Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

NHS Mental Health Service Inspection (Unannounced)

Prince Philip Hospital

Bryngofal Ward

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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 Prince Philip Hospital within Hywel Dda University Health Board on 5 and 6 April 2018. The following ward was visited during this inspection:

- Bryngofal Ward

Our team, for the inspection comprised of four people. Two clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one lay reviewer. The inspection was led by a 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 Health (Wales) Measure (2010), Mental Capacity Act (2005) 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

We saw evidence that confirmed the care provided at Bryngofal was generally safe and effective. However, we found some evidence that the health board was not fully compliant with all Health and Care Standards in all areas.

We sent an Immediate Assurance letter to the health board regarding the effectiveness of the alarm system. This seems to be an area of concern in many of the mental health and learning disability services provided by the health board and it could compromise the safety of patients, staff and visitors.

Mental Health Act documentation needs audit and review to ensure compliant with the legislative requirements of the Act.

We were concerned regarding the fragility of the service from a medical staffing perspective.

This is what we found the service did well:

- Patients told us that staff treated them with respect and kindness
- Patients' records were completed to a very good professional standard
- Reviews of care were undertaken regularly

This is what we recommend the service could improve:

- The alarm system needs to be addressed immediately
- Medical staffing levels need to be improved
- Copies of statutory detention documentation retained in the patient ward records needs to be audited and re-organised
- Improved support for new and newly qualified nursing staff
- Some areas of the ward require redecoration and the garden needs to be cleaned.

3. What we found

Background of the service

Bryngofal ward provides NHS mental health services at Prince Philip Hospital, Caebryn Mental Health Unit, Bryngwynmawr, Llanelli SA14 8QF within Hywel Dda University Health Board.

The service is an adult acute assessment mental health ward.

It is a mixed gender ward with 18 beds. It has the bed capacity, in an emergency, to accommodate 21 patients. At the time of inspection, there were 18 mixed gender patients on the ward.

The service currently employs a staff team which includes a ward manager and deputy ward manager, registered mental health nurses and health care support workers. The multi-disciplinary team includes a locum psychiatrist, medical consultant, a clinical fellow, assistant psychologist (over seen by a peripatetic psychologist) occupational therapy and activity leads. The team could also access specialist behavioural support from psychology (on request) and advocacy services. In addition, the health board employs maintenance, catering, domestic and administration staff that support the day to day running of the hospital.

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.

During the course of our inspection we received positive comments from patients regarding the care provided in Bryngofal.

We saw staff engaging with patients in a friendly, yet professional, manner.

We found that staff were attentive and helped patients in a timely way.

Arrangements were in place to promote patients' rights and for them to provide feedback on the service.

We spoke with a number of patients during the inspection who made positive comments about the attitude and approach of the staff. Patients told us that they were treated with respect and courtesy and that they felt safe on the ward.

Other comments from patients indicated that they were able to keep in contact with their families and had a choice of activities which they could do.

Staying healthy

There was information available about how patients can improve their health. Facilities were available to promote healthy living and patients' wellbeing.

We saw that posters were displayed which provided information on smoking cessation, healthy eating and the benefits of exercise.

Patients had access to limited indoor and outdoor activities. These included watching television, reading and spending time in the garden. There was a large garden area with raised flower beds where patients could get involved in growing flowers or vegetables and the day to day maintenance of the area. We noted that the area was overgrown (due to the time of year), the safe smoking areas were overflowing and paths were strewn with cigarettes ends.

There was also a gym with a variety of exercise equipment, although this was not in use because a health board physiotherapist has presented a challenge to the level of training required by the staff to supervise the use of the equipment. . This has been an ongoing issue for some time and HIW have reflected this is previous reports. We also noted that paper had been stuck to the windows to maintain privacy, however this is a fire hazard and needs to be removed.

Improvement needed

The ward manager needs to develop a wider activity programme

The ward manager needs to ensure that the gym is safe and that there are enough staff trained in the use of the equipment to enable patients to use the facilities.

The ward manager needs to ensure that the grounds of the ward are free from cigarette ends.

Dignified care

The ward did not always promote patients' privacy and dignity. However, we observed staff interacting with patients in a friendly and polite manner.

There were designated male and female areas with gender specific and communal lounges. This gave patients a choice in where they wished to sit and relax. Each patient had their own individual bedroom with en suite toilet and washing facilities. This promoted patients' privacy. Patients told us that they could personalise their rooms with their own belongings depending on their mental state at that time. Patients also told us that staff knocked their bedroom doors before entering which helped respect patients' privacy.

We did see however that bedroom door observation panels were set at open and staff told us that there were no keys available to open and close the window panels. This means that other patients and staff can look in to the bedrooms at any time and therefore does not promote dignity and respect.

Patients told us that the showers were cold and water needed to be run for some time before it even became slightly warm. We discussed this with the staff and the maintenance team arrived during the inspection to correct the temperature settings.

In addition to the communal areas on the ward, there were also smaller quiet rooms. Patients could spend time in these smaller rooms, in private, away from other patients according to their wishes and care needs.

There was a small family room for visitors with books and toys for younger family members. This was in close proximity to the section 136 suite and staff told us that visitors were sometimes asked to leave if a patient was being admitted to the suite. This reduces the visiting time and can be to the detriment of the patient and their visitors.

All the patients we saw were appropriately dressed to maintain their dignity. We saw many examples of staff being kind to patients and treating them with respect. Patients we spoke with also confirmed that staff were kind to them but felt they were not always treated as adults.

We found that patients' care records were kept securely with the aim to prevent unauthorised access to confidential information.

Patient information

Written information was displayed on the ward for patients and their families. We saw that posters displayed information about advocacy services and how patients could provide feedback on the care they received on the ward. Information on visiting times was also displayed.

We saw that there was clear signage within the ward in both Welsh and English.

Communicating effectively

We saw staff engaging with patients and speaking to them in a way to help them understand their care.

During the course of our inspection we observed friendly, yet professional, interactions between staff and patients. Staff took time and used appropriate language when speaking to patients to promote their understanding of what was being said.

Patients had access to their own mobile phones, subject to an individual patient risk assessment. Patients without a mobile phone could use the ward phone to call relatives, friends or advocates.

Timely care

We found that patients were provided with timely care to meet their needs.

We saw staff being attentive and responding to patients' requests in a timely way. Patients also told us that when they needed help, staff organised this quickly.

We were concerned that due to staffing numbers, should an incident occur it may be the case that staff would not be available to see to other patients care in a timely manner. This is discussed in more detail later in the report.

Individual care

People's rights

We found that arrangements were in place to promote and protect patients' rights.

There were facilities for patients to see their families in private although this room was very small. Rooms were also available for patients to spend time away from other patients according to their needs and wishes. Arrangements were in place for patients to make telephone calls in private.

We looked at the records for patients who were detained under the Mental Health Act (MHA) and saw that documentation required by legislation was in place within the sample of patients' records we saw. This demonstrated that patients' rights had been promoted and protected as required by the Act. The quality of these documents are discussed later in the report.

Listening and learning from feedback

Arrangements were in place for patients and their families to provide feedback about the services they had received.

Information was displayed for patients and their families on how they could provide feedback or raise a concern (complaint). Suggestion boxes were available which could be used by patients and their families to provide feedback about the service.

The health board had arrangements in place for handling concerns (complaints) raised by patients and/or their carers. These were in accordance with 'Putting Things Right', the arrangements for handling concerns about NHS care and treatment in Wales.

Information on advocacy was displayed within communal areas. Senior ward staff confirmed that patients would be supported to access the advocacy service (to help them raise concerns) if needed. We were told that a representative visited the ward daily and was available via telephone at other times.

Delivery of safe and effective care

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

We found that the staff team was committed to providing patients with individualised care that was safe and effective.

However, we were not satisfied that the arrangements in place to manage risk and promote staff and patients' safety and wellbeing were always effective specifically the ineffective alarm system and blind spots in the garden.

Generally, there were effective procedures for the safe management of medicines and infection prevention and control.

Written care plans were in place that were detailed and patient focussed.

Statutory detention documentation was complete and demonstrated that the patient's rights had been promoted and protected as required by the Mental Health Act. However the quality of the retention of statutory documentation retained on the ward was in disarray.

Safe care

Our concerns regarding the mobile alarms were dealt with under our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken.

Immediate Assurance:

We identified the following area of concern that impacted upon the safety of patients, staff and visitors at Bryngofal Ward:

- **The ward alarm system did not have sufficient personal alarms for all staff and visitors. The health board must ensure that there are sufficient appropriate alarms with adequate range available**

on the ward for staff and visitors. This has been raised in previous inspections and has not been sufficiently addressed

Further details of the immediate improvements are provided in Appendix B.

Managing risk and promoting health and safety

We were not satisfied that arrangements were always in place to maintain the safety of patients and staff.

Bryngofal is an adult assessment unit and consists of a single storey building with all facilities located on one level. There is level access to the main entrance. Access is via an intercom system to deter unauthorised persons from entering the building. Access to some areas within the ward is restricted for safety reasons. The ward was spacious and there was suitable indoor and enclosed outdoor facilities for the patient groups for which they were intended.

Overall, the ward appeared well maintained and systems were in place to report environmental hazards that required attention and repair. We did see that there was some damage to the carpet outside the section 136 suite which could become a trip hazard and the office carpet was threadbare in places. We informed senior staff of our findings so that these issues could be addressed.

Storage rooms and cupboards were locked to prevent unauthorised and accidental access by patients and visitors. However, we saw that there could be better use of the rooms which are not currently in use other than for storage. For instance the family visiting room was small and quite claustrophobic with no outside windows. However, there was a spacious room next door with a window which was being used for storage. Understandably this room was nearer to the section 136 suite and would perhaps need risk assessing but staff told us that if family were visiting and a significantly unwell patient was brought into the section 136 suite, the family would sometimes be asked to leave.

We saw that relevant risk assessments had been completed as part of the care planning process to help identify patients' needs in relation to promoting their safety and wellbeing.

We saw that staff were issued with personal alarms to promote their personal safety whilst in work. Although we were told and shown that there were not enough for each individual member of staff or any visiting professional. Additionally they were not always in good working order. We were also concerned that due to the large outside area the range on the alarms would not be sufficient. Senior staff assured us on the second day that this was not the

case and that they had tested the effectiveness of the alarm in the garden as soon as we raised the concern. HIW issued an immediate assurance regarding the alarms to ensure that senior management acted in a timely manner to reduce risk of harm to patients and staff. Although HIW have received a satisfactory response we have suggested that this safety issue is reviewed as it is a re-occurring theme within the Mental Health and Learning Disability inspections.

We were also concerned that there were many "blind spots" in the garden area where patients or staff could not be viewed from the main building. We also discussed this with senior staff and they understood our concerns.

We were also told that when a person brought to the section 136 suite who wanted a cigarette would need to walk through the communal ward area to access the outside smoking area. This is not suitable if the person is very unwell; these arrangements need to be reviewed.

We were also told about the pilot working arrangements between Dyfed Powys Police and the health board under the Policing and Crime Act and the Crisis Concordat in Wales. To date there had been 35 issues raised and two compliments from the current working arrangements. These arrangements state that officers will wait with the detained individual where need demands (aggressive behaviour) and they should agree with the nurse in charge when safe for them to leave. However, we were told of incidents where police had responded in the community to difficult and sometimes dangerous patients, brought the person to the section 136 suite and then left. There was no support for the ward staff. When we asked staff how working conditions could improve we were told that if the police liaison officer would contact the crisis team before attending at the section 136 suite, more appropriate care could be provided such as, the patient being redirected if the section 136 suite was in use or if known to other areas of the mental health directorate for example, the Community Mental Health Teams (CMHT) contact with the appropriate on call team member.

Senior staff provided a summary of staff training. This showed that no staff were totally up to date with mandatory training. Satisfactory explanations were given for some staff with outstanding training.

Improvement needed

The health board need to ensure that carpets are clean and free from hazards.

The health board needs to be satisfied that the blind spots in the garden area

have been risk assessed and any remedial safety action undertaken.

The ward manager needs to look at the available space within the unit and use the rooms to their best advantage.

The ward manager needs to look at the safety issues involved in potentially very unwell patients from the section 136 suite walking through the main communal area of the ward to access the smoking area.

The health board needs to re-establish improved lines of communication and working arrangements with Dyfed Powys Police.

Infection prevention and control

We found that arrangements were in place to reduce cross infection.

We saw that the ward was clean, tidy and designed to facilitate effective cleaning. We also saw that staff had access to personal protective equipment (PPE) such as disposable gloves and aprons to reduce cross infection. Hand washing and drying facilities were available. We saw hand sanitising gel within clinical areas. Effective hand hygiene is important to reduce the risk of patients developing healthcare acquired infections.

Staff confirmed that cleaning schedules were in place to promote regular and effective cleaning of both wards. Staff also confirmed that patients had their own schedules for using the laundry facilities to wash their own clothes.

All patients had their own individual bedroom with en-suite washing and toilet facilities. This would help reduce cross infection as patients did not need to share these facilities.

Designated plastic bins were used for the safe storage and disposal of medical sharps, for example, hypodermic needles. These were stored safely.

A system of regular audit in respect of infection control was described. This was completed with the aim of identifying areas for improvement so that appropriate action could be taken where necessary. Staff we spoke with were aware of their responsibilities around infection prevention and control.

We did note that staff toilet facilities were upstairs and if there was not enough staff to allow a member to leave the ward, they could use the disabled toilet on the ward. There was however an en-suite bedroom which had been de-commissioned which could have been used as a staff room / toilet and shower area. Again the ward manager and the estates manager need to look at the facilities available and use the rooms to their best advantage.

We also noted that a hoist was being stored in the sluice room. With sufficient storage space within the ward, the hoist needs to be moved to a more appropriate room.

Nutrition and hydration

Patients were supported to meet their eating and drinking needs.

We found that patients were provided with a choice of meals. We saw that a varied menu was displayed and patients told us that they had a choice of what to eat. Drinks and snacks were available throughout the day. Most patients told us that they enjoyed the food and felt that it was of good quality.

Patients had access to a small open kitchen area to make hot or cold drinks. However we noted that there was no hot water available during our visit and patients told us that they had to ask kitchen staff for this. We also saw that there was an open milk bottle left out on the worktop all day, otherwise patients had to ask permission to get the milk from the fridge in the locked kitchen. We suggest that a small fridge is purchased to store the milk at an appropriate temperature and arrangements are made for patients to access hot water.

Improvement needed

The health board needs to consider purchasing a small fridge to enable the storage of milk in the patients' small kitchen area

The ward manager needs to make arrangements for patients to access hot water without having to ask staff for access to the kitchen.

Medicines management

We found arrangements were in place for the safe management of medicines.

The clinical room was currently being refurbished to accept the new computerised medication equipment which will support the medication management systems currently in place. The room was generally well organised. We did however see a patients' liquid medication bottle left by a sink instead of being returned to the correct storage area.

- We saw two emergency drugs boxes; one was out of date and needs removing from the clinical room as a safety precaution.
- We also looked at the emergency resuscitation trolley and saw that it had not been checked by staff for some days. When we spoke with staff regarding this issue we were told that there were two

documents. We looked at both and there were still discrepancies which evidenced that checks were not being completed as required.

- There was also an out of date first aidbox in the gym.

We saw that medicines were stored securely within a locked cupboard and fridge within a locked room. We saw that fridge temperatures were being monitored and recorded by ward staff to show that fridges were at the correct temperature to store medicines that required refrigeration. Although, we saw that the fridge itself was frosted over with a considerable thickness of ice. This could affect the efficacy of medication requiring storage in cool temperatures. Clinic room temperatures were not being recorded which we suggest the health board should consider commencing.

We found that Controlled Drugs (CDs), which have strict and well defined management arrangements, were managed safely. We saw records that showed regular stock checks of the CDs had been conducted by two registered nurses.

Staff had access to a pharmacist who could provide help and advice on medicines used on the ward.

We looked at a sample of drug charts and saw that these had been completed in full. We saw that the charts had been signed and dated by medical and nursing staff when medication had been prescribed and administered. All the drug charts we looked at had the legal status of each patient (i.e. the section of the MHA under which they were detained) recorded together with the corresponding documentation setting out which medicines could be given.

Improvement needed

The ward manager needs to ensure that staff know when and where to record emergency trolley daily checks

The ward manager needs to ensure that the fridge for storing medication is fit for purpose

The health board must implement a suitable system for routinely checking that other medication (that does not require refrigeration) is being stored at the temperature recommended by the manufacturer.

Safeguarding children and adults at risk

We found that arrangements were in place to promote the welfare and safety of adults who become vulnerable or at risk.

Bryngofal provides care to adults only. Senior ward staff-were able to describe the safeguarding process and the arrangements for multi agency working to safeguard adults.

Senior staff provided a summary of staff training and this showed that most staff were up to date with safeguarding training. Training is discussed in more detail later in the report

Effective care

Safe and clinically effective care

During the course of our inspection, we found that (with the exception of the personal alarms) arrangements were in place to promote safe and effective care to patients.

We saw that the ward provided a safe environment for patients and that care plans were developed from a range of relevant risk assessments. Staff were knowledgeable about the care needs of patients and we found them providing care and support to meet patients' needs.

Record keeping

We found that records were in very good order and securely stored when not being used.

Patients' care records were electronic based and we did observe that there were difficulties in maintaining intranet connectivity whilst we were reviewing the notes. Staff told us that this was an ongoing problem. The electronic notes were well organised which made them easy to navigate.

Improvement needed

The health board needs to ensure that there is a robust IT system within its hospitals, which can be accessed easily and without interruption.

Mental Health Act Monitoring

We reviewed the statutory detention documents of four patients across the ward. The applications for the detentions of each patient in hospital had been made in accordance with the requirements of the Act. This demonstrated that the patients' rights had been promoted and protected as required by the Act.

However the paper files were in completely disorganised due to the overload of documentation. These need to be improved because of the importance of securing and retaining orderly records to support the Mental Health Act processes. For instance we found;

- A "discharge lounge handover" document (possibly from a general hospital admission) filed in the Mental Health Act (MHA) section of the file
- One copy of records made by statutory consultees of their discussion with the Second Opinion Appointed Doctor (SOAD)[1] when there should be two from different statutory consultees
- Section 17 leave forms located in the "Correspondence and reports" section of the file. This should have been in the MHA section
- Section 37 Hospital Order not located in patient's case notes file
- Fundamentals of Care Intentional rounding log detached and loose in the file (this again could possibly have been from a general hospital admission)
- Paper and electronic MHA records did not correspond due to lack of file maintenance
- Copy of Hospital Managers Decision located in observation charts
- We saw that associated documentation had generally been completed in full although there could be improvement in recording the capacity assessments more robustly.
- Some reviews of assessments were out of date

[1] The SOAD service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient.

The MHA Manager brought all original MHA documentation to the ward for inspection. The health board's Mental Health Act team had developed an efficient system whereby Mental Health Act documentation is retained electronically providing access only to authorised staff across the service. However we saw that there had been delays in sending documents to the MHA department from the ward.

The MHA lead told us that there was training available specifically for ward clerks in MHA documentation, copies and retention, which has been particularly tailored for this group of staff. We were also told that there was a general difficulty for staff to attend training in the MHA because the wards were unable to release staff.

Information about the Act and how to access advocacy support was available to patients.

Copies of the Mental Health Act Code of Practice for Wales, 2016 (English and Welsh) were not available on the ward, although the MHA lead assured us that they had been issued. We were told that new copies would be made available.

Improvement needed

The ward manager needs to ensure that the ward clerk accesses relevant training in the Mental Health Act, its statutory documentation and its retention

The ward manager needs to ensure that the MHA documentation is audited and reviewed to ensure compliance with the statutory documentation

The ward manager must ensure that copies of the Mental Health Act 1983 Codes of Practice (English and Welsh language versions) are retained and not removed from the ward.

The ward manager needs to ensure that paper documentation is filed appropriately.

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

We reviewed the care plans of a total of four patients.

Although we had difficulty in accessing the electronic records (which staff told us was a regular occurrence) we saw that care co-ordinators had been identified for the patients and, where appropriate, family members were involved in care planning arrangements. The Care and Treatment Plans

reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed.

Individual Care and Treatment Plans drew on patient's strengths and focused on treatment and recovery. Care and treatment plans included good physical health monitoring and health promotion.

To support patient care plans, there were an extensive range of patient assessments to identify and monitor the provision of patient care, along with comprehensive risk assessments that set out the identified risks and how to mitigate and manage them. We did note however that some assessment reviews were overdue.

There was clear involvement of patients in the care planning and we saw examples of noteworthy practice whereby unmet needs were being recorded where appropriate.

Improvement needed

The ward manager needs to ensure that assessment reviews are undertaken in a timely manner.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our inspection, staff confirmed that there were no patients subject to Deprivation of Liberty Safeguards (DoLS) authorisations.

Senior staff provided a summary of staff training and this showed that not all ward staff were up to date with Mental Capacity Act / Deprivation of Liberty Safeguards training. Training is discussed in more detail later in the report.

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.

We saw clear management and leadership at Bryngofal. There was an open door policy for staff and the ward manager was visible and approachable. Staff told us when the ward was busy the manager could often be seen on the ward helping.

Attendance of mandatory training must be improved.

There was good evidence of preceptorship support for newly qualified nurses off the ward (training and clinical supervision) but support on a day to day occurrence was less obvious.

Clinical staffing remains a concern although nurses were almost at full compliment. The health board were progressive in employing an Advanced Nurse Practitioner to support the clinical team.

Governance, leadership and accountability

Hywel Dda University Health Board is currently in the process of reshaping and re-developing the adult mental health service provision for patients within the health board. There has been wide consultation and collaboration with stakeholders including the public, patient group and staff. This is a significant time for the service and HIW will follow the progress with interest.

Currently we found that there were well defined systems and processes in place to ensure that the hospital 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. Those arrangements were recorded so that they could be reviewed.

Identified senior managers had specific responsibilities for ensuring that the programme for governance remained at the forefront of service delivery. There was dedicated leadership from the ward manager who was supported by a deputy manager a committed ward team and a small multi-disciplinary team.

A system for reporting, investigating and learning from patient safety incidents was explained to us; this included learning from near-misses. Staff confirmed that they were supported following incidents or near-misses. This included formal and informal debrief and reflective practice. Lessons learnt were disseminated through formal structure of staff meetings. The Quality and Safety Group issued monthly updates.

During our feedback meeting at the end of the inspection, senior staff and managers were receptive to our comments. They demonstrated a commitment to learn from the inspection.

Staff and resources

Workforce

Throughout the inspection, there was evidence of joined-up team working within teams and between disciplines to provide individualised care and treatment.

At the time of our inspection, senior staff explained that there had been retention difficulties with medical staff. The current consultant was on a locum contract and was due to leave a few weeks following our inspection. There was no middle grade doctor but there was a clinical fellow.[2] Medical consultant cover was from the on site general hospital. The ward had a very able and competent advanced nurse practitioner who complimented and supported the medical team. When we spoke with the medical team we were told that there were currently no job descriptions. Senior management assured us that this was being rectified.

[2] Academic Clinical Fellowships (ACFs) are Specialty Training posts which allow you to spend 25% of your time on academic training as well as 75% in clinical training.

Observations made during the course of our inspection indicated that nursing staff had the right skills and knowledge to meet the needs of patients however the team was made up of many newly qualified or new to the ward staff. On the first day we were met by a newly qualified nurse who was still in her preceptorship[3] and a nurse who had been qualified for one year who had recently joined the ward. There were no senior staff on site on the first day of our inspection. However both the staff answered our questions and were professional throughout our visit.

We were also told and saw from nursing shift rotas that numbers were at a minimum level. If, for instance, there was a need to restrain a patient there would not be enough staff to administer any required medication or to oversee the care of the remaining patients. This is particularly relevant at nights where in the event of two incidents occurring there would be insufficient staff to safely manage the ward. Discussions with senior staff indicated that in these cases agency or bank staff would be requested, however these are unforeseen, unplanned circumstances and therefore additional staff coming in later would not be of immediate benefit.

We reviewed staff training. Whilst it was evident that this was being monitored by the ward manager, there were deficiencies in mandatory training. There was a significant difference with some staff reaching 90% compliance and others only 4.5%. From our findings within this report we saw that there was a shortfall in Mental Health Act and Deprivation of Liberty Standards training. We discussed this with the ward manager and a clear explanation was offered in one instance. The ward manager does however need to ensure that the staff team receive all the appropriate training and updates.

Senior staff provided information that showed that not all staff had received an appraisal of their work within the last year. The unit manager explained that the deputy manager intended on undertaking the role but was maternity leave. The deputy who is covering the maternity leave will continue with the outstanding supervisions.

[3] A period where more senior staff guide and support newly qualified practitioners to make the transition from student and give opportunities to develop their practice further

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, Mental Health (Wales) Measure 2010 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
Patients told us that the showers were cold and water needed to be run for some time before it even became slightly warm.	This meant that patients could not enjoy a warm shower and maintain personal hygiene effectively.	We discussed this with the ward staff.	The maintenance team arrived during the inspection to correct the temperature settings.

Appendix B – Immediate improvement plan

Service: Mental Health NHS

Ward/unit(s): Bryngofal Ward, Prince Philip Hospital, Llanelli

Date of inspection: 5 and 6 April 2018

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
Immediate Assurance: We identified the following area of concern that impacted upon the safety of patients, staff and visitors at Bryngofal Ward: The ward alarm system did not have sufficient personal alarms for all staff and visitors. The health board must ensure that there are sufficient appropriate alarms with adequate range available on the ward for staff and visitors.	2.1 Managing risk and promoting health and safety	Identify how many alarm handsets could be in use at any one time. Get cost for purchase of new handsets and potential charging unit if required Identify how many surplus alarms are required to ensure that any broken alarms can be either replaced or repaired. Approve and order alarm handset and charger unit if required	Ward Manager/Service Manager AMH Business Manager Ward Manager/Service manager Head of Service/AMH	Immediate completed Immediate completed 16th April 2018 20th April 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
This has been raised in previous inspections and has not been sufficiently addressed.			Business Manager	
		Complete a risk assessment of the range of all alarms across all areas of the ward	Ward Manager/Service Manager	17th April 2018
		Complete a risk management plan if risk assessment identifies blind spots within the footprint of Bryngofal ward	Ward manager/Service manager	18th April 2018
		Contact the provider of the alarm systems to address any blind spots should the risk assessment identify any	Head of Service/AMH Business Manager	18th April 2018

Appendix C – Improvement plan

Service: Mental Health NHS

Ward/unit(s): Bryngofal Ward, Prince Philip Hospital, Llanelli

Date of inspection: 5 and 6 April 2018

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 ward manager needs to develop a wider activity programme	1.1 Health promotion, protection and improvement	Review current activity timetable	Occupational Therapist Professional Lead and Ward Manager	30th June 2018
		Develop meaningful activity programme	Multidisciplinary Team led by Professional OT Lead	31st July 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
The ward manager needs to ensure that the gym is safe and that there are enough staff trained in the use of the equipment to enable patients to use the facilities.		Display activity timetable clearly in an agreed format within the communal area.	Ward Manager	31st July 2018
		Agree a review timetable and system for recording review	Ward OT/Ward Manager	31st July 2018
		Paper screening to be removed from gym to ensure clear observation.	Ward Manager	Completed
		Level of training was challenged therefore review will be undertaken to establish best practice available for implementation.	Professional Lead OT	31st July 2018
		Complete staff training needs analysis and implementation plan.	Service Manager/Ward Manager	30th September 2018
The ward manager needs to ensure that the grounds of the ward are free from cigarette		Cleaning schedule to be introduced	Ward Manager	31st May 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
ends.				
Delivery of safe and effective care				
The health board need to ensure that carpets are clean and free from hazards.	2.1 Managing risk and promoting health and safety	Review current carpet provision and arrange for cleaning where required Implement weekly and monthly environmental checks.	Ward Manager Service Manager/Ward Manager	31st May 2018 1st July 2018
The health board needs to be satisfied that the blind spots in the garden area have been risk assessed and any remedial safety action undertaken.		CCTV to be installed that covers all blind spots in the garden.	Ward Manager	Completed
The ward manager needs to look at the available space within the unit and use the rooms to their best advantage.		15 steps challenge to be undertaken to establish best use of available space.	Senior Nurse for Quality/ Assurance Team	31st August 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
The ward manager needs to look at the safety issues involved in potentially very unwell patients from the section 136 suite walking through the main communal area of the ward to access the smoking area.		Complete individual risk assessment as part of 136 assessment.	Service Manager Ward Manager Service	30th June 2018
		Review 136 environmental provision to consider dedicated 136 smoking area	Manager/Ward Manager	31st July 2018
The Health board needs to re-establish improved lines of communication and working arrangements with Dyfed-Powys police.		Review current system of communication between HB and Police	Head of Service AMH/ Head of Service Clinical innovation & strategy	30th June 2018
The health board needs to consider purchasing a small fridge to enable the storage of milk in the patients' small kitchen area	2.5 Nutrition and Hydration	Order a table top fridge	Head of Service	31st May 2018
The ward manager needs to make arrangements for patients to access hot water without having to ask staff for access to the		Introduce system to ensure that hot water is always available.	Ward Manager	31st May 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
kitchen.				
The ward manager needs to ensure that staff know when and where to record emergency trolley daily checks	2.6 Medicines Management	Introduce as standard agenda item for staff meetings. Include on daily tasks list.	Ward Manager Ward Manager	19th May 2018 19th May 2018
The ward manager needs to ensure that the fridge for storing medication is fit for purpose		Implement weekly and monthly environmental checks. Check fridge is fit for purpose and take appropriate action.	Service Manager/ Ward Manager Ward Manager	1st July 2018 31st May 2018
The health board must implement a suitable system for routinely checking that other medication (that does not require refrigeration) is being stored at the temperature recommended by the manufacturer.		Purchase a room thermometer and implement daily checks Conform optimum temperature ranges for safe storage of medication through medication optimisation group	Head of Service Lead Pharmacist MH/LD	30th June 2018 30th September 2018
The health board needs to ensure that there is a	3.5 Record	To communicate to staff the need to	Service Manager	1st June

Improvement needed	Standard	Service action	Responsible officer	Timescale
robust IT system within its hospitals, which can be accessed easily and without interruption.	keeping	complete an incident report on the Datix system when there is a system failure. As part of the UHB wider rollout plan for wi-fi and network improvements, all sites have been assessed, and action plans have been developed, however there are financial implications for the development plans which will be considered as part of the wider capital implications for ICT.	Assistant Director of Informatics	2018 Subject to availability of capital funding
The ward manager needs to ensure that the ward clerk accesses relevant training in the Mental Health Act, its statutory documentation and its retention The ward manager needs to ensure that the MHA documentation is audited and reviewed to ensure compliance with the statutory	Application of the Mental Health Act	Training need to be identified through PADR review. Training session to be completed on MHA documentation filing Introduce a system for ensuring compliance with statutory documentation	Service Manager/administration manager MHA administration team Ward Manager/ MHA	30th June 2018 31st July 2018 31st July 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
documentation The ward manager must ensure that copies of the Mental Health Act 1983 Codes of Practice (English and Welsh language versions) are retained and not removed from the ward. The ward manager needs to ensure that paper documentation is filed appropriately.		Electronic link to Code of Practice to be sent to all Registered Nurses and Medics Hard copies to be placed in Ward Manager's office.	administrator Mental Health Act Administrator Service Manager Ward Manager	 30th June 2018 30th June 2018
The ward manager needs to ensure that assessment reviews are undertaken in a timely manner.	Monitoring the Mental Health Measure	Assessment review need be identified in the ward diary/information board Introduce a system for monitoring compliance	Ward Manager Ward Manager	30th June 2018 30th June 2018
Quality of management and leadership				
No improvements identified				

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): Sara Rees

Job role: Head of Service Adult Mental Health

Date: 16 May 2018