Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Mental Health Act Monitoring Inspection: NHS Mental Health Service (Unannounced)

Ysbyty Ystrad Fawr/Ty Cyfannol,
Ty Glas & Annwylfan/Aneurin
Bevan 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 NHS Mental Health Act monitoring inspection of Ysbyty Ystrad Fawr within Aneurin Bevan University Health Board on 10 October 2017. The following wards were visited during this inspection:

- Ty Cyfannol
- Ty Glas
- Annwylfan

Our team, for the inspection comprised a HIW inspector and a Mental Health Act peer reviewer.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act. We look at how the service complies with:

- Mental Health Act 1983
- Mental Health (Wales) Measure 2010
- Mental Capacity Act 2005

HIW also explored how the service met aspects of the Health and Care Standards (2015).

Further details about how we conduct NHS Mental Health Act monitoring inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we found the records we reviewed were legally compliant within the requirements of the Mental Health Act. However, we recommended that section 17 leave forms are clearly marked to indicate when they are no longer valid. This is to avoid confusion once a particular period of leave has been taken. Section 17 leave forms also needed to be completed fully, with no blank spaces.

We found the environment was suitable for the patient groups, visibly clean and well maintained. We recommended the garden on Ty Cyfannol was cleared of the littered cigarette ends that made the space appear dirty and uninviting.

Through discussions with staff and observations on all wards, we concluded there was good team working taking place and staff were committed to providing patient care to high standards.

We recommended that complaint information is clearly displayed to assist patients and visitors and the on-line training system is updated to accurately reflect the status of staff training (on Ty Cyfannol ward).

This is what we found the service did well:

- We observed good team working taking place across all wards and there were mental health act champions in each area to support all staff
- There was good liaison between the mental health act team, ward clerks and general hospital services
- There was good physical health care monitoring taking place in-line with national guidance
- 'This is Me' booklets were in place for patients providing records of patient's lives which contributed to their reminiscence therapy

This is what we recommend the service could improve:

- Section 17 leave forms must be clearly marked when a period of leave has finished to avoid any unnecessary confusion
- Section 17 leave forms must be fully completed with no blank spaces
- Complaint information should be clearly displayed for the benefit of patients and visitors
- A review of staff training on Ty Cyfannol is required to ensure staff are up to date
- The garden on Ty Cyfannol needs to be improved by removing the littered cigarette ends and ensuring there is sufficient lighting

3. What we found

Background of the service

Ysbyty Ystrad Fawr provides a number of services including NHS mental health services at Ystrad Fawr Way, Ystrad Mynach, Hengoed CF82 7GP, within Aneurin Bevan University Health Board.

The mental health wards at Ysbyty Ystrad Fawr are Annwylfan, Ty Cyfannol and Ty Glas. Annwylfan provides assessment and treatment interventions for older people with dementia. The ward has 16 en-suite bedrooms, an enclosed courtyard and other therapeutic areas. Annwylfan is a mixed gender ward and at the time of the inspection there were 10 patients accommodated.

Ty Cyfannol is an acute in-patient unit with 23 beds, providing recovery focused care for patients with wide ranging mental health issues, between the age of 18 and 65. This mixed gender ward had 22 patients present at the time of our visit. The ward had therapeutic areas including two enclosed garden courtyards.

Ty Glas is a self contained, one bedded unit in a separate area of the ward, but managed by staff from Ty Cyfannol. The staff from Ty Cyfannol oversee the care and treatment provided by this facility.

The wards had a staff team which includes a ward manager, ward clerk, registered nurses, health care support workers, consultants, occupational therapy (OT) and hotel services. Psychology sessions are provided three to four times a week and input from community mental health and home treatment teams is available to patients.

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.

We observed staff treating patients respectfully and with warm engagement throughout our inspection. Staff made every effort to maintain patients' dignity and the en-suite bedrooms provided additional privacy for patients.

Both wards were suitable for the patient group and were clean and well maintained. Equally, both wards had pleasant outside spaces for patients to enjoy. However, the outside area associated with Ty Cyfannol was littered with cigarette ends which made it appear dirty and unwelcoming.

We saw notice boards displaying a variety of information for patients and visitors, however there was nothing visible regarding complaints and we recommended this is displayed clearly.

We saw patients engaging in activities and noted the variety available, however there were limited activities taking place at weekends and the evenings.

During our inspection, we offered patients, staff and visitors the opportunity to speak with us. Those that we spoke with told us that, overall, they were happy with the care and treatment being received and that staff were helpful and supportive.

Staying healthy

Staff told us that patients were encouraged to maintain a healthy lifestyle and some nutritional information was displayed in the dining area on Ty Cyfannol. Three meals were provided daily at breakfast, lunch and evening. Patients made their preferred choices when the food arrived on the ward, however, some comments from patients confirmed that their requests for certain foods

had not been met. It is therefore important that the provisions of specific dietary requirements are met wherever possible.

Patients were able to move freely within both wards and had access to their bedrooms, lounges and outside courtyards. Ligature points had been assessed throughout both ward environments and risks limited, as appropriate for the patient group. Annwyflan ward was shaped like a letter 'P', with wide doorways and smooth corridors which provided easy orientation for patients and those requiring the use of mobility aids.

Outside spaces were easily accessible and there had been staff and patient involvement to make them as inviting and therapeutic as possible. However, the garden area linked to Ty Cyfannol which had a smoking shelter, was littered with cigarette ends. This made the area appear dirty and unattractive. We recommended that the area is tidied-up and individuals encouraged to maintain the area. In addition, there was no outside light, despite staff confirming that a request had been made. It is recommended that appropriate lighting is available for all patient areas to ensure their safety.

On both wards, we saw patients involved in activities, including games, arts and crafts and cooking. These were supported by enthusiastic and energetic occupational therapists (OTs). We noted at the time of our visit that the OT working on Ty Cyfannol made every effort to engage in activities with patients, as well as completing OT assessments. However, as there was only one OT on this ward, we concluded that this was stretching this function thinly. In addition, we were told that activity groups that had been in place, specifically gardening at a local allotment had been cancelled as there was no staff to facilitate the session. During the feedback meeting with senior managers we discussed this matter and asked for this to be reviewed as soon as possible and consider ways to improve the issue highlighted above.

A hydrotherapy pool was available at the hospital which some patients had used and a small room on Ty Cyfannol was used as a gym. However, there was only one piece of equipment available and there were no staff at the time of our visit, trained to support patients to use the equipment. Discussions with staff and patients also confirmed that there were limited, or no, activities during the evenings and weekends. This was discussed with senior staff and is reported fully in the Quality of Management and Leadership section of this report.

The wards were secured from unauthorised access and all visitors would report to the reception area to gain access. This meant that there was an emphasis

on ensuring patients and staff were safe. The entrance doors had opaque glass that enabled patient privacy and dignity on the wards.

In each ward office, there was a patient status board[1] displaying confidential information regarding each patient being cared for on the ward. There were facilities to hide the confidential information when the boards were not in use. This meant that the staff team were making every effort to protect patient confidentiality.

Improvement needed

Improvements are required on Ty Cyfannol, specifically the garden area to remove the littered cigarette ends and encourage individuals who use the facility to maintain a clean and welcoming appearance.

Lighting needs to be appropriate; specifically in the outside spaces to ensure the safety of those using these areas is maintained.

Dignified care

We observed staff on all wards interacting and engaging with patients appropriately and treating patients with warmth and dignity and respect. The staff we spoke to, were enthusiastic about how they supported and cared for the patients.

We heard staff speaking with patients in calm tones throughout our inspection. There was evidence that staff addressed patients by their preferred name.

Each bedroom had an observation panel (window) in the door and we saw that these were mainly in the open position. As patients could not operate these from within their bedroom, observation panels should be closed for privacy and only open for observation or if the patient chooses. This is in support of patients' dignity and their right to privacy.

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

Patients on Annwylfan had 'This is Me' booklets in place which were completed with family involvement. The information contained included basic information about the patient, their previous career, interests, hobbies, likes, dislikes and family members. We recognised these booklets as good practice, especially as they formed part of patients' reminiscence therapy.

Patient information

Plenty of notice boards and patient information was displayed on the wards and within the waiting area of the mental health unit. On Ty Cyfannol there were three notice boards providing information for relatives, student nurses and staff. The relatives' board included visiting times, guidance on items allowed onto the ward, carer and autism information. The staff board had pictures of all the staff including their name and role. This information was helpful to patients and visitors alike in order to become familiar with the team.

On Ty Cyfannol, a board was updated daily that displayed the date and the staff on duty. This enabled patients to orientate themselves and the staff available to support them.

Information leaflets were available and included advocacy, self-harming and eating disorder information, as well as specific leaflets in the Welsh language.

There was no information visible and/or available on how patients and their families could make a complaint. See the 'listening and learning from feedback' section below for further details and recommendations.

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff ensured that they communicated with patients effectively. For example, we heard staff undertake discussions using words and language suitable to the individual patient.

Timely care

All wards had a multi-disciplinary team which included occupational therapy, psychology and consultants. Regular multi-disciplinary meetings embedded a collaborative approach to patient centred care. Patients had access to advocacy services and Independent Mental Health Advocates (IMHA) when required.

Individual care

People's rights

Patients could utilise the Independent Mental Health Advocacy (IMHA) service and also access the Independent Mental Capacity Advocacy (IMCA) service when required.

There were suitable places for patients to meet with visitors in private on both wards along with arrangements to make private telephone calls.

TY Cyfannol had a children's visit area that was decorated suitably for children and well equipped with toys, books and some art and craft material.

Listening and learning from feedback

Ty Cyfannol ward had a 'Hear Me Out' group that was facilitated by occupational therapy. This group allowed patients an opportunity to comment on the service. Staff told us that patient surveys were provided as and when and the results of which were discussed with staff and improvements made where possible.

Staff told us that they would assist patients who provided any verbal comments to ensure it was documented and dealt with accordingly.

Advocacy services were available to provide independent advice for any patient who wished to raise any concerns.

There was however, no information visible about how patients and/or their families could make a complaint. Discussions with staff also highlighted their limited knowledge about the formal NHS complaint process. We recommended therefore, that complaint information be made clearly visible and available for patients and visitors and that staff understanding be improved so they understand the process they need to follow if a complaint is received.

Improvement needed

Complaint information needs to be visible and available for patients and families. Staff understanding needs to be improved regarding the process they need to follow if a complaint is received.

Delivery of safe and effective care

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

The hospital environment appeared well maintained and each ward was equipped with suitable furniture, fixtures and fittings for the patient group.

We found that legal documentation to detain patients under the Mental Health Act were compliant with the requirements of the legislation. We recommended that Section 17 leave forms were marked as cancelled to avoid any confusion as to when periods of leave have expired. In addition, Section 17 leave forms are to be completed fully with no blank spaces.

Patients' Care and Treatment Plans reflected the domains of the Welsh Measure[2] and were regularly reviewed.

There were established processes and audits in place to manage risk, health and safety and infection control. This enabled staff to continue to provide safe and clinically effective care.

[2] Mental Health (Wales) Measure 2010 sets out provision for primary mental health support services; the coordination of and planning for secondary mental health services; assessments of the needs of former users of secondary mental health services; independent advocacy for persons detained under the Mental Health Act 1983 and other persons who are receiving in-patient hospital treatment for mental health; and for connected purposes.

Safe care

Managing risk and promoting health and safety

There were processes in place to manage and review risks and maintain health and safety on all wards. Ty Cyfannol and Annwylfan wards provided individualised patient care that was supported by least restrictive practices.

On entering the area where the wards are located, a reception desk is situated and visitors report here for access to the appropriate ward. Both wards are locked, but staff access them via a key fob system. Staff escort visitors onto the ward and this ensures the safety of patients and visitors onto the ward.

Staff had access to personal alarms and we saw staff wearing these during our visit. There were call bells seen in patient bedrooms on all wards and at certain locations in the corridors on Ty Cyfannol. Additionally, each 'shift' had an allocated security nurse that was responsible for maintaining the security protocols on the ward.

Both wards appeared well maintained which upheld the safety of patients, staff and visitors. Staff were able to report environmental issues to the hospital estates team who confirmed they were actioned promptly.

The furniture, fixtures and fittings on Ty Cyfannol and Annylfan wards were appropriate for the patient group.

We saw that there was no fridge temperature record in the treatment room on Ty Cyfannol and that no disposable gloves were in the dispenser. We informed staff of these issues at the time of discovery and were provided with verbal assurance that these would be addressed. It is essential that fridge temperature records are maintained to ensure the drugs are stored at the correct temperatures and that gloves are always available to ensure the health and safety of staff.

Safeguarding children and adults at risk

There were established processes in place to ensure that the hospital focused on safeguarding vulnerable adults and children, with referrals being made to external agencies as and when required.

We were assured at the time of our visit that a patient who was not suitable for this hospital was in the process of being discharged to a more appropriate hospital. Staff had recognised this and the patient was being supported by a number of organisations suitable for the patients' condition to make the move as seamless as possible.

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.

Physical health care was being monitored and recorded for all patients using the National Early Warning Score[3] (NEWS). This type of monitoring helps staff recognise patients whose condition is deteriorating so they can benefit from being treated as quickly as possible.

Record keeping

The patient records we reviewed were a mix of electronic and paper based files. There were secure storage arrangements in place to prevent unauthorised access and breaches in confidentiality.

In general, of the records we reviewed we found documented, clear accountability and evidence of how decisions relating to patient care were made. The records were of a good standard in terms of accuracy, completeness and were legible.

Of the records we reviewed, we noted the comprehensive assessments for monitoring patients' physical health.

There was also excellent risk formulation and management plans in place.

Mental Health Act Monitoring

We reviewed the statutory detention documents of four patients across two wards. In general, the records reviewed were legally compliant within the requirements of the Act and of a good standard, reflecting the Code of Practice.

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[3] National Early Warning Score (NEWS) is a guide used by medical services to quickly determine the degree of illness of a patient. NEWS is based on the principle that clinical deterioration can be seen through changes in multiple physiological measurements (respiratory rate, oxygen saturation, temperature, blood pressure, pulse/heart rate and level of consciousness), as well as large changes within a single variable.

Of the patient records we reviewed, we identified that mental capacity was assessed as part of the admission process and that the responsible clinician's assessment was documented.

In all the records, we saw that an Approved Mental Health Professional (AMHP) had interviewed and assessed the patient and provided a detailed and comprehensive record in accordance with the legal requirements of the Mental Health Act and Code of Practice.

We noted that all leave had been authorised by the responsible clinician on section 17 leave authorisation forms. However, we identified a leave form that had not been fully completed, with sections of the form left blank. This meant that we were unable to determine if the information had been refused by the patient or that they did not want a copy. We therefore recommended that all sections of section 17 leave forms are fully completed to provide comprehensive information.

In addition, we identified that section 17 forms were not being clearly marked as expired once that period of leave had ended. We therefore recommended that section 17 leave forms are marked as expired when they are no longer valid. This was to avoid any confusion.

Of the records we reviewed, the detained patients on section 17 leave did not have photographs for identification on their file. It is good practice to have a photograph of the patient on file, as this can help with any 'absent without leave' situations.

The health board's mental health act administration team ensured that patients were provided with their statutory rights under the Act, including appealing against their detention. There was evidence that patients were supported by the advocacy service.

We were told that the mental health act monitoring committee was re-starting and there was good liaison between the mental health act team and ward clerks. These positive initiatives ensure that the legal requirements of the Act are considered collectively.

Improvement needed

Section 17 leave forms need to be marked as cancelled when that period of leave has finished.

Section 17 forms need to be fully completed with no sections left blank.

Monitoring the Mental Health (Wales) Measure 2010

Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010. We reviewed a sample of care and treatment plans (CTP) and found that there was evidence that care co-ordinators had been identified for the patients and, where appropriate, family members were involved in care planning arrangements.

There was clear evidence in the CTPs we reviewed, that advocacy services were available to all patients and information relating to these services was easily accessible.

To support patient care plans, there were an extensive range of patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them.

We found that Care and Treatment Plans reflected the domains of the Welsh Measure.

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.

Through discussions with staff and observations on all wards, we concluded there was good team working taking place and staff were committed to providing patient care to high standards.

There were processes in place for staff to receive an annual appraisal and complete a programme of mandatory training including regular Mental Health Act training. However, we recommended that the system used to record and monitor staff training (ESR) be reviewed urgently because the records reviewed on Ty Cyfannol ward showed that staff were not up to date in this regard.

There was good multi disciplinary team input for all wards and we welcomed the views put forward by the senior managers at the feedback meeting that activities and therapies should not be restricted by a Monday to Friday, 9-5 p.m. approach.

Governance, leadership and accountability

We found that there were systems and processes in place to ensure all wards focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit, the results of which are submitted to senior managers so outcomes can be monitored and clinical outcomes discussed regarding the delivery of patient care.

Annwylfan and Ty Cyfannol had dedicated ward managers who were supported by committed ward and multi-disciplinary teams. At the time of our visit the ward manager for Ty Cyfannol was not on duty, but there were three band 6 registered nurses available. It was difficult to ascertain the person in charge of

Ty Cyfannol in the absence of the ward manager and we suggested this is reviewed with the possibility of having a named person in charge of the ward when the ward manager is unavailable.

We found that staff were committed to providing patient care to high standards and staff commented that team working on the wards was very good. Staff told us that there had been a number of staff changes on Ty Cyfannol and as a result were developing a changing culture. Staff from all wards said they felt supported by senior managers and described them as approachable and felt valued.

It was positive that throughout the inspection, the staff on all wards were receptive to our views, findings and recommendations.

Staff and resources

Workforce

We observed, and staff told us, that their wards had formed good teams. We saw good team working and motivated individuals providing dedicated care for patients. This was positive to see and hear from staff, especially from Ty Cyfannol due to the high staff turnover they have experienced in the last couple of months. At the time of our visit, there were only a small number of vacancies which were being recruited for.

It was positive to see the impact and significant benefit occupational therapy was having on the wards and patient group and we observed activities taking place on both wards during our visit. However, feedback from patients and some staff, confirmed that very little activity takes place during the evenings and at weekends, especially on Ty Cyfannol. During the feedback meeting with senior staff we discussed this issue and we were reassured that this matter hasn't gone unnoticed. We welcomed the views put forward by the senior managers and would encourage an approach to activities and therapies that are not restricted by a Monday to Friday, 9-5 p.m. approach.

We reviewed staff training and noted that there was a mandatory programme in place for all staff. A review of the systems on Ty Cyfannol identified that staff were not up to date with their training, with some staff verbally confirming this. Discussions with staff and senior managers highlighted that the Electronic Staff Record (ESR) system has a delay which doesn't accurately reflect the current status of staff training. The training matrix made available to us on Ty Cyfannol also highlighted significant training gaps. With two systems in place and neither able to provide an accurate record of staff training, it was recommended that

this issue be resolved as soon as possible to ensure that staff have the necessary skills and knowledge to care for the patient group.

A training matrix displayed in the nursing station on Annwylfan ward was more reassuring as the majority of training was evidenced as up to date.

Staff told us they could access additional and relevant external training with line manager approval which would be recorded to confirm their attendance.

Discussions with staff highlighted that specific Mental Health Act training was provided internally and each ward had a mental health act champion to support staff. This role we perceived as an area of noteworthy practice due to the complexities of the legislation. Although there was not a definite timeframe in place for update training, we were told staff were encouraged to attend on a regular basis.

Staff were receiving annual, documented appraisals with completion dates recorded on the ESR system. Supervision was in place for student nurses via the preceptorship booklet and also offered to all other staff.

Incidents were recorded on the Datix[4] system and lessons learnt staff told us would be discussed with the ward teams as and when required.

Improvement needed

The Electronic Staff Record (ESR) system needs urgent attention so that an accurate staff training status can be obtained and therefore reviewed to ensure all staff have and are up to date with their training in order to provide safe care and treatment to the patient group.

[4] Datix is an incident reporting and risk management system to report and track clinical incidents.

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 conduct NHS Mental Health Act monitoring inspections

Our NHS Mental Health Act monitoring inspections 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.

During our NHS Mental Health Act monitoring inspections will look at how services:

- Comply with the Mental Health Act 1983, Mental Health (Wales) Measure 2010 and Mental Capacity Act 2005
- Meet aspects of 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 during this inspection			

Appendix B – Immediate improvement plan

Service: Ysbyty Ystrad Fawr

Ward(s): Annwylfan, Ty Cyfannol & Ty Glas

Date of inspection: 10 October 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 assurances were identified during this inspection.				

Appendix C – Improvement plan

Service: Ysbyty Ystrad Fawr

Ward(s): Annwylfan, Ty Cyfannol & Ty Glas

Date of inspection: 10 October 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	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
Improvements are required on Ty Cyfannol, specifically the garden area to remove the littered cigarette ends and encourage individuals who use the facility to maintain a clean and welcoming appearance.	2.1 Managing risk and promoting health and safety	Maintenance of the communal garden area will be reviewed with the estates team to determine if domestic staff can take on cleaning. Patient community group raise the matter as discussion and action point in relation to Smoking hygiene and etiquette and sensitivity to the needs of other users	Brahms Robinson (senior Nurse) Karen James (Ward manager)	December 1st 2017 December 1st 2017

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Lighting needs to be appropriate; specifically in the outside spaces, to ensure the safety of those using these areas is maintained.	2.1 Managing risk and promoting health and safety	The Directorate will now risk assess the lighting and consider options and resources for upgrading with a view to presenting an options paper to the Divisional Management Team and Chief Operating Officer for consideration by 18 December 2017	Brahms Robinson (senior Nurse)/Esther Lowe (Service Improvement manager)	December 18th 2017
Complaint information needs to be visible and available for patients and families. Staff understanding needs to be improved regarding the process they need to follow if a complaint is received.	6.3 Listening and learning from feedback	Inpatient staff will undertake refresher training in relation to Putting Things right processes. This to be facilitated by Directorate QPS team. Patient /carers information boards have been updated with current information available	Alison Lewis (QPS lead) Karen James	1st December 2017 Complete
Delivery of safe and effective care				
Section 17 leave forms need to be marked as cancelled when that period of leave has finished.	Mental Health Act 1983 Code of Practice for Wales 2016 27.17	All registered staff informed of recommendations through handover and supervision	Karen James	Complete

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Local Audit to be undertaken to determine compliance	Alison Lewis (QPS lead)	30th January 2018
Section 17 forms need to be fully completed with no sections left blank.	Mental Health Act 1983 Code of Practice for Wales 2016 27.17 - 27.20	All registered staff informed of recommendations through handover and supervision Local Audit to be undertaken to determine compliance	Karen James Alison Lewis (QPS Lead)	Complete 30th January 2018
Quality of management and leadership				
The Electronic Staff Record (ESR) system needs urgent attention so that an accurate staff training status can be obtained and therefore reviewed to ensure all staff have and are up to date with their training in order to provide safe care and treatment to the patient group.	7.1 Workforce	This action point has been escalated to ESR team and action will be reviewed in next Directorate QPS meeting	Martin Price	1st December 2017

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): Ana Llewellyn

Job role: Divisional Nurse

Date: 10 November 2017