Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

NHS Mental Health Service Inspection (Unannounced)

Heddfan Psychiatric Unit

Betsi Cadwaladr University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced mental health inspection of Heddfan Psychiatric Unit within Betsi Cadwaladr University Health Board on the evening of 12 June and the following days of 13 and 14 June 2017. The following sites and wards were visited during this inspection:

- Clywedog - Acute Adult Mental Health
- Dyfrdwy - Acute Adult Mental Health
- Tryweryn - Psychiatric Intensive Care Unit (PICU)
- Gwanwyn - Older Persons Mental Health
- Hydref - Older Persons Mental Health

Our team, for the inspection comprised of one HIW inspector, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one lay reviewer. The inspection was led by the HIW inspection manager.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act.

HIW explored how the service met the Health and Care Standards (2015). Where appropriate, HIW also consider how services comply with the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards.

Further details about how we conduct NHS mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we found evidence that Heddfan provided safe and effective care. However, we found some evidence that the health board was not fully compliant with all Health and Care Standards in all areas.

This is what we found the service did well:

- Patients and relatives that we spoke to were very happy with the care received
- Staff we spoke to were happy in their roles and stated that they felt supported by peers and management
- Established clinical processes in place to maintain patients' safety
- Legal documentation under the Mental Health Act and Deprivation of Liberty Safeguards was compliant with the relevant legislation
- Provided individualised patient focused care.

This is what we recommend the service could improve:

- The service model of mental health services within the health board to meet the needs of its population
- Areas of the environment to help maintain patients' privacy and dignity
- The prescribing, storage and recording of medication use
- Staff bank system to ensure it meets the requirements of Heddfan.

3. What we found

Background of the service

Heddfan Psychiatric Unit provides NHS mental health services at Heddfan Unit, Wrexham Maelor Hospital, Croesnewydd Rd, Wrexham LL13 7TD within Betsi Cadwaladr University Health Board. .

Heddfan has three mixed gender adult mental health wards: Clywedog 18 beds, Dyfrdwy 18 beds and Tryweryn 8 beds. There are also two mixed gender Older Persons Mental Health wards: Gwanwyn 13 beds and Hydref 14 beds.

At the time of inspection each ward was at full occupancy.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

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 bed capacity pressures within the health board's Adult Mental Health Service which on occasions resulted in patients sleeping in non-bedroom areas or out of area. 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.

Staying healthy

There was a wide range of relevant information leaflets for patients, families and other visitors available in the reception areas of the hospital and on the individual wards. These areas contained information on mental health issues, guidance around mental health legislation and physical wellbeing such as healthy eating. Along with information on organisations that can support patients, their families and carers.

Heddfan had a team of occupational therapists and activity co-ordinators that provided a wide range of activities for patients within the hospital and within the community for those patients that were authorised to leave the hospital.

There was a sports hall available to patients in which the occupational therapy team would facilitate activities. However, at the time of the inspection there was ward furniture that was awaiting collection being stored in an area of the hall. This may impact on the use for the hall for some activities.

There was also a hospital gym; however we were informed that some of the exercise equipment had been removed because it was no longer safe to use. These items had not been replaced which left the gym poorly equipped with limited facilities for patients. The health board should consider improving the gym facilities at Heddfan Unit.

Improvement needed

The health board must ensure that all furniture awaiting disposal is removed promptly from the hospital.

The health board should consider improving the gym facilities at Heddfan Unit.

Dignified care

We observed that ward staff and senior management at the hospital interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke to were enthusiastic about how they supported and cared for the patients.

When patients approached staff members they were met with polite and responsive caring attitudes. We heard staff speaking with patients in calm tones throughout our inspection. We observed staff being respectful toward patients including prompt and appropriate interaction in an attempt to prevent patient behaviours escalating.

On each of the wards, patients had their own en-suite bedroom which included a toilet, sink and shower. We observed a number of patient bedrooms and it was evident that patients were able to personalise their rooms. However, we observed that on Gwanwyn some bedroom curtains required to be rehung or replaced as they did not provide sufficient privacy for patients.

The health board had taken the decision on the adult mental health wards to replace the en-suite doors with curtains on collapsible rails. We understand that this was to mitigate the risk of attempted patient self-harm. Whilst dignity is maintained through individual bedrooms (only accessible by the patient and staff via a swipe key) and the en-suite curtains, we feel there is a potential for patients' dignity to be compromised if the en-suite curtain moves as a staff member enters the bedroom.

The senior members of the health board confirmed at the verbal inspection feedback meeting that the health board were exploring options with their estates department. However, the health board explained that a more suitable

solution to maintain patient privacy may not be identified and that it would be a priority to ensure patient safety. Longer term, as part of a programme of environmental works, the doorways to the en-suite bathrooms will have an archway and more robust options for privacy screening will be explored following the trial in the hospital's Section 136 Suite[1].

There were bathrooms available on each ward that patients could utilise if they wished to have a bath. There were appropriate aids available to provide additional support for patients if required. However, patients' individual toiletries on Gwanwyn were kept in individual lockers within the ward's sluice to prevent misuse. Staff stated that this caused difficulties in providing prompt assistance to personal hygiene and on occasions toiletries get mixed up.

Bedroom doors had observation panels so that staff could undertake observation on patients without opening the door and potentially disturbing the patient. Patients were able to close the observation panels from inside their bedroom. However, it was reported on Gwanwyn that some of the observation panels were stuck in the open position and that for some observation panels, staff did not have the specialist key to open and close them. This meant that staff could not ensure that observation panels were left in the closed position to maintain patient's privacy from people passing by the bedroom door. The health board must ensure that staff are able to maintain observation panels in the closed position and open them for the duration to undertake an observation.

As per our previous inspection in 2015 the adult wards: Clywedog, Dyfrdwy and Tryweryn, had open nursing stations on the wards. This impacted upon staff's ability to protect confidential information whether paper based, computer based or during conversations on the telephone or in person. However, we observed staff throughout the inspection protecting confidential information by locking it away if they were required to leave the nursing station, being conscious of the whereabouts of others when having conversations or taking calls and having conversations in private rooms if required.

The patient status at a glance boards on the adult wards were displayed within the nursing stations. Whilst efforts had been made to code confidential

[1] Section 136 Suite is a designated place of safety where police can bring a person for a Mental Health Act assessment.

information (to stop patients reading confidential information about other patients) there was the potential for patients to be able to decipher confidential information of other patients.

Heddfan Unit had a Section 136 Suite where the police could bring people for a Mental Health Act assessment. The Section 136 Suite was suitably furnished to provide comfort and safety for a person awaiting and undergoing an assessment. There was a toilet available within the Section 136 Suite; however there was no door or screen within the toilet entrance to afford privacy to a person using the facility.

Improvement needed

The health board must ensure that all curtains at Heddfan are correctly hung and afford patients privacy.

The health board must ensure that there are accessible and appropriate storage facilities for patients' toiletries on Gwanwyn.

The health board must ensure that staff are able to maintain observation panels in the closed position across Heddfan and open them for the duration to undertake an observation.

The health board must review the open nursing stations on Clywedog, Dyfrdwy and Tryweryn to ensure that required information can be maintained confidentially.

The health board must ensure that there is appropriate privacy measure for the toilet located in the Section 136.

Patient information

There was plenty of relevant information available to patient, families and other visitors. There was a wide range of information available on each of the wards and within the reception areas of Heddfan. This information included detailed information on mental health issues and information from the third sector.

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. Patient families and carers were also included in some individual meetings.

The "Care to Talk" initiative was implemented for family and carers to provide significant input to the care of their relatives. The health board had also provided a Dementia Care Mapping workshop to patients' relatives and carers

to inform them on the philosophy of care being provided to patient on Gwanwyn.

Communicating effectively

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.

There were a number of meetings that involved patients and staff, this included formal individual care planning meetings and group community meetings.

For individual meetings patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. Patients' families and carers were also included in some individual meetings. During our inspection we attended a Dementia Mapping Session with patients' relatives which provided attendees with information on patient care.

Timely care

During our inspection all five wards were at full occupancy. Staff confirmed that this was regular occurrence and that this was the case for other mental health wards within the health board. Across the health board, occupancy levels were monitored by senior management daily.

Due to the bed occupancy levels, there were occasions when patients from Betsi Cadwaladr were being admitted to a ward within the health board that had an available bed instead of the ward at the patient's local mental health hospital. Where there were insufficient number of beds within the health board the service would identify a hospital bed within other Welsh health boards, NHS Trusts in England or independent provider to fulfil the service need of the population. Any "Out of Area Placements" were monitored daily by senior management so that attempts to return the patient to their local hospital could be facilitated as soon as possible.

When beds were not available (particularly during the evening or night) patients would be admitted on to wards and the patient was accommodated overnight in ward communal areas that were made private for that person's sole use. 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.

In addition, there was a high usage of the Section 136 Suite at Heddfan; this increased the demand on the health board's mental health service with unscheduled assessments at Heddfan. Staff from Heddfan would be required to facilitate the mental health assessment within the Section 136 Suite. Where the person was assessed as requiring admission to hospital, Heddfan staff would be required to remain with the patient in the Section 136 Suite until an available bed was at Heddfan or another hospital.

Due to the occupancy levels of the mental health wards during the inspection a patient occupied the Section 136 Suite for almost 24 hours whilst an appropriate bed was available, which was reliant upon another patient at Heddfan being transferred to their local mental health hospital within the health board.

The occupancy levels and demand on the capacity of the mental health service caused delays to patients accessing timely care within their local mental health hospital.

It was positive to hear that the health board have been working with the local Police to ensure that only appropriate individuals were brought to the Section 136 Suite for assessment. During the inspection staff gave examples of when persons had been brought to the Section 136 Suite which who could have been directed to other more appropriate services. However, the health board demonstrated joint working with the Police to learn from previous experiences to provide a better service for people.

When people under the age of 18 years were brought out of hours to the Section 136 Suite at Heddfan, arrangements were in place with doctors at Heddfan and Wrexham Maelor Hospital to undertake assessments due to the unavailability of Child and Adolescent Mental Health Service (CAMHS) doctors out of hours. Whilst this provided an assessment on the person, the doctor undertaking the assessment may lack CAMHS experience compared to a doctor from the CAMHS service. This may impact upon the timeliness of an under 18 year old receiving the appropriate level of care required.

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 the arrangements for out of hour mental health assessments for people aged under 18 years.

Individual care

People's rights

Legal documentation to detain patients under the Mental Health Act or restrict patients leaving the hospital by Deprivation of Liberty Safeguards were compliant with the relevant legislation.

Patients could also utilise the Independent Mental Health Advocacy (IMHA) service with a representative that attended the hospital weekly. Patients could also access the Independent Mental Capacity Advocacy (IMCA) service.

There were suitable places for patients to meet with visitors in private on each of the wards along with arrangements in place to make telephone calls in private. There was a visiting room suitable for child visitors located near Clywedog and Dyfrdwy for the adult wards and near Hydref for the older person wards. However, the visiting room on the older person wards could be made more child friendly.

Improvement needed

The health board should consider improvements to the visiting room for the older persons wards to make it more child friendly.

Listening and learning from feedback

There was the opportunity for patients, relatives and carers to provide feedback on the care provided via the NHS Putting Things Right[2] process. It was positive to see "Thank You" cards on display from former patients and family members.

[2] Putting Things Right is the integrated processes for the raising, investigation of and learning from concerns regarding treatment within the NHS

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Staff at Heddfan provided safe and effective care for the patients. There were good processes in place to maintain patients' safety whilst receiving a high standard of care on the wards. However, improvements are required in the prescribing, storage and recording of medication use at Heddfan.

Legal documentation to detain patients under the Mental Health Act or restrict patients leaving the hospital by Deprivation of Liberty Safeguards were compliant with the relevant legislation.

Safe care

Managing risk and promoting health and safety

There were processes in place to manage risk and maintain health and safety at Heddfan Unit. Four of the wards were located on the ground floor with Hydref on the first floor of the hospital. There was a lift available to the first floor which ensured accessible entry to all areas of the hospital.

There were nurse call points around the ward and within patient bedrooms so that patients could summon assistance if required. The older persons wards, Gwanwyn and Hydref, had bedroom sensors that would alert staff to patients rising from their beds so that staff could provide the required level of support for patients. However, some staff reported that there had been occasions when the alarms had not activated as required. Staff also stated that when an alarm sounds it can be heard throughout the ward and therefore can disturb other patients, particularly at night. The health board must review the bedroom sensor system to ensure that they function when required and alerts staff without disturbing patients.

There were established systems in place for assessing and monitoring patients' level of agitation and staff were trained in recognised Restrictive Physical Intervention (RPI) techniques for managing patient behaviours. However, some staff reported that on occasions that not all bank staff that have worked on the

wards have been RPI trained and unable to assist staff as would be required. This could impact upon ward staff's ability to maintain safety of the ward.

Staff at Heddfan had access to personal alarms to call for assistance if required. Staff felt that the alarm system could be improved as the current system only notifies the 'bleep-holder' on the ward of where the incident is occurring.

Due to the high occupancy levels across Heddfan staff were not always able to transfer patients to Tryweryn, the Psychiatric Intensive Care Unit (PICU) at Heddfan, to enable the patient to receive lower stimulus higher intensity of nursing care. Staff confirmed that they would use areas of the wards that were lower stimulus to manage patient's behaviours if PICU was unavailable or not required.

There were up-to-date ligature point risk assessments in place for both wards. These identified potential ligature points and what action had been taken to remove or manage these.

The furniture, fixtures and fittings on both wards were, on the whole, more appropriate to the respective patient groups than our previous inspection in 2015. However, some communal furniture on Gwanwyn and Hydref could be improved to provide more comfort for patients. Staff also stated that the older persons wards would benefit from additional high-low profiling beds to assist in maintaining the safety of patients with reduced stability and mobility.

Each ward had its own garden area that patients could access. It was evident on the first evening of our inspection that the lighting in Clywedog and Dyfrdwy gardens was insufficient for staff to clearly observe the garden area. Whilst the lighting was significantly better in the Tryweryn garden staff reported that whilst the lighting was controlled by sensors. Staff reported however, that it would on occasions switch on and off sporadically. The health board must ensure that all garden areas are appropriately lit when required.

Staff on Gwanwyn and Hydref reported that there were trip hazards within their garden areas that were a risk to patient safety. Staff confirmed that these had been reported to the health board's estates department however no date for completion had been provided and the rectifying works remained incomplete.

At the inspection feedback meeting senior management confirmed that improvements to the garden areas would be prioritised.

Improvement needed

The health board must review the bedroom sensor system to ensure that they function when required and alerts staff without disturbing patients.

The health board must ensure that all staff (including bank staff) working at Heddfan have up to date RPI training.

The health board must ensure that there are appropriate beds (including high-low profiling beds) to assist in maintaining the safety of patients with reduced stability and mobility.

The health board must ensure that all garden areas are appropriately lit when required.

The health board must ensure that all garden areas are free from trip hazards.

Infection prevention and control

Throughout the inspection we observed the hospital to be visibly clean and free from clutter. Cleaning equipment was stored and organised appropriately.

There were hand hygiene products available in relevant areas on both wards; these were accompanied by appropriate signage. Staff also had access to infection prevention and control and decontamination (Personal Protective Equipment) PPE when required.

There were laundry facilities for the wards which were well maintained and we found that laundry rooms and linen cupboards were well organised.

There were schedules of cleaning undertaken by health board housekeeping staff across Heddfan. Ward staff stated that they undertook additional cleaning in clinical areas; however, when we reviewed the ward clinical staff rota/checklist on Gwanwyn, we observed omissions. The health board must ensure that staff complete and record systematic cleaning of clinical areas.

Staff confirmed that they undertook eLearning modules on infection prevention and control; however they felt that it lacked sufficient detail for clinical practices and cleaning schedules. Given the omissions identified on Gwanwyn ward the health board should review the infection prevention and control eLearning module to ensure it provides all staff with sufficient training appropriate to their roles.

Improvement needed

The health board must ensure that staff complete and record systematic cleaning of clinical areas

The health board must ensure that the infection prevention and control eLearning module provides all staff with sufficient training appropriate to their roles.

Medicines management

We found inconsistencies in the safe and effective management of medicines across Heddfan.

Each ward had its own medication trolley with individual locked drawers for each patient. Each medication trolley was secured within the clinic rooms; however a number of individual patient drawers were left unlocked when we checked the Clywedog and Tryweryn clinic rooms. We also found that not all medication cupboards and medication fridges at Heddfan were kept locked when not in use. The health board must ensure that registered nurses maintain the secure storage of medication at Heddfan to prevent unauthorised access.

Whilst medication fridge temperatures were taken and recorded daily on the majority of the wards, this was not the case on Clywedog where there were regular omissions in the recording of medication fridge temperature. This means the health board can not be assured that medication was always stored at the manufacture's advised temperature on Clywedog. There were also items within the Clywedog medication fridge that should have not been stored there, including medication that did not require cold storage and carbonated drinks.

The Medication Admission Record (MAR) charts we reviewed contained the individual patient's full name; however there were some MAR charts where the full name was recorded on the front only. Thereafter, only the patient's first name was detailed within the MAR Chart.

On review of some MAR Charts we identified that the prescriber had not clearly identified the route of administration for some medication; the prescriber had indicated oral or intra-muscular and not one specific route.

Where medication had been prescribed as regular or as required, on occasions no maximum daily dosage had been stated, therefore the total daily dosage could exceed the stated BNF[3] daily limit.

On Tryweryn one set of notes evidenced the use of poly-pharmacy but no evidence of regular medication review and the requirement for the medication prescribed.

There was also the lack of monitoring around the use of clopixol-acuphase[4] (in conjunction with other antipsychotic medication) and associated physical monitoring of the patient.

There were MAR charts with omissions around the recording administration or when medication had been refused by the patient. There were also occasions when the use of controlled drugs had not been signed by two registered staff on Clywedog, Dyfrdwy and Tryweryn.

The health board must ensure that registered nurses accurately record the administration of medication and use of controlled drugs.

Improvement needed

The health board must ensure that medication fridge temperatures are taken and recorded.

The health board must ensure that medication fridges only contain medicines that require refrigeration.

The health board must ensure that prescribers indicate the specific route of administration of medication.

The health board must ensure that prescribers indicate the maximum daily medication dosage.

[3] British National Formulary is a reference guide on prescribing, dispensing and administering medicines, intended primarily for use by clinicians

[4] Clopixol-acuphase is an antipsychotic administered via inter-muscular injection.

The health board must ensure that there are records of medication reviews maintained in patients' notes.

The health board must ensure that the required physical monitoring is documented in patients' notes following the use of clopixol-acuphase.

The health board must ensure that registered nurses accurately record the administration of medication.

The health board must ensure that registered nurses accurately record the use of controlled drugs.

Safeguarding children and adults at risk

There were established processes in place to ensure that staff at Heddfan safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Effective care

Safe and clinically effective care

Overall we found governance arrangements in place that helped ensure that staff on both wards provided safe and clinically effective care for patients. However, as identified above, improvements are required in the safe and effective management of medication at Heddfan.

Record keeping

Patient records were mainly paper files that were stored and maintained within the locked nursing office, with some electronic documentation, which was password-protected. We observed staff storing the records appropriately during our inspection.

Due to the open nursing stations on Clywedog, Dyfrdwy and Tryweryn we raised our concerns about maintaining information and record confidentially in these areas on the wards. Staff were able to provide reassurance around their practices that assisted in maintaining confidentiality. However, some staff did state that the open nursing stations made it more difficult to maintain confidential information, particularly if they are required to respond to an incident on the ward.

Overall it was noted that patient records were better organised on Clywedog, Dyfrdwy and Tryweryn, where as patient records were more difficult to review on Gwanwyn and Hydref.

Improvement needed

The health board must ensure that the patient records are better organised on Gwanwyn and Hydref.

Mental Health Act Monitoring

We reviewed the statutory detention documents of five patients across two wards, which included Clywedog and Hydref.

It was evident that detentions had been applied and renewed within the requirements of the Act.

Medication was provided to patient in line with Section 58 of the Act, Consent to Treatment. Where a Second Opinion Appointed Doctor (SOAD) a record of the statutory consultees discussion was completed and kept with SOAD documentation.

Consent to treatment certificates were kept with the corresponding Medication Administration Record (MAR) chart. This meant staff administering medication could refer to the certificate to ensure that medication was prescribed under the consent to treatment provisions of section 58 of the Act.

Patients were provided with their statutory rights under the Act, including appealing against their detention. There was evidence that some patients were supported by the advocacy service.

We also noted that all leave had been authorised by the responsible clinician on Section 17 Leave authorisation forms.

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

We reviewed the care plans of a total of five patients. There was evidence that care co-ordinators had been identified for the patients and, where appropriate, that family members were involved in care planning arrangements. However, for one patient on Dyfrdwy the care co-ordinator had left their post and a new care co-ordinator had not been recorded on the most recent Care and Treatment Plan (CTP).

Care documentation for patients evidenced a range of risk assessments that set out the identified risks and how to mitigate and manage them. There were also physical health assessments and monitoring recorded in some patients' notes. However, this information was not always included in the most recent CTP within patient files; this was a commonly omitted within CTPs on Clywedog and Dyfrdwy. This information had been recorded on CTP review documentation but not the CTPs. Therefore the CTPs held on some patient files did not provide the most up-to-date information on how to care and support the patient.

We reviewed notes on Clywedog and Dyfrdwy that had identified that regular weight monitoring should be undertaken. However, the patients' notes did not always evidence that this had been completed or the reason for not completing, i.e. patient refused or weight monitoring no longer required.

It was also common that staff were not documenting any unmet needs a patient may have whilst being cared for at the hospital. It is important that unmet needs are documented so that these can be regularly reviewed by the multi-disciplinary team to look at options for meeting those needs.

Improvement needed

The health board must ensure that the care co-ordinator is recorded on the Care and Treatment Plans.

The health board must ensure that when weight monitoring is identified that this is undertaken and recorded within patients' notes.

The health board must ensure that patients' unmet needs are documented in their Care and Treatment Plans.

Mental Capacity Act and Deprivation of Liberty Safeguards

Where required, staff at Heddfan referred to the local authority to apply Deprivation of Liberty Safeguards for applicable patients. It was evident that the process was being applied appropriately.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

There was good leadership and management across Heddfan with ward teams that evidenced good team working and spoke of positive staff morale. The ward teams were supported by viable health board senior management .

We found that staff were committed to providing patient care to high standards and throughout the inspection were receptive to our views, findings and recommendations.

Governance, leadership and accountability

We found that there were well defined systems and processes in place to ensure that wards at Heddfan focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and its established governance structure which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

There was dedicated and passionate leadership from the modern matrons and ward managers. Ward managers were supported by committed ward teams, strong multi-disciplinary teams and senior health board managers who regularly attended Heddfan. We found that staff were committed to providing patient care to high standards.

Staff spoke positively about the leadership and support provided by the modern matrons and ward managers at Heddfan. Staff also commented that team-working and staff morale on the wards was good and much improved since our previous inspection.

Patients' and relatives' feedback on the care received at Heddfan was positive.

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

Staff and resources

Workforce

Heddfan had established ward teams that evidenced good team working and motivated individuals to provide dedicated care for patients. There were registered nurse vacancies at Heddfan, however senior management demonstrated the efforts being made to recruit to the vacancies. Staff sickness rate for Heddfan were monitored by senior management and we were provided with evidence that sickness rates were low.

It was positive to hear that since our previous inspection in 2015 the health board have appointed housekeeping staff on Clywedog, Dyfrdwy and Tryweryn to undertake non-clinical roles that were being completed by the nursing team. This has enabled the nursing team to have greater focus on providing nursing input for patients.

We reviewed staff training; it was evident that this was being monitored by the ward managers and senior management. There had been great improvements in the completion of mandatory training since our previous inspection. However, across Heddfan, completion rates of Infection Prevention and Control - Level 2 required improving. As stated earlier in the report, staff reported that the Infection Prevention and Control training that they received was not sufficient to support all staff with their individual roles.

Staff were receiving annual appraisals with completion dates recorded on the electronic staff record (ESR) system. This verified the high appraisal completion rates across Heddfan. Staff at Heddfan also received regular supervision; this was documented on paper records only, and therefore more difficult to monitor the completion rates. Staff and managers across Heddfan confirmed that supervision was regularly completed by staff. However, it was confirmed that this happened less frequently on Tryweryn. This was due to only one deputy ward manager supporting the ward manager and therefore more difficult to ensure that all staff received regular supervision.

When staffing rotas were unable to be filled by the ward teams at Heddfan, the shortfalls in the shift were referred to the health board's bank system. As stated earlier in the report staff at Heddfan felt that on occasions the bank staff were not always suitable to work on the wards at Heddfan, lacking the skills required for the patient groups. Staff confirmed that there was a process to provide feedback on the suitability of bank staff following a shift which informed the

bank system for any future bank shifts. Staff had also stated that there had been a few occasions when the bank system was unable to fill the shortfall in the rotas and therefore the shift was short staffed.

Improvement needed

The health board must ensure that staff receive regular supervision.

The health board must review the staff bank system to ensure it meets the requirements of Heddfan.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

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

5. How we inspect NHS mental health services

Our inspections of NHS mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of NHS mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005 and implementation of Deprivation of Liberty Safeguards
- Meet the Health and Care Standards 2015

We also consider other professional standards and guidance as applicable. These inspections capture a snapshot of the standards of care within NHS mental health services.

Further detail about how HIW inspects mental health and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection	Not applicable	Not applicable	Not applicable

Appendix B – Immediate improvement plan

Service: Heddfan Psychiatric Unit

Wards: Clywedog, Dyfrdwy, Trywerryn, Gwanwyn and Hydref

Date of inspection: 12 - 14 June 2017

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No immediate concerns were identified on this inspection	Not applicable	Not applicable	Not applicable	Not applicable

Appendix C – Improvement plan

Service: Heddfan Psychiatric Unit

Ward/unit(s): Clywedog, Dyfrdwy, Trywerryn, Gwanwyn and Hydref

Date of inspection: 12 - 14 June 2017

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that all furniture awaiting disposal is removed promptly from the hospital.	1.1 Health promotion, protection and improvement	Some items removed since the visit however there are now additional items that require removal, we have assurance from the East Hotel Services Manager that these will be removed on 02 August 17.	Lead Nurse – East	02 Aug 17
The health board should consider improving the gym facilities at Heddfan Unit.	1.1 Health promotion, protection and improvement	Options appraisal for gym equipment has been developed by the Occupational Therapist in the unit. Money has been identified to purchase some equipment. Equipment needs to be ordered and induction process to be	Matron – Adult Mental Health [AMH]	30 Sep 17

Improvement needed	Standard	Service action	Responsible officer	Timescale
		developed taking into account potential health and safety issues.		
The health board must ensure that all curtains at Heddfan are correctly hung and afford patients privacy.	4.1 Dignified Care	Matrons have checked all curtains are in place, 4 missing curtains identified which have been ordered with tracks, these rooms are not public facing. Weekly check to be added to housekeepers schedule to ensure ongoing monitoring.	Matron – Adult Mental Health [AMH]) & Matron – Older Persons Mental Health [OPMH]	11Aug 17
The health board must ensure that there are accessible and appropriate storage facilities for patients' toiletries on Gwanwyn.	4.1 Dignified Care	As part of the environmental works the wardrobes will be altered to include a lockable storage box for individual patient storage. In the meantime individual boxes will be kept on the ward to store items.	Matron – Older Persons Mental Health [OPMH]	31 Mar 18
The health board must ensure that staff are able to maintain observation panels in the closed position across Heddfan and open them for the duration to undertake an observation.	4.1 Dignified Care	Staff have been reminded to ensure all vision panels are kept in the closed position and only opened for observations.	Matron – Adult Mental Health [AMH] & Matron – Older Persons Mental Health [OPMH]	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Keys are available to open and close the vision panels. Longer term, as part of the environmental works, each bedroom door is being replaced with a new door. A control for the vision panel that patients can use will be incorporated into each door.	Lead Nurse – East	31 Mar 18
The health board must review the open nursing stations on Clywedog, Dyfrdwy and Tryweryn to ensure that required information can be maintained confidentially.	4.1 Dignified Care	Staff awareness has been raised to ensure the lockable cupboards that are available behind the nursing stations on the Adult Mental Health wards (Clywedog and Dyfrdwy) are utilised. PSAAG boards to be reviewed and either moved or replaced for boards with folding doors.	Matron – Adult Mental Health [AMH]	4 Aug 17
		On Tryweryn Ward, as the nurse base in completely open and accessible from both ends, work is planned as part of the environmental project to enclose the nursing station which will improve the ability to maintain confidentiality.	Lead Nurse – East	31 Mar 18

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that there is appropriate privacy measure for the toilet located in the Section 136.	4.1 Dignified Care	As safety is the priority in order to reduce the risks in this area, the en-suite doors have been removed. Dignity had been maintained through a curtain on a collapsible rail, however this proved to be unsuitable as has been pulled down on 2 occasions by patients. A prototype of a more robust privacy screen has been ordered, delivery is awaited.	Lead Nurse – East	31 Aug 17
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 Timely access	The Health Board is participating in the national benchmarking work which is currently ongoing. Medical Director will review results of 2017 benchmarking data for inpatient provision and consider whether acute adult capacity is sufficient.	Medical Director	30 Nov 17
		Re-launch of the partnership board will create local implementation teams to consider alternatives to admission and appropriate response to crisis.	Clinical Network Manager – East	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board should review the arrangements for out of hour mental health assessments for people aged under 18 years.	5.1 Timely access	CAMHS colleagues are leading on further developments working with partners to consider alternatives to admission for under 16's. CAMHS currently provides a 7 day service ensuring that young people are assessed either on the day of admission or the following day by a CAMHS practitioner. The CAMHS psychiatrists provide 24 hour telephone on call rota. Acute Paediatricians support the care being provided to young people under the age of 16 years admitted to the Section 136 Suite. A work stream has been established to review the pathways and models of provision for young people in crisis who attend Section 136 Suites, paediatric wards and emergency departments, with the intention of remodelling and developing a more responsive appropriate service provision in	Assistant Area Director – Children's	31 Jan 18

Improvement needed	Standard	Service action	Responsible officer	Timescale
		partnership with the Local Authorities, Police, Adult Mental Health, Paediatrics and CAMHS.		
The health board should consider improvements to the visiting room for the older persons wards to make it more child friendly.	6.2 Peoples rights	The Adult Mental Health family visiting room can also be utilised. Nurse Consultant is reviewing the area in Older Persons Mental Health and will consider any relevant guidance that may assist in improving this area.	Consultant Nurse - Dementia	31 Aug 17
Delivery of safe and effective care				
The health board must review the bedroom sensor system to ensure that they function when required and alerts staff without disturbing patients.	2.1 Managing risk and promoting health and safety	As safety is the priority staff do need to be alerted throughout the ward of alarms sounding so that they can respond in a timely manner. The system is being reviewed as part of the environmental works to ensure that it functions as it should. A survey has been completed by the manufacturer, alteration of the sensor position and type is being made as each bedroom is upgraded.	Lead Nurse – East	31 Mar 18

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that all staff (including bank staff) working at Heddfan have up to date RPI training.	2.1 Managing risk and promoting health and safety	Current compliance with RPI training for the inpatient areas is: Older Persons Mental Health - 85%, Adult Mental Health - 91%. Any member of bank staff who undertakes regular work in Heddfan is supported to attend RPI training. Matrons are liaising with the nurse bank manager and RPI team for additional sessions to enable more bank staff to undertake the training. Ascertain what percentage of bank staff are at least complaint with the mandatory Violence & Aggression training, module B.	Matron – Adult Mental Health [AMH] Matron – Older Persons Mental Health [OPMH]	31 Aug 17
The health board must ensure that there are appropriate beds (including high-low profiling beds) on Older Persons Mental Health wards to assist in maintaining the safety of patients with reduced stability and mobility.	2.1 Managing risk and promoting health and safety	There are only profiling beds on the wards, this includes 5 high-low beds and 2 ultra-low beds. This has been reviewed and 7 floor lowering beds within the unit which is 25% of the total number of beds is deemed to be sufficient at the present time to meet the demand for this type of bed.	Service Manager – Older Persons Mental Health [OPMH]	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that all garden areas are appropriately lit when required.	2.1 Managing risk and promoting health and safety	As part of the programme of environmental works new lighting has been installed on Tryweryn, this is also planned for Clywedog and Dyfrdwy gardens.	Lead Nurse – East	31 Aug 17
The health board must ensure that Older Persons Mental Health garden areas are free from trip hazards.	2.1 Managing risk and promoting health and safety	Some immediate remedial work was carried out to try address the trip hazards however this has not been successful and trip hazards remain. As part of the programme of environmental works a section of the damaged flooring will be replaced. In the meantime a bench has been placed across the trip hazards to stop the hazards from being accessed.	Matron – Older Persons Mental Health [OPMH]	15 Sep 17
The health board must ensure that staff complete and record systematic cleaning of clinical areas.	2.4 Infection Prevention and Control (IPC) and Decontaminati on	Matrons have liaised with IPC team in Wrexham and adapted their nurse cleaning schedule. This was implemented in Heddfan on 1 July 17 and will be monitored by Matrons.	Matron – Adult Mental Health [AMH] Matron – Older Persons Mental Health [OPMH]	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that the infection prevention and control eLearning module provides all staff with sufficient training appropriate to their roles.	2.4 Infection Prevention and Control (IPC) and Decontamination	Current compliance percentages for Infection Prevention and Control are: Level 1: OPMH – 90%, AMH – 92% Level 2: OPMH – 60%, AMH – 60% Compliance will continue to be monitored through the weekly Operations Meeting, with the aim of getting Level 2 compliance to 90%.	Matron – Adult Mental Health [AMH] Matron – Older Persons Mental Health [OPMH]	31 Dec 17
		Feedback to the health board mandatory training development group to review the training.	Clinical Nurse Specialist - Older Persons Mental Health [OPMH]	30 Sep 17
The health board must ensure that medication fridge temperatures are taken and recorded.	2.6 Medicines Management	Awareness has been raised with ward staff verbally and with visual prompts, Matrons to monitor via monthly Matron checks.	Matron – Adult Mental Health [AMH] Matron – Older Persons Mental Health [OPMH]	Completed and Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that medication fridges only contain medicines that require refrigeration.	2.6 Medicines Management	Awareness has been raised with ward staff verbally and with visual prompts, Matrons to monitor via monthly Matron checks and have confirmed there are currently no inappropriate items in the fridges.	Matron – Adult Mental Health [AMH] Matron – Older Persons Mental Health [OPMH]	Completed and Ongoing
The health board must ensure that prescribers indicate the specific route of administration of medication.	2.6 Medicines Management	The trainee doctor's induction will be amended to include a training session from pharmacy on prescribing.	Clinical Director – East	31 Dec 17
		An audit will be developed to monitor standards in relation to prescribing as this is not monitored through any of the existing audits in place. The baseline audit should be completed in August 2017 then repeated at quarterly intervals.	Clinical Director – East	31 Aug 17
The health board must ensure that prescribers indicate the maximum daily medication dosage.	2.6 Medicines Management	The trainee doctor's induction will be amended to include a training session from pharmacy on prescribing.	Clinical Director – East	31 Dec 17

Improvement needed	Standard	Service action	Responsible officer	Timescale
		An audit will be developed to monitor standards in relation to prescribing as this is not monitored through any of the existing audits in place. The baseline audit should be completed in August 2017 then repeated at quarterly intervals.	Clinical Director – East	31 Aug 17
The health board must ensure that there are records of medication reviews maintained in patients' notes.	2.6 Medicines Management	Clinical Director will remind all medical staff of the need to ensure that medication reviews are documented on a weekly basis (minimum). This will be monitored through the audits.	Clinical Director – East	4 Aug 17
The health board must ensure that the required physical monitoring is documented in patients' notes following the use of clopixol-acuphase.	2.6 Medicines Management	This was in relation to a specific patient, there was evidence of other patients having regular physical monitoring. Staff have since received Rapid Tranquillisation training by the ward Consultant and Pharmacist on 30/06/17, this session will be repeated on an ongoing basis.	Ward Manager – Tryweryn	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Monthly Matron checks will monitor standards related to physical health monitoring, in addition to monthly Quality and Safety audits.	Matron – Adult Mental Health [AMH] Matron – Older Persons Mental Health [OPMH]	Ongoing
The health board must ensure that registered nurses accurately record the administration of medication.	2.6 Medicines Management	Staff have been reminded of the importance of checking drug charts and also completing the daily CD check verbally and via a visual prompt.	Matron – Adult Mental Health [AMH] Matron – Older Persons Mental Health [OPMH]	Completed
		Controlled drugs audits conducted by pharmacy on a monthly basis to monitor this.	Lead Pharmacist Mental Health – East	Completed and Ongoing
		Baseline audit to be conducted of all patient drug charts to ascertain a level of assurance around standards relating to medicines management, not covered by the monthly pharmacy audits.	Service Manager – Older Persons Mental Health [OPMH]	31 Aug 17

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that registered nurses accurately record the use of controlled drugs.	2.6 Medicines Management	Staff have been reminded of the importance of checking drug charts and also completing the daily CD check verbally and via a visual prompt.	Matron – Adult Mental Health [AMH] Matron – Older Persons Mental Health [OPMH]	Completed
		Controlled drugs audits conducted by pharmacy on a monthly basis to monitor this.	Lead Pharmacist Mental Health – East	Completed and Ongoing
		Baseline audit to be conducted of all patient drug charts to ascertain a level of assurance around standards relating to medicines management, not covered by the monthly pharmacy audits.	Service Manager – Older Persons Mental Health [OPMH]	31 Aug 17
The health board must ensure that the patient records are better organised on Gwanwyn and Hydref.	3.5 Record keeping	There is an agreed format for medical records within the Division, ward clerks will assist in ensuring this format is followed. Ward clerks have been appointed and are awaiting start dates which will support the two Older Persons Mental Health wards with improving the organisation of records.	Service Manager – Older Persons Mental Health [OPMH]	30 Sep 17

Improvement needed	Standard	Service action	Responsible officer	Timescale
		One has a confirmed start date of 1 August 17 and the other a provisional start date of 01 September 17.		
The health board must ensure that the care co-ordinator is recorded on the Care and Treatment Plans.	Monitoring the Mental Health Measure	Immediate reminders to staff about the importance of ensuring care co-ordinators are recorded on the CTP have been issued.	Matron – Adult Mental Health [AMH] Matron – Older Persons Mental Health [OPMH]	Completed
		There will be a baseline audit of the East Inpatient Area of CTP's to look in more detail at the quality and content of these documents.	Service Manager – Adult Mental Health [AMH]) Lead Nurse – East	15 Sep 17
The health board must ensure that when weight monitoring is identified that this is undertaken and recorded within patients' notes.	Monitoring the Mental Health Measure	Weekly weights have been introduced on the Adult Mental Health wards as part of improving physical health monitoring, this already happens in Older Persons Mental Health. This will be monitored by Matrons.	Matron – Adult Mental Health [AMH] Matron – Older Persons Mental Health [OPMH]	Completed and Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that patients' unmet needs are documented in their Care and Treatment Plans.	Monitoring the Mental Health Measure	Immediate reminders to staff to ensure that unmet needs are documented in the CTP have been issued.	Matron – Adult Mental Health [AMH] Matron – Older Persons Mental Health [OPMH]	Completed
		There will be a baseline audit of the East Inpatient Area of CTP's to look in more detail at the quality and content of these documents.	Service Manager –East Adult Mental Health [AMH) Lead Nurse – East	15 Sep 17
Quality of management and leadership				
The health board must ensure that staff receive regular supervision.	7.1 Workforce	This was a specific issue on Tryweryn during the inspection which has subsequently been resolved. Each Ward has a system in place to ensure that supervision happens regularly. Performance with this will be monitored through the weekly East Area	Clinical Network Manager – East Lead Nurse – East	Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Operations meeting.		
The health board must review the staff bank system to ensure it meets the requirements of Heddfan.	7.1 Workforce	Any significant concerns in relation to bank staff are raised immediately with the nurse bank manager. Bank staff are to receive an induction the first time they work in the unit, this is in place currently.	Mental Health [AMH] Matron – Older Persons Mental Health [OPMH]	Completed
		Shifts do go to agency if bank cannot be sourced. The option of a mental health specific bank will be explored with the nurse bank manager.	Lead Nurse – East	30 Sep 17

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Rebekah Roshan**

Job role: **Lead Nurse**

Date: **27 July 2017**