in NHS Wales. The seven themes are intended to work together. Collectively they describe how a service provides high quality, safe and reliable care centred on the person. The Standards are key to the judgements that we make about the quality, safety and effectiveness of services provided to patients.

Where appropriate, HIW inspections of mental health services consider how services comply with the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards.

Figure 1: Health and Care Standards 2015

Mental health service inspections are unannounced and we inspect and report against three themes:

- **Quality of the patient experience:** We speak to patients (adults and children), their relatives, representatives and/or advocates to ensure that the patients' perspective is at the centre of our approach to how we inspect

- **Delivery of safe and effective care:** We consider the extent to which services provide high quality, safe and reliable care centred on the person

- **Quality of management and leadership**: We consider how services are managed and led and whether the culture is conducive to providing safe and effective care. We also consider how services review and monitor their own performance against relevant standards and guidance.

We reviewed documentation and information from a number of sources including:

- Information held by HIW

- Conversations with patients and interviews with staff

- General observation of the environment of care and care practice

- Discussions with senior management within the directorate

- Examination of a sample of patient medical records

- Scrutiny of particular policies and procedures which underpin patient care

- Consideration of quality improvement processes, activities and programmes.

HIW inspections capture a snapshot of the standards of care patients receive. They may also point to wider issues associated with the quality, safety and effectiveness of healthcare provided and the way which service delivery upholds essential care and dignity.

We provide an overview of our main findings to representatives of the service at the feedback meeting held at the end of each of our inspections.

Any urgent concerns emerging from these inspections are brought to the attention of the service via an immediate action letter. These findings (where they apply) are detailed within Appendix A of the inspection report.

Appendix A

Mental Health Service: Improvement Plan

Service: Talygarn Ward, County Hospital

Date of Inspection: 15 – 17 January 2017

Page Number	Improvement Needed	Standard	Health Board Action	Responsible Officer	Timescale
Quality of the patient experience					
7	The health board must review the dormitory accommodation and provide single bedroom accommodation.	4.1	The remodelling of Adult Inpatient and Crisis Resolution Home Treatment Team Services is currently taking place. As part of this work, an options appraisal paper will be developed to consider the feasibility of creating single bedroom accommodation on Inpatient Wards.	Divisional Lead Nurse	September 2017
7	The health board must review the visual appearance of the ward and garden area to provide appropriate decoration, pictures, etc.	4.1	Garth (Gwent Art in Health, Charity) have met with the ward OT to arrange five sessions for the develop of patient artwork. Local businesses have donated artwork which will be displayed on the ward. New furniture will be purchased for the garden area.	Ward manager	September 2017

Page Number	Improvement Needed	Standard	Health Board Action	Responsible Officer	Timescale
7	The health board must ensure that there are appropriate visiting facilities available on Talygarn Ward, including child friendly facilities.	4.1	A visiting room will be allocated within the Talygarn Unit. This area will be staffed. Child friendly equipment will be acquired for the room.	Senior Nurse for Torfaen	April 2017
7	The health board must ensure that payphones are in working order and provide patients with a private area to make phone calls.	4.1	The phones will be repaired. Due to the risk of ligature it is not possible for the payphone to be located in a private area. If a patient wishes to make a private call this will be facilitated. A poster will be created to make patients aware of this.	Ward Manager	April 2017 March 2017
10	The health board must review the adult in-patient mental health model to ensure that there is sufficient capacity and processes to timely admit patients to their local hospital when required.	5.1	The remodelling of Adult Inpatient and Crisis Resolution Home Treatment Team Services is currently taking place.	Divisional Lead Nurse	September 2017
11	The health board must ensure that Section 17 Leave forms indicate who has received a copy.	Mental Health Act	The Section 17 Leave form has a section to document who has received a copy of the form. This will be considered as part of the Mental Health Act audit.	Mental Health Act Manger	June 2017

Page Number	Improvement Needed	Standard	Health Board Action	Responsible Officer	Timescale
Delivery of safe and effective care					
11	The health board must ensure that all spent or expired Section 17 Leave authorisation forms are marked as no longer valid.	Mental Health Act	All staff have been reminded, via the ward staff meeting, of the need to mark spent or expired Section 17 Leave forms.	Ward Manager	Complete
12	The health board must ensure that all Care and Treatment Plans are signed and dated by staff and patients. Staff must indicate if a patient has declined to sign.	Mental Health (Wales) Measure	Patients are asked to read and signed their care plan to confirm agreement. The CTP Lead has, so far, met with 10 of the 12 inpatient care coordinators to remind them of their responsibilities. This will also be considered as part of the annual Divisional CTP Audit.	Care & Treatment Planning Lead	June 2017
12	The health board must ensure that all Care and Treatment Plans document family involvement or indicate why this has not occurred.	Mental Health (Wales) Measure	The CTP Lead has, so far, met with 10 of the 12 inpatient care coordinators to remind them of their responsibilities. This will also be considered as part of ongoing line management of the Ward Care Coordinators.	Care & Treatment Planning Lead Ward Manager	June 2017 April 2017

Page Number	Improvement Needed	Standard	Health Board Action	Responsible Officer	Timescale
13	The health board must ensure that informal patients are made aware of their right to leave the hospital if they wish, 2016 Code of Practice for Wales paragraph 4.22.	2.1	A sign is now displayed informing patients of this right. The locked door policy will be complied with.	Ward Manager	Complete
13	The health board must ensure that all staff working at Talygarn Ward have personal alarms.	2.1	Costing will be obtained for a nurse call system for Talygarn Ward. This will be discussed at Ward Managers meeting to ensure that there is standardisation across all wards.	Senior Nurse for Talygarn	April 2017
14	The health board must ensure that staff record the reasoning for the use of As Required medication in patient notes.	2.6	This will be documented in the case notes by all staff. This was agreed at the ward staff meeting. All wards will be emailed to ensure that there is consistent approach.	Ward Manager	Complete
14	The health board must ensure that the multi-disciplinary team undertaken and document reviews of regular As Required medication usage.	2.6	Prescribers will be advised of the need to review As Required medication weekly via ward round. This will be considered in the pharmacy audit.	Clinical Director for Adult Services Mental Health Pharmacist	April 2017

Page Number	Improvement Needed	Standard	Health Board Action	Responsible Officer	Timescale
17	The health board must ensure that there are appropriate arrangements in place to meet the health board's mental health Senior House Officer (SHO) requirement.	Part 2 – Governance, leadership and accountability	This has been highlighted via the Health Boards Risk Register. The Ward has a Nurse Practitioner (Independent Prescriber). Two Nurse Practitioner posts have been advertised. The Out Of Hours on call rota is being filled using Locum SHO's. Full time agency locum SHO commenced to cover ward area. Short term medical workforce action plan developed with longer term strategy being developed through Divisional Medical Workforce Group.	General Manager	Completed In recruitment cycle Complete - February 17 Monthly review and update
19	The health board must ensure that there are suitable facilities available at Talygarn Ward to support staff to complete mandatory training	7.1	Compliance with mandatory training is currently 100% on the ward. A quiet space will be allocated for staff to undertake their mandatory training. A laptop will be purchased and Wifi is currently being made available on the Unit.	Ward Manger	April 2017
19	The health board must ensure staff have dedicated time to complete mandatory training.	7.1	All staff will be given dedicated time to complete their mandatory training.	Ward Manager	April 2017

Service representative:

Name (print): .....

Title: .....

Date: .....