Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

Ysbyty'r Tri Chwm/Cedar Parc/Aneurin Bevan University Health Board

Inspection date: 28 November 2017

Publication date: 1 March 2018

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Digital ISBN 978-1-78903-193-5

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Contents

1. What we did 5

2. Summary of our inspection 6

3. What we found 8

Quality of patient experience 9

Delivery of safe and effective care 17

Quality of management and leadership 21

4. What next? 25

5. How we conduct NHS Mental Health Act monitoring inspections 26

Appendix A – Summary of concerns resolved during the inspection 27

Appendix B – Immediate improvement plan 28

Appendix C – Improvement plan 29

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'r Tri Chwm within Aneurin Bevan University Health Board on 28 November 2017. The following wards were visited during this inspection:

- Cedar Parc

Our team, for the inspection comprised of 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 that the files we reviewed were satisfactory regarding the requirements of the Mental Health Act 1983. However, we found some paperwork to be missing and/or incomplete and whilst this was addressed at the time of the visit, we have asked the health board to provide assurance that the issues identified have been completed.

Though the ward appeared clean and there were plans to improve the environment with new patient facilities and garden area, we identified issues that were compromising patients' privacy and dignity. Bedroom door vision panels and views into patient bedrooms from the garden were some of the areas we have asked the health board to improve.

The garden area requires an overhaul to make it safe and suitable for the patient group. A garden project has been established and is being managed by ward staff, and funds were being raised for this purpose. However, this project cannot be delivered in isolation and needs better support from the health board, so that the garden can be completed quickly and used by the patient group.

We observed staff working well together and providing care to patients in a kind and respectful way. We have though, recommended that the skill mix of staff is reviewed; especially when periods of patient acuity/need is high. This is to ensure that the safety, care and treatment of the patient group is appropriate.

Processes were in place for staff to receive an annual appraisal and complete mandatory training.

This is what we found the service did well:

- We observed good team working taking place

- The ward provided patients with a variety of places where they could meet visitors in private
- There was a high percentage of compliance for staff appraisals

This is what we recommend the service could improve:

- Areas of the environment were impacting negatively upon patients' privacy and dignity and these need to be improved
- The garden area was inaccessible for patients without staff accompanying them due to the hazards we observed. The garden project needs full support and quick completion so patients can use the area unattended by staff
- Staff skill mix needs to be reviewed to ensure that during periods of high acuity, appropriate skilled staff are available to provide safe care and treatment
- Improved patient information is required for the ward. For example, Putting Things Right and advocacy information were not visible on the ward

3. What we found

Background of the service

Ysbyty'r Tri Chwm provides NHS mental health services at College Road, Ebbw Vale, NP23 6GT, within Aneurin Bevan University Health Board.

Ysbyty’r Tri Chwm is a purpose built facility offering a range of facilities for older persons with mental health problems, including clinics, day hospitals, wards and community Mental Health Services.

Our visit was based on Cedar Parc, a mixed gender ward for patients with organic[1] and functional[2] illnesses. The ward had 13 beds and at the time of our visit, 10 patients were being accommodated.

Cedar Park has a staff team comprising of a consultant psychiatrist and ward doctor, occupational therapists, nurses, healthcare support workers, hotel services staff and a receptionist/ward clerk.

Social services staff were also based at the unit with social workers and administrative support being available Monday to Friday 9:00 a.m. to 5:00 p.m. Third sector services also have an active presence with Crossroads, Age Concern and the Alzheimer’s Society working from the unit.

[1] Common symptoms of Organic Mental Disorders include confusion, memory loss, loss of brain function, and agitation, but symptoms can differ somewhat based on the condition. Examples of common Organic Mental Disorders are delirium, dementia, Alzheimer's disease, and amnesia.

[2] The term ‘functional’ mental illness applies to mental disorders other than dementia, and includes severe mental illness such as schizophrenia and bipolar mood disorder. Symptoms of these disorders frequently persist into old age or, less frequently, begin in old age.

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 throughout our inspection and saw patients engaged in social and leisure activities on the ward.

The ward appeared clean and we were told of the plans to improve the environment with a new hairdressing salon and nail bar for patients.

We identified issues that were compromising patients' privacy and dignity and recommended that these were addressed as a matter of urgency. The bedroom door vision panels were made from clear glass and were therefore inappropriate as they allowed anyone to see directly into two bedrooms. There were also clear views into patient bedrooms, from the garden.

Cedar Parc had an enclosed garden, however, due to many trip and other hazards, patients were unable to access the space without being accompanied by staff. There was a staff project in place to raise funds so the garden could be made accessible; however this project needs to be supported by the health board to ensure patients have an extra facility to undertake regular exercise, garden and outdoor activities and the freedom to enjoy some safe outdoor space.

The foyer had a range of patient and visitor information, but there needed to be some improvement to ensure up to date information is displayed, including 'Putting Things Right' arrangements.

During our inspection, we offered patients, staff and visitors the opportunity to speak with us. Those we spoke with told us that there was good care and treatment being provided.

Staying healthy

In the dining room area, a chalk board presented lunchtime selections for the day, which included hot and cold options as well as a pudding. Pictures of different foods were displayed in the area, but there was no specific healthy eating information displayed.

Staff told us that patients were provided with choices of what they wanted to eat and these were made in advance. We saw jugs of water in the lounge area and staff told us that there were snacks and drinks available outside of set mealtimes.

Patients were able to move freely on the ward, which was suitable to accommodate anyone requiring a mobility aid.

Cedar Parc had an enclosed garden which was overlooked from some patient bedrooms and the open plan lounge-dining room. The space was large and had areas suitable for therapeutic activities, but required an overhaul to make the space suitable for patient group. The garden area had some raised beds to encourage patients to participate in planting and paths to walk along. However, there were a number of hazards that stopped patient access unless accompanied by staff. As a result, the door to the garden was kept locked to avoid unaccompanied access. Curb stones at the edges of the pathways were observed as trip hazards and the wooden decking area had been cordoned-off as it was unsafe due to rotten wood. Staff told us that the fences were not appropriate because there had been occasions when patients had tried to leave the hospital premises. Staff told us, and we saw evidence of the garden project that was raising funds to make the garden appropriate for the patient group. It is recommended that this project is supported by the health board so patients have a suitable facility to undertake regular exercise, garden and outdoor activities and the freedom to enjoy some safe outdoor space.

In the open plan lounge-dining room, patients had access to a television and we saw some enjoying a classic movie, with staff providing popcorn to enrich the experience. Other patients were engaged with some art and craft activities and some with completing crosswords.

Near the dining area, there was a replica bar. Staff told us that the bar was used to provide patients with non-alcoholic cocktails and other beverages. We

saw pictures displayed of patients enjoying this activity and were told it was very popular.

A notice board displaying patient social and leisure activities was situated outside of the ward. This meant that patients were unable to see this information. We therefore recommended that such information is located in an area for patients to see what activities are available each day.

Mounted on the wall in the ward corridor there was a board with tactile locks and switches for patients to move and touch. Hats and scarfs were also displayed and could be used and/or touched by the patients. We were reassured by staff that the hooks on which the hats and scarves were placed were suitable for the patient group and risk assessments had taken into consideration possible ligature points.

A room called the Singing Kettle had been designed to resemble a café. The room could be used by patients and visitors and there were objects on display that could help with memory therapies.

Staff told us that new memory pictorial boards were due to be installed within the ward for the benefit of patients. Welsh scenery and local history was also displayed on the walls in an attempt to stimulate patients in an appropriate way.

A gym was situated off the ward. Patients needed to be assessed to use this facility and were accompanied by staff. In addition, plans to convert a room into a hair salon and nail bar for patients were discussed. This facility would add an extra benefit to the ward and provide another space where patients could engage socially with visiting staff who regularly attend the ward to provide those services.

Cedar Parc was secured from unauthorised access by an intercom system. Access to the ward was appropriate to maintain the privacy and dignity of patients on the wards.

Improvement needed

The garden for Cedar Parc needs to be made accessible for the patient group so patients have an extra facility to undertake regular exercise, garden and outdoor activities and the freedom to enjoy some safe outdoor space.

Dignified care

We observed staff interacting and engaging with patients appropriately and treating patients with dignity and respect. There was evidence that staff addressed patients by their preferred name. The staff we spoke with were also enthusiastic about how they supported and cared for patients.

The nurses' office had a patient status board[3] 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 patients' confidential information.

From our observations of the environment, we identified a number of issues that were compromising the privacy and dignity of the patients. Two bedrooms had clear glass vision panels in the doors, which meant that all who passed the area could see into the bedroom. Sheets and car window sunscreen blinds were being used to help maintain privacy and dignity, but these were unacceptable methods of addressing the matter. The other bedroom doors had opaque sections and one clear panel. The clear panels could not be closed or covered, so again the privacy and dignity was being compromised. We therefore recommended that appropriate vision panels are fitted to all bedroom doors to ensure patients' privacy and dignity can be maintained, whilst allowing staff observation at appropriate times.

Some bedrooms had windows that faced onto the bedroom corridor and we noted that one of these rooms had blinds fitted on the outside of the window. This meant that the patient had to come outside of the bedroom to operate the blind. In addition, anyone passing could move the blinds and see into the bedroom. This issue needs to be resolved in-line with the other privacy and dignity recommendations made in the paragraph above.

From the garden, you could see clearly into patient bedrooms. From discussions with staff it was clear that visitors had access to the garden. Suitable action must be taken to resolve this issue and ensure that patients' privacy and dignity is not compromised.

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

We saw that windows required cleaning (outside) because they were dirty and smeared. Staff said windows were cleaned annually, but this frequency needs to be reviewed to ensure patients are able to see the outside space clearly.

Some bedrooms required new curtains and/or black out blinds. At the time of our visit, it was a sunny day and some bedrooms were flooded with sunlight. However, the curtains appeared thin and sun-bleached. We recommended that consideration is given to all patient environments to ensure appropriate furnishings are in place so patients may rest and sleep in comfort.

At the bottom of the bedroom corridor, a door led to the main kitchen and main entrance to the Willow ward. Although the Willow Ward was unoccupied at the time of our inspection, we found that patients and visitors for the Willows ward would have to pass through the bedroom area of Cedar Parc. During our feedback discussions, we therefore advised that any future plans take into consideration that inappropriate route, in order to prevent visitor access to Cedar Parc bedroom areas.

In addition, the main kitchen was situated just off the Cedar Parc bedroom corridor. As a result, all food was transported through the bedroom area. This was considered to be unsuitable. We recommended that risks are assessed to ensure patient safety and optimum hygiene and if an alternative route could be made.

The door that leads from Cedar Parc bedroom corridor to the kitchen and Willows main entrance displayed a sign to highlight that the door was faulty. We were told that the issue had been on-going for a long time. We also saw that the faulty door closure could result in patients leaving the ward on an unauthorised basis. Additionally, the door was a designated fire exit route and was consistently used by kitchen staff to transport foods. This issue needs to be resolved as a matter of urgency.

Bathroom facilities were clearly sign-posted and toilets were designated for male and female patients. We saw one bedroom which had an en-suite facility. However, bathing facilities were generally unsuitable for older persons because no hoists could be used. The female toilet in the day corridor had a call alarm that was situated next to the door, so was not within easy reach of patients to request help from staff. Other toilets had emergency pull cords which were in a more suitable location. We therefore recommended that a review of all toilet and bathing facilities are undertaken to ensure emergency call devices are available and accessible to all patients.

Improvement needed

Bedroom door vision panels need to be assessed to ensure patient privacy and dignity is not compromised and that the panels have the ability to be controlled by both patient and staff.

Patient bedrooms that had windows which faced onto the corridor and blinds attached which could not be operated within the bedroom by the occupants need to be reviewed to ensure privacy and dignity is not compromised.

Patients need protection from other patients and visitors who may use the enclosed garden and can see into their bedrooms. Views from within the bedrooms should not be restricted.

Windows on Cedar Parc require cleaning because they were dirty. The frequency of window cleaning needs to be reviewed to ensure patients can see clearly the outside space.

A review of the bedroom curtains is required to ensure the sun-bleached ones are replaced and consideration is given to all patient environments to ensure appropriate furnishings are in place so patients may rest and sleep in comfort.

Bathing and toilet facilities need to be assessed to ensure they are appropriate for the patient group. In addition, emergency pull cords need to be available and accessible to patients within all facilities.

A review of the main entrance for Willow ward is required and should be reflected in any future plans for the ward. It is inappropriate that the main entrance to Willow ward has to cut across patient bedrooms on Cedar Parc.

The faulty door (that leads from Cedar Parc bedroom corridor to the kitchen) needs to be fixed to ensure patient and staff safety is maintained.

A review of food transportation from the main kitchen through Cedar Parc bedroom corridor is required to ensure patient safety; optimum hygiene and if an alternative route could be made.

Patient information

Cedar Parc reception area displayed a wide variety of information for both visitors and patients. Boards with photos and information about the garden project were displayed along with leaflets and posters from voluntary organisations including the Alzheimer's Society and Age UK.

Information about the activities available on the ward were displayed along with advocacy leaflets. Thank you cards and ward specific statistics including incidents were available for patients and visitors to see.

On the ward, there was information displayed regarding the 'All About Me' booklets that patients had in place. These booklets help others to understand and communicate aspects of the patient's identity, including their background, interests, likes and dislikes.

A carer's notice board had specific information regarding support groups, guidance on brining food onto the ward as well as information in the Welsh language.

There was however, limited patient information visible on the ward and we recommended that services such as advocacy and Putting Things Right are displayed on the ward. (See recommendations made in the Listening and Learning from Feedback section).

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.

Timely care

The ward had a multi-disciplinary team (MDT) which included a Consultant, Occupational Therapist, Psychologist and a ward doctor. Weekly multi-disciplinary meetings and ward rounds took place. These embedded a collaborative and timely approach to patient centred care.

Advocacy services, we were told, usually attended weekly.

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 on the ward for patients to meet with visitors in private, along with arrangements to make/receive private telephone calls.

Listening and learning from feedback

At the time of our visit there was no information visible to encourage patients and/or their families to providing feedback about the service. Staff told us that due to a recent event the feedback box had been moved and not put back. Staff said this would be replaced following our visit.

There were no leaflets and/or posters for how patients and visitors could raise concerns using the NHS process of 'Putting Things Right'. There were obsolete complaints procedure leaflets displayed in the foyer which had incorrect details of the chief executive and were written for the former Gwent NHS Trust. We therefore advised staff that the old leaflets were removed and 'Putting Things Right' information clearly displayed for patients and visitors in the foyer and on the ward.

Staff told us that any verbal concerns would be passed onto the nurse in charge who would then ensure that appropriate paperwork was completed and the concern dealt with.

Advocacy leaflets were displayed in the foyer, but nothing visible on the ward. We therefore recommended that staff provide patients with information about advocacy services within the ward.

Improvement needed

Old complaints procedure leaflets and/or posters need to be removed and replaced with 'Putting Things Right'

Systems for capturing patient and visitor feedback needs to be clearly displayed in the foyer and on the ward

Advocacy service information needs to be visible for patients and visitors and clearly displayed in the foyer and on the ward

Delivery of safe and effective care

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

Our review of the Mental Health Act paperwork was generally satisfactory. We identified however, that some paperwork was absent and/or incomplete on the files we reviewed. As a result, we have asked the health board to provide confirmation that the issues we found have been actioned.

The care and treatment plans reviewed, reflected the domains of the Welsh Measure.

The ward provided suitable spaces whereby patients could meet with relatives in private.

Despite the audits and risk assessments that are completed for the ward, we identified no ligature cutters[4] available and recommended that these are available.

Safe care

Managing risk and promoting health and safety

Staff told us there were processes in place to manage and review risks and maintain health and safety on the unit, however, we observed that there were no ligature cutters available. As the ward was caring for and treating patients

[4] Ligature cutters allow for the speedy and relatively safe insertion under the ligature, whilst minimising the risk of secondary injury to the person or staff.

with functional mental illness, it was recommended that ligature cutters were available in case of an emergency.

On entering the area where the ward was located, a reception desk and waiting area are situated. The ward is locked, but staff access it via a key fob system. Staff escort visitors onto the ward and this ensures the safety of patients and visitors.

Of the bedrooms we observed, nurse call bells were situated above the beds. This meant that patients could call for assistance if required. We noted that no staff were using or had access to personal alarms. We suggest the health board review this arrangement, taking into account incidents that have occurred where staff are required to manage patients' behaviour that challenges.

Despite the environmental issues highlighted we observed in the section above, the ward appeared well maintained and we were told that in general, they received a prompt service from the maintenance department when required. At the time of our visit, bedrooms were being decorated, which was part of an on-going refurbishment programme.

The ward had rooms where patients could receive visitors in private. There was also sufficient space for mobility aids to be used on the unit.

Improvement needed

Ligature cutters should be available on the ward.

Staff safety needs to be reviewed in-line with incidents that have occurred on the ward to determine the reasons staff do not use personal safety alarms.

Safeguarding children and adults at risk

There were 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.

Effective care

Safe and clinically effective care

Overall, we found governance arrangements in place that helped ensure that staff on Cedar Parc provided safe and clinically effective care for patients. Staff told us about the type of quality audits/risk assessments completed at ward level, which were submitted to senior management for review.

Record keeping

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

Overall the records we reviewed evidenced clear accountability and evidenced how decisions relating to patient care were made. The records were of satisfactory quality in terms of accuracy and being up to date. There were some notes, where the handwriting was not impossible to understand, but difficult to decipher.

Mental Health Act Monitoring

We reviewed the statutory detention documents of three patients and found that, in general, the files were satisfactory.

In the records reviewed, we saw that the Approved Mental Health Professional (AMHP) had ensured the criteria for detention had been met and provided a concise and comprehensive record in accordance with the legal requirements of the Mental Health Act and Code of Practice.

Of the three files reviewed, only one file contained evidenced of how information about the section of the Mental Health Act which the patient was detained under was provided to the patient. The record which did not contain any information was discussed at the time of our visit. We were given reassurance by staff that this process was going to be started straight away. Therefore we require confirmation that this action has been completed.

On one file, we found that only one Responsible Clinician had made reference to the patient's lack of capacity. It was clear that the patient was not from the local area and that the documentation relating to mental capacity assessment may not have reached the ward. We require confirmation that the appropriate paperwork has been received and/or completed and are evident of the patients file.

A 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) form was located on one file but was completed to a poor standard. There were numerous sections lacking responses and reasons were not highlighted to support the clinical summary. This meant that decisions may not be taken in accordance with the patient/family's wishes. The form did not evidence that discussions with the patient, a Health and Welfare Attorney, or IMCA had taken place. Despite evidence that an Accident and Emergency doctor had signed and dated the form, there was no information recorded that the Senior

Responsible Clinician had signed and dated the form, or any record of communication that the multidisciplinary team had been informed of the decision. This was discussed at the time of our visit and staff took steps to address this issue with the appropriate Clinicians. A full resolution of this matter was not achievable before we left the ward. We therefore advised the service of the need to provide HIW with confirmation that this issue has been dealt with in accordance with the conversations held during the inspection.

Improvement needed

Confirmation is required that fully completed Mental Capacity Assessments are on file, clearly documenting the Responsible Clinicians assessment of capacity.

Confirmation is required to verify that patients' receive and is evidenced in their files how information about the section of the Mental Health Act the patient is detained under was provided.

Confirmation is required to verify that the issues raised regarding a Do Not Attempt Cardio-Pulmonary Resuscitation form, have been actioned and communicated appropriately to all relevant staff.

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 two care and treatment plans (CTPs) and found 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 patients.

To support patient care plans, there was 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 Cedar Parc, we concluded there was good team working taking place. Staff were committed to providing patient care to high standards and said they felt supported by senior management.

The skill mix of staff needs to be reviewed to ensure that when there are periods of high patient acuity, the skills of staff are appropriate to ensure the safety, care and treatment of the patient group.

Processes were in place for staff to receive an annual appraisal and complete mandatory training.

Staff had received specific mental health training, but this was not being documented and it is recommended that all completed training is recorded. Consideration needs to be given to providing staff with more training specific to the patient group they care for and support.

The staff we spoke to were able to describe the process for reporting incidents and lessons learnt were communicated to all staff as a means of improving patient care.

Governance, leadership and accountability

We found that there were systems and processes in place to ensure that the ward focused 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.

Cedar Parc had a dedicated ward and deputy manager who were supported by a ward and multi-disciplinary team.

We found that staff were committed to providing patient care to high standards and staff commented that team working on the ward was very good. Staff said they felt supported by managers and described them as approachable and felt valued.

It was positive that throughout the inspection, the staff working within the ward were receptive to our views, findings and recommendations.

Staff and resources

Workforce

We observed, and staff told us, that the ward had a good team. We saw the team working well and providing compassionate care for patients. At the time of our visit we were told that patient acuity[5] was higher than normal and had been for a couple of weeks. It was positive to hear that during these times, staffing levels are considered to ensure patient acuity and observations can be managed appropriately. However, discussions during the visit highlighted that healthcare support workers were mainly used to support periods of high patient acuity and therefore the skill mix may be unsuitable. This issue needs to be fully explored and adjusted to ensure that the skill mix is appropriate for the patient group and safety of everyone.

Regular staff meetings took place and were documented. This ensured that any staff not on duty would be kept up to date.

We reviewed staff training and noted that there was a mandatory programme in place for all staff. Systems were in place to monitor completion rates; however

[5] Patient acuity is a concept commonly referenced by caregivers and the health science literature but without specificity or consistency of definition or measurement. Acuity has become a reference for estimating nurse staffing allocations and budget determinations of the intensity of care required for a patient.

we were told that there were delays of having up to date records shown on the Electronic Staff Record (ESR) system. As a result, an additional system is used to provide an overview of compliance. This issue was discussed at the feedback meeting and we were reassured that the health board is aware of the problem and are looking to resolve it.

Staff had access to computers to complete on-line training, but said there was no dedicated time to complete training. Night shifts were used mainly to catch up on training. We were told that the ward was given a fixed number of places so staff could attend the Prevention Management of Violence and Aggression (PMVA) training.

Some specific mental health training was provided. Mental Health Act and Code of Practice for Wales had been delivered in the last six months, plus other appropriate courses, however, these modules were not documented and it is important that a comprehensive record of all completed staff training is captured. Staff had access to online dementia awareness training, but no regular updates or higher level training was available which would benefit staff that care, support and treat patients with this condition.

It was revealed that, at times when the ward recruits new staff, there was a delay in them obtaining their staff number. This number is required to complete online training and therefore because there have been delays obtaining staff numbers, completion of online training courses have also been delayed. We therefore, recommended that the health board consider this issue and seek a solution that will enable new starters access to online training as soon as possible so they gain the necessary skills and knowledge for their role.

There were no issues of staff accessing additional and relevant external training with line manager approval.

Staff were receiving annual, documented appraisals with completion dates recorded on the ESR system. The system showed a 97% compliance rate for staff appraisals.

Nursing staff described the procedure of reporting incidents and there was clear understanding and knowledge provided from them regarding this process.

Incidents were recorded on the Datix[6] system and lessons learnt staff told us would be discussed with the ward team when required.

Improvement needed

The skill mix of staff, especially when there are periods of high patient acuity needs to be explored and addressed to ensure staff and patients are safe and care and treatment can be provided as required.

[6] 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 on this inspection			

Appendix B – Immediate improvement plan

Service: Ysbyty'r Tri Chwm

Ward(s): Cedar Parc

Date of inspection: 28 November 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 assurance issues identified				

Appendix C – Improvement plan

Service: Ysbyty'r Tri Chwm

Ward(s): Cedar Parc

Date of inspection: 28 November 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				
The garden for Cedar Parc needs to be made accessible for the patient group so patients have an extra facility to undertake regular exercise, garden and outdoor activities and the freedom to enjoy some safe outdoor space.	2.1 Managing risk and promoting health and safety	Costings requested for work to be completed and added to the Divisional risk register.	Directorate Management Team/Works and Estates.	March 2018
Bedroom door vision panels need to be assessed to ensure patient privacy and dignity is not compromised and that the panels have the	4.1 Dignified Care	Costings requested for work to be completed. Concern added to the Divisional risk	Senior Nurse /Directorate Management Team/Works and	March 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
ability to be controlled by both patients and staff.		register. Care and treatment plan will reflect provision to maintain patient's privacy and dignity. Covers are being utilised in the interim.	Estates	
Patient bedrooms that had windows which faced onto the corridor and blinds attached which could not be operated within the bedroom by the occupants need to be reviewed. This is to ensure that their privacy and dignity is not compromised.	4.1 Dignified Care	Costings requested for work to be completed. Concern added to Divisional risk register. The care and treatment plan will reflect provision to maintain patients' privacy and dignity.	Senior Nurse/ Directorate Management Team/ Works and Estates	March 2018
Patients need protection from other patients and visitors who can see into their bedrooms from the garden area. In addition, views from within the bedrooms should not be restricted.	4.1 Dignified Care	Costings requested for privacy film to be applied to the outside windows of bedrooms. Concern added to Divisional risk register.	Senior Nurse/Directorate Management Team/Works and Estates	March 2018
Windows on Cedar Parc require cleaning because they were dirty. The frequency of	2.1 Managing risk and	Senior Nurse will contact facilities manager to ensure windows are	Senior Nurse.	January 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
window cleaning needs to be reviewed to ensure patients can see clearly the outside space.	promoting health and safety	cleaned.		
A review of the bedroom curtains is required to ensure the sun-bleached ones are replaced and consideration is given to all patient environments to ensure appropriate furnishings are in place so patients may rest and sleep in comfort.	2.1 Managing risk and promoting health and safety	Costings requested for new blinds and curtains. Inventory will be completed to review all furnishings on the ward and a plan to replace unacceptable furniture will be implemented.	Senior Nurse/Directorate Management team/Service Improvement Manager.	March 2018
Bathing and toilet facilities need to be assessed to ensure they are appropriate for the patient group. Additionally, emergency pull cords need to be available and accessible to patients in all toilet facilities.	2.1 Managing risk and promoting health and safety	The current bathroom facilities have been assessed and deemed suitable for maintaining patient who require a low level of support to maintain activities of daily living. If a higher level of support is required there are bathroom facilities in the vicinity to facilitate these individual needs. Patients' individual hygiene needs will	Senior Nurse/ Ward Manager. Senior Nurse/ward	Ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		be assessed on admission and reflected in the care and treatment plan. A risk assessment will be carried out to assess suitability of pull cords versus ligature risks.	Manager Ward Manager/Directorate management team	 February 2018
A review of the main entrance for Willow ward is required and should be reflected/subject to action in any future plans for the ward. This is because It is inappropriate that the main entrance to Willow ward has to cut across patient bedrooms on Cedar Parc.	2.1 Managing risk and promoting health and safety	A review of the Willows entrance will be carried out to identify an alternative to maintain patient's dignity.	Senior Nurse/ Directorate Management Team	January 2018
The faulty door (that leads from Cedar Parc bedroom corridor to the kitchen) needs to be fixed to ensure patient and staff safety is maintained.	2.1 Managing risk and promoting health and safety	Works and estates will be contacted to complete the outstanding work. Concern will be added to the Divisional risk register.	Senior Nurse/Directorate management team/works and estates.	January 2018
A review of food transportation from the main kitchen through Cedar Parc bedroom corridor is required to ensure patient safety; optimum	2.1 Managing risk and promoting	Review will be carried out to identify an alternative route	Senior Nurse/Facilities Manager	January 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
hygiene and if an alternative route could be made.	health and safety			
Delivery of safe and effective care				
Ligature cutters should be available on the ward.	2.1 Managing risk and promoting health and safety	Ligature cutters ordered.	Ward Manager/Senior Nurse	January 2018
Staff safety needs to be reviewed in-line with incidents that have occurred on the ward to determine the reasons staff do not use personal safety alarms.	2.1 Managing risk and promoting health and safety 7.1 Workforce	A review will be carried out to establish the rationale for non-adherence with personal alarms.	Senior Nurse/ Lead Nurse	January 2018.
Confirmation is required that fully completed Mental Capacity Assessments are on file, clearly documenting the Responsible Clinician's assessment of capacity.	3.5 Record keeping Mental Health Act Code of Practice for Wales (2016) - Chapter 13	All current case notes will be reviewed to ensure documentation is compliant. 6 monthly audit programme	Ward Manager/ Responsible Clinician. Mental Health Act team and CTP Lead.	January 2018 March 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Confirmation is required to verify that patients' receive, and evidence is presented in patient files with regard to how information about the section of the Mental Health Act the patient is detained under was provided.	3.2 Communicating Effectively 3.5 Record keeping Mental Health Act Code of Practice for Wales (2016) - Chapter 4	To ensure that all staff follow the legal requirement that all patients who are detained under the Mental Health Act patients will receive information leaflets regarding their section. This is incorporated in to the Mental Health Act training programme. 6 monthly audit programme	Ward Manager/Responsible clinician/Directorate Management team Mental Health Act Team.	January 2018 March 2018
Confirmation is required to verify that the issues raised regarding a Do Not Attempt Cardio-Pulmonary Resuscitation form have been actioned and communicated appropriately to all applicable staff.	3.5 Record keeping Code of Practice for Wales (2016) - Chapter 35	Training has been provided to all staff. Staff have been directed in all areas to ensure adherence to the health board process and policy for DNAR and to ensure that these are clearly documented in the case notes. All DNAR's are reviewed and discussed at the weekly ward round.	Directorate Management Team/GSPC/ MH training lead	January 2018

Quality of management and leadership

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The skill mix of staff, especially when there are periods of high patient acuity need to be explored and addressed. This is to ensure staff and patients are safe and patients are able to receive the care and treatment required.	7.1 Workforce	Ward Rosters are agreed in line with safe Staffing guidelines and agreed by the Divisional and Lead Nurse. Staffing requirements are reassessed at the commencement of each shift. Both patient numbers and acuity are considered with the ward manager/ senior nurse in order to agree correct staffing. Concerns in respect of staffing are always escalated to Directorate management team.	Divisional Nurse/ Lead Nurse/Senior Nurse Nurse in Charge/ Ward manager/ Senior Nurse.	March 2018

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: 15/1/18