Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health Service Inspection (Unannounced)

Prince Philip Hospital, Bryngofal Ward

Hywel Dda 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 Bryngofal adult mental health ward within Hywel Dda on the evening of 19 February 2017 and subsequent days of 20 and 21 February 2017. The following hospital sites and wards were visited during this inspection:

- Prince Philip Hospital, Bryngofal Ward, Adult Mental Health Service
- Prince Philip Hospital, Bryngolau Ward, Older People's Mental Health Service (see separate report)

Our inspection team was made up of two HIW inspection managers (one of whom led the inspection) 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.

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

2. Context

Bryngofal Ward, Prince Philip Hospital currently provides mental health services in the Llanelli area of Carmarthenshire County Council. Bryngofal Ward falls under the Adult Mental Health Directorate within Hywel Dda University Health Board.

Bryngofal Ward is an adult acute assessment mental health ward. The ward has 24 individual bedrooms; however, at the time of our inspection the ward was commissioned for 21 beds. This had been increased from 18 beds to assist in meeting the bed capacity pressures within the health board's adult mental health service.

The service employs a staff team which includes a ward manager and deputy ward manager. At the time of the inspection these posts were temporarily filled. The ward team includes a number of registered mental health nurses and health care support workers; however the ward was relying on the use of bank and agency staff to meet shortfalls in shifts due to vacancies and sickness.

3. Summary

Overall, we found evidence that Bryngofal Ward lacked appropriate systems and sufficient regular staff to provide safe and effective care for patients.

This is what we found the service did well:

- Staff provided care to patients on Bryngofal Ward in a respectful manner
- Occupational therapy input provided a good range of patient assessments and activities
- Detentions under the Mental Health Act were compliant with the Act.

This is what we recommend the practice could improve:

- The service model of adult inpatient mental health services within the health board to meet the needs of its population
- The safety procedures of the ward, particularly the suitability and availability of personal alarms
- The recruitment and retention of registered nurses and health care support workers to provide consistent care to patients
- The stability of leadership
- The completion of documentation, including Care and Treatment Plan documentation and enhanced patient observation charts.

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 and the en-suite bedrooms provided additional privacy for patients.

We found evidence of concern in regards to the bed capacity pressures on the health board's Adult Mental Health Service which on occasions resulted in patients sleeping in non-bedroom areas, such as Section 136 facilities or on lounge settees. 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.

It was positive to note that the newly appointed occupational therapist had commenced a weekly mutual self help group for patients.

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.*

We found that patients at the hospital were treated with dignity and respect by the staff working on Bryngofal 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 facilities to conceal the confidential information when the boards were not in use; however these were not being used consistently..

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

Patients had their own bedrooms with en-suite facilities including toilet, sink and shower. Patient bedrooms were suitably furnished and had sufficient space for the patient and their belongings. Patients were able to access their bedrooms freely and lock them from within; staff were able to over-ride the locks if required.

All en-suite doors had been removed and replaced with a shower curtain following a health board wide risk assessment. This reduced the privacy for patients using their en-suite facilities. The health board should reconsider the associated risks to ensure there is an individualised approach to managing risks of self harm that affords as much privacy and dignity as possible to patients.

Improvement needed

The health board must ensure that the patient at a glance information board is covered when not in use.

The health board should reconsidering the associated reconsider the associated risks of en-suite doors to ensure there is an individualised approach to managing risks.

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.

Throughout the ward there were areas where up-to-date patient information was clearly displayed and we noted appropriate signage throughout the ward.

Through our observations of staff-patient interactions it was evident that staff ensured that they communicated with patients effectively. Staff took time to undertake discussions using words and language suitable to the individual

patient. Where patients remained unclear or misunderstood, staff would patiently clarify what they had said.

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.

At the time of our inspection Bryngofal Ward was designated as an 18 bedded ward. The ward had 24 bedrooms, six of which were designated as decommissioned. Three decommissioned bedrooms were undergoing refurbishment work so could not be used. Throughout the inspection the other three decommissioned bedrooms were opened, giving the ward 21 beds, all of which were occupied.

The health board held a daily bed status meeting to identify where, if anywhere, there was an unoccupied bed, whether there were likely discharges from the wards and any potential ward admissions.

We reviewed the last six months bed occupancy levels for the health board's adult mental health service. There were clear bed capacity issues with demand for beds exceeding the number available within the health board.

Due to the bed occupancy levels, patients from Hywel Dda were being admitted to a ward within the health board that had an available bed instead of the locality ward for the patient. This meant that sometimes the patient would be admitted to a neighbouring health board until a bed within Hywel Dda was available. On occasions when beds were not available patients would be admitted on to wards and either the patient was accommodated overnight in the Section 136[2] facility or in the ward lounge. Whilst the use of these measures required authorisation from the on-call Manager it is not appropriate for patients to be temporarily accommodated outside of a designated bedroom.

2

The health board has no adult mental health rehabilitation and recovery beds. This means some patients may be required to stay on an acute admission ward until they are ready for discharge to community services, therefore potentially prolonging their inpatient stay on an acute ward and delaying another patient admission due to the bed capacity issues within the health board.

The use of Section 136 facilities to alleviate bed occupancy pressures meant that if a patient was located within the facility it would be unavailable for its intended purpose. We were informed by staff and senior management that health board's Section 136 facilities were staffed by ward staff as and when required. However, given the continued high level of occupancy of wards within the health board staff and management expressed difficulty in releasing staff from wards to staff Section 136 facilities. We were informed that on these occasions the health board would nominally 'close' a Section 136 facility to admissions. The health board should review its Section 136 facilities and arrangements to ensure it meets the needs of its population in providing timely admissions to hospital under the requirements of the Mental Health Act (the Act).

Improvement needed

The health board should review the bed capacity and service provision available for Adult Mental Health services to ensure it can timely meet the needs of its population.

The health board should review its Section 136 facilities and arrangements to ensure it meets the needs of its population in providing timely admissions to hospital under the requirements of the Mental Health Act.

Standard 6.3 Listening and learning from feedback

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback.

It was positive to note that the newly appointed occupational therapist held a weekly patient meeting. The meeting allowed for patients to provide feedback

on the care and facilities at Bryngofal Ward. The meetings were documented and actions recorded.

Delivery of safe and effective care

We reviewed the original statutory papers held by the Mental Health Act Department to verify compliance with the Act. The health board confirmed that a review of ward-based Act documentation will be undertaken to ensure that the appropriate documentation is readily available for ward staff.

The health board had a good electronic patient record system in place. However, Care and Treatment Plan (CTP) documentation had not been inputted into the designated section of the electronic record. We noted that some Care and Treatment Plans were incomplete and/or had not identified the patient's Care Coordinator.

There were two areas of concern regarding patient and staff safety that required the health board to provide immediate reassurance following the inspection. The health board have implemented measures to mitigate the risks whilst additional work is undertaken to address the issues.

Application of the Mental Health Act

We reviewed the statutory detention documents of three patients on Bryngofal Ward with the health board's Mental Health Act Manager who was able to provide all statutory documentation so that we could be satisfied that detentions under the Act were compliant.

Given the poor ward record keeping of statutory documentation that we identified within another ward at Prince Philip Hospital, Bryngolau (inspected at the same time as Bryngofal), the health board confirmed that a review of ward based Act documentation will be undertaken.

Improvement needed

The health board must ensure that Mental Health Act documentation is suitably filed and available for ward staff.

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

We reviewed four sets of Care and Treatment Plan documentation that were kept on the electronic patient record. The following observations were identified:

- Care and Treatment Plans were of an inconsistent standard with key information omitted
- Not all patients had a record of an identified Care Coordinator, this include two patients who had been on the ward for a month
- For longer stay patients there was evidence of extensive care plan reviews with patient involvement.

Care and Treatment Plans were kept on the electronic patient record. However, patient's Care and Treatment Plans were not maintained in the designated Care Planning section of the electronic records but entered into the same section as all clinical information. This meant it was complex and time consuming to review care plans amongst other clinical entries. This was of particular concern due to the lack of continuity of staff and there was therefore the risk that temporary staff would have difficulty in learning about patients from their care plans.

Improvement needed

The health board must ensure that all Care and Treatment Plans are completed to the requirements of the Mental Health (Wales) Measure 2010.

The health board must ensure that all Care and Treatment Plans identify the patient's Care Coordinator.

Safe care

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 would attend to the door to facilitate entry. Throughout the inspection the door was secured to prevent anyone who was unauthorised from 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 to alert other staff if they required assistance. The ward was equipped with an integrated personal alarm and wall mounted alarms, however there was only one working personal alarm.

There were a number of areas on the ward where staff may be working alone out of sight of colleagues and, without personal alarms, could have difficulty in alerting staff that assistance was required.

We were informed by senior management that a new alarm system was to be installed during 2017; however at the time of our inspection ward staff did not have appropriate personal alarms. Our concerns regarding the lack of personal alarms were dealt with under our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. The health board have stated that they have accelerated the scoping of the provision of alarms in all adult in patient mental health services and in the meantime the health board have implemented their Standard Operating Procedure in place for use of interim personal attack alarms. Further details of this are provided in Appendix A.

We also raised concerns regarding the lack of appropriate lighting within the garden area. During the evenings the garden area was poorly lit at night in a number of areas which created dark areas. Staff were unable to easily observe these areas to identify if a patient was located in the dark areas and therefore unable to ensure that all patients were safe. Our concerns regarding the poor lighting within the garden were dealt with under our immediate assurance process. The health board have stated that the existing lights have been surveyed to identify any adjustments and additional lighting required, torches have been made available and measures put in place for increased checks of the garden area. Further details of this are provided in Appendix A.

During a review of patient records we identified that on a number of occasions enhanced observation check sheets were not completed by staff. This means we can not be assured that staff were completing enhanced observations as required. If staff can not demonstrate that they have completed enhanced observations the health board cannot guarantee that staff are providing safe care and mitigating safety risks which could impact on the welfare of patients, staff and visitors.

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 there are sufficient appropriate alarms available on the ward for staff and visitors.

The health board must ensure that all patient areas within the garden are adequately lit.

The Health Board must ensure that staff maintain full records of enhanced observation.

Standard 2.4 Infection Prevention and Control (IPC) and Decontamination

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.

The health board employs dedicated housekeeping staff; all areas of Bryngofal Ward appeared clean throughout the inspection. The communal bathroom, showers and toilets were clean, tidy and clutter free.

Standard 2.5 Nutrition and hydration

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

Patients were offered options for their meals which included a vegetarian option. Patients had access to hot and cold drinks throughout the day and a range of snacks and fruit were also available to patients on the ward.

On the whole patients did not raise any concerns regarding food and felt that it was reasonable. However, some patients we spoke to said that fruit/healthy snacks were not always available on the ward.

Improvement needed

The Health Board must ensure that fruit/healthy snacks are readily available at all times.

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 Bryngofal Ward. All medication was stored securely and all medication that we checked was in date. 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 Controlled Drug cupboard.

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

Standard 2.7 Safeguarding children and adults at risk

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

We found that staff had access to, and sufficient knowledge of, the current health board policy on the protection of vulnerable adults.

Effective care

Standard 3.1 Safe and clinically effective care

Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.

The ward had a dedicated team however over the past 12 months there were high levels of sickness and vacancies that meant the ward had significant levels of bank and agency staff working on the ward. During our inspection we noted that often the registered nurses working on the ward were not permanent to the ward, therefore they had limited knowledge of the patient group and/or ward layout and procedures.

We could see that staff were doing their upmost to ensure that patients received appropriate care and to provide a safe environment for patients. However, due to the lack of consistency in staff and some staff members' limited knowledge of the patients, they were unable to provide detailed individualised and effective care for patients.

The health board had established systems for revising policies, procedures and guidelines on a regular basis, or at the point when a change was required. This meant that staff had access to up-to-date policy guidance to help them care for their patients.

Incidents were recorded through the health board's computerised incident reporting system. This provided governance around the monitoring and review of incidents on Bryngofal Ward.

Standard 3.5: Record keeping

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.

Records were stored securely to prevent unauthorised people from accessing and reading them. Daily entries in individual patients' records were regular throughout the day and detailed so that it was easily understandable of the patient's activity and presentation.

However as identified above, care plans information was inputted amongst other clinical entries which meant it was complex and time-consuming to review care plans.

Quality of management and leadership

There was evidence that the interim ward manager and interim deputy ward manager had provided support and leadership since moving into the roles. However, health board bed capacity pressures and inconsistent staffing, through the use of bank and agency, had impacted upon the managers' ability to manage and run the ward. The health board should review the managerial support requirements for Bryngofal Ward.

Senior health board management were aware of the challenges faced across the health board's adult mental health service and how they impacted upon the provision of mental health services at ward level. Senior management had considered the health board's future service provision and the health board must review the current service model to ensure that the provision of inpatient mental health services meet the needs of the health board's population.

The health board needs to provide stability to the workforce of Bryngofal Ward to provide a consistency of staff and reduce the reliance on bank and agency staff.

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, despite the issues identified on Bryngofal Ward, that the staff were receptive to our views, findings and recommendations.

An interim ward manager and an interim deputy ward manager were in place on Bryngofal Ward who were able to provide support to the ward along with stability in leadership. Ward staff were complimentary about the support that they received from each other and spoke of a strong team commitment despite the pressures of the ward.

It was evident throughout the inspection that the interim ward manager was required to spend significant amounts of time identifying staff for shift shortfalls. This meant that they had less time to provide direct support to the ward. The interim deputy ward manager was able to provide the ward with managerial support. However, the difficulties faced by the ward due to bed capacity pressures and insufficient staff at the time of our inspection impacted upon how much time the individuals could provide to supporting and managing the ward. The health board should review the managerial support requirements of the ward to ensure that there is sufficient support for ward staff and to ensure that clinical procedures and audits are completed.

Within the previous 12 months there had also been a number of personnel changes in senior management within the adult mental health directorate. During our discussions with ward staff working at Bryngofal Ward a number of staff lacked knowledge of the recent senior management personnel changes. The health board should consider how to improve ward staff knowledge of the health board's senior management and how to access them.

Senior health board management were aware of the challenges faced across the health board's adult mental health service; particularly pressures on bed capacity and staff resources, and how they impacted upon the operation of Bryngofal Ward. Senior management were also considering how to address the lack of health board adult inpatient rehabilitation beds and the difficulties in the provision of Section 136 facilities across the health board.

Speaking to senior management there was a vision for future service provision in an attempt to meet the challenges the adult mental health service was currently facing. There were a number of considerations on the future adult mental health service given by senior management.

As stated under the ***Timely Care*** section of this report, the health board must review the current service model to ensure that the provision of inpatient mental health services meet the needs of the health board's population.

The responsible clinician designated to Bryngofal Ward was due to move on from their post in May 2017. At the time of our inspection the health board could not confirm permanent arrangements once the current responsible clinician vacated their post. We were given verbal assurance that the health board were considering options to replace the responsible clinician. The health board must confirm arrangements to fill the vacant responsible clinician post.

Improvement needed

The health board should review the managerial support requirements for Bryngofal Ward.

The health board should consider how to improve ward staff knowledge of the health board's senior management.

The health board must confirm what arrangements are in place to fill the vacant responsible clinician post.

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.

Over the previous 12 months Bryngofal Ward had a number of registered nurse vacancies and high sickness levels, including some long-term sickness. In addition, due to the presentation and challenges of some patients the ward had regularly been required to implement enhanced observation levels with required additional staff. As a result the ward had been required to use a high proportion of health board bank staff or agency staff, on occasions being the majority of staff on the shift. As a result, there had been inconsistency of staffing at Bryngofal Ward.

Ward staff were understandably concerned about the high levels of bank and agency staff required for fulfilling the ward rotas. It was evident that regular staff were working additional shifts to fill gaps in rotas, sometimes at short notice to work additional hours at the end of their planned shift. It is of concern that the pressures on ward staff to work additional and extended shifts could impact upon staff members' wellbeing.

During our inspection we met health board staff completing shifts that had rarely worked at the ward, and for one shift the nurse in charge had not worked at the ward previously. It was evident that staff were working to the best of their abilities despite limited knowledge of the patient group, ward layout and procedures, and other staff members. It was apparent that the regular ward staff were supporting and assisting staff who were less familiar with the patients and the ward.

With staff members not being familiar with the patient group or the ward there was an impact on how long ward procedures took, e.g. ward round meetings,

medication rounds handover meetings, and therefore reduced the amount of time available to staff to engage with patients.

The health board had recently recruited to the ward's registered nurse vacancies, with staff due to take up their positions. This should improve the consistency of staffing and reduce the requirements of bank and/or agency staff.

Staff also raised concerns that due to the staffing pressures that they are unable to have regular team meetings and on occasions staff have to cancel their training to ensure that there were sufficient staff on the ward.

Some patient raised concerns that due to inconsistent staffing they had difficulty in speaking to a nurse who could have an informed discussion about their care and treatment.

There was good occupational therapy input to Bryngofal Ward with some of the occupational therapy team members being dedicated to the ward. The occupational therapy team provided a good range of assessments, onward and community focused actives to help patient maintain and develop skills.

There was a ward gym on Bryngofal Ward and at the time of the inspection the ward had two members of staff who were trained instructors. However, patients and staff stated that due to staffing pressures and staff working shifts that additional instructors would be beneficial so that patients could use the gym more regularly.

Improvement needed

The health board must ensure that there is a workforce management plan to provide Bryngofal Ward with a consistent staff team and minimise the use of bank and agency staff.

The health board should consider increasing the number of trained gym instructors for Bryngofal Ward.

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 Bryngofal Ward 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: Prince Philip Hospital, Bryngofal Ward

Date of Inspection: 19 – 21 February 2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
Quality of the patient experience					
6	The health board must ensure that the patient at a glance information board is covered when not in use.	4.1	Complete Training Needs Analysis of substantive staff re compliance with Information Governance Training. Out of Compliance staff to complete Information Governance e learning training as per mandatory training requirements. Communication briefing to be sent to all staff reminding them to close the patient at a glance board when not in use.	Ward Manager Ward Manager Head of Service	7th April 2017 7th October 2017 7th April 2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
			Communication briefing will be included in the induction pack for new staff.	Ward Manager	7th April 2017
6	The health board should reconsider the associated risks of en-suite doors to ensure there is an individualised approach to managing risks.	4.1	En-suite doors are to be re-fitted as part of the anti-ligature capital works on all inpatient wards	Head of Service	Complete
8	The health board should review the bed capacity and service provision available for Adult Mental Health services to ensure it can timely meet the needs of its population.	5.1	Transforming Mental Health Services engagement has been completed. Consensus Model developed, of which, components will require public consultation. Consultation paper to be submitted to Health Board for agreement to go to public consultation.	Directorate Management Team Transforming Mental Health Project team	Complete Complete 31st May 2017
8	The health board should review its Section 136 facilities and arrangements to ensure it meets the needs of its population in providing timely admissions to hospital under the requirements of the Mental Health Act.	5.1	Transforming Mental Health Services engagement has been completed Consensus Model developed, of which, components will require public consultation.	Directorate Management Team Transforming Mental health project team	Complete Complete

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
			Consultation paper to be submitted to Health Board for agreement.		May 2017
Delivery of safe and effective care					
10	The health board must ensure that Mental Health Act documentation is suitably filed and available for ward staff.	Application of the Mental Health Act	Audit of ward based mental health act documentation to be undertaken to ensure compliance with record keeping	Mental Health Act manager	31st May 2017
11	The health board must ensure that all Care and Treatment Plans are completed to the requirements of the Mental Health (Wales) Measure 2010.	Mental Health (Wales) Measure 2010	Identify in service peer reviewers to participate in the Delivery Unit CTP Review. Implement Delivery Unit Review Recommendations	Head of Service Head of Service	31st March 2017 Date to be determined on the basis of when the feedback is received from the Delivery Unit
11	The health board must ensure that all Care and Treatment Plans identify the patient's Care Coordinator.	Mental Health (Wales) Measure 2010	Complete brief audit of current CTP's Communication briefing to be sent to all named nurses reminding them	Service Manager Head of Service	7th April 2017 7h April 2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
			of the necessity to document name of care coordinator Care coordinator information to be added to documentation Review of one set of patient documentation to be included in 1-1 supervision records for Registered Nurses	Named Nurses Ward Manager	14th April 2017 14th April 2017
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	The rights of informal patients will be reinforced as part of the admission pathway.	Ward Manager	14th April 2017
13	The health board must ensure that there are sufficient appropriate alarms available on the ward for staff and visitors.	2.1	Establish cost of purchasing ten new alarms and maintenance contract for the current system Submit Capital Bid for purchase of the alarms and maintenance contract for the current system.	Business Manager Head of Service	Complete Complete
13	The health board must ensure that all patient areas within the garden are adequately lit.	2.1	Submit request to estates department to increase lighting in garden area.	Service Manager	Complete

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
13	The Health Board must ensure that staff maintain full records of enhanced observation.	2.1	Communication briefing to be sent to all Registered Nurses.	Ward Manager	7th April 2017
Quality of management and leadership					
18	The health board should review the managerial support requirements for Bryngofal Ward.	Part 2 - Governance, leadership & accountability	Undertake a staff survey and meetings with staff regarding leadership/management support. Triangulate information from skill mix review and staff engagement to formulate recommendations for future leadership/management of Bryngofal Ward.	Service Manager Head of Service	30th May 2017 30th June 2017
18	The health board should consider how to improve ward staff knowledge of the health board's senior management.	Part 2 - Governance, leadership & accountability	To purchase lockable display cabinets to show a who is who guide for members of the Senior Management Team. There will also be a facility developed to display feedback from Senior Management visits.	Interim Director MHLD Interim Director MHLD	30th June 2017 30th June 2017
18	The health board must confirm what arrangements are in place to fill the vacant responsible clinician post.	Part 2 - Governance, leadership &	Locum cover to be sourced until substantive vacancy filled	Clinical/ Medical	30th April 2017

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
		accountability		Director	
19	The health board must ensure that there is a workforce management plan to provide Bryngofal Ward with a consistent staff team and minimise the use of bank and agency staff.	7.1	Agree over-establishment of two health care support workers. Undertake review of agency and bank use for February, March & April 2017 Analyse results of agency bank Review to inform development of a workforce management plan	Head of Service Service Manager Head of Service	Complete 5th May 2017 31st May 2017
19	The health board should consider increasing the number of trained gym instructors for Bryngofal Ward.	7.1	Record episodes of unmet need due to lack of suitably qualified gym supervisor.	Ward Manager	July 2017

Service representative:

Name (print): Julie Denley / Liz Carroll

Title: Interim Director of Mental Health and Learning Disabilities / Head of Nursing

Date: 10 April 2017