Arolygiaeth Gofal Iechyd Cymru

Healthcare Inspectorate Wales

NHS Mental Health Service Inspection (Unannounced)

Talygarn Ward, County Hospital:

Aneurin Bevan University Health Board.

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

Our purpose

To check that people in Wales are receiving good care.

Our values

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

Our priorities

Through our work we aim to:

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

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced mental health inspection of County Hospital, Pontypool within Aneurin Bevan University Health Board on 1, 2 and 3 May 2018. The following mental health ward was visited during this inspection:

- Taylgarn Ward

Our team, for the inspection comprised of four HIW inspectors, 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 were satisfied that the care provided at Talygarn 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 were disappointed that many of the areas identified in last year's report had not been addressed despite the health board giving HIW completion dates for summer 2017.

We sent an Immediate Assurance letter to the health board regarding the effectiveness of the personal safety 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. This was one area identified last year which has not been addressed.

Care and Treatment Plans (CTP) were not fully completed. This was another area of improvement from last year which has not been addressed.

The Mental Health Act (MHA) documentation also needs audit and review to ensure compliance with the legislative requirements of the Act. Again this was an area identified last year which has not been addressed.

There were some health and safety issues regarding fire doors, the hot water boiler, electrical sockets and rodents in the courtyard.

This is what we found the service did well:

- Patients told us that staff treated them with respect and kindness
- The occupational therapy department were innovative and forward thinking in their care and treatment activities

This is what we recommend the service could improve:

- The alarm system needs to be addressed immediately
- The rodents in the courtyard area needs to be addressed
- Plans with timescales to move towards single room accommodation needs to be in place
- Care plans needs to be audited and reviewed
- Mental Health Act documentation requires reviewing
- Signage needs to be visible to identify areas where CCTV cameras are in use. The health board must review their policy of CCTV use to ensure that it follows the Information Commissioner's Office guidance set out in their 2018 CCTV Code of Practice
- Some areas of the ward require redecoration and the outside area needs to be more aesthetically pleasant.

Further detail regarding improvements can be found in Appendix A

3. What we found

Background of the service

Taylgarn ward provides NHS mental health services at County Hospital, Coed-y-Gric Road, Griffithstown, Pontypool, Torfaen NP4 5YA within Aneurin Bevan University Health Board.

The service is a 21 bed, mixed gender, adult acute mental health assessment and treatment ward. Two of the 21 beds are reserved for out of hour's service.

At the time of inspection, there were 11 in-patients and four new patients were admitted during the visit.

The service employees a staff team which includes a ward manager, three deputy ward managers, registered mental health nurses and health care support workers. The multi-disciplinary team includes three consultant's psychiatrists (one part time), one senior house officer, three psychologists, an occupational therapist (OT) and a small team of psychology and OT assistants. The team could also access advocacy services and the crisis intervention team. In addition, the health board employs maintenance, domestic and administration staff that support the day to day running of the unit.

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 Talygarn.

We saw staff engaging with patients in a friendly, yet professional, manner, especially the occupational health team who are innovative and enthusiastic team members. This good engagement by all staff was confirmed by patients and the advocacy service member.

We saw that patients continue to be cared for in multiple occupancy rooms and there are no plans for this to change despite HIW being advised that an option appraisal paper was developed in September 2017.

The courtyard area was bleak and vermin were regularly seen in the area by staff and patients. Again this was highlighted in the last report and had not been addressed despite HIW being advised that this would be completed by September 2017.

There was no dedicated visitors' room despite HIW being told that a staffed, child friendly visiting room would be allocated within the Talygarn unit by April 2017.

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. However they also stated that the days were long and could be quite boring at times.

"Be nice if we had a gym."

"Food excellent."

"Feel safe."

Staying healthy

Facilities were available to promote healthy living and patients' wellbeing.

We saw that posters were displayed which provided information on smoking cessation and healthy eating.

Patients had access to limited indoor and outdoor activities. These included working on an allotment within the grounds of the hospital (which is innovative and an example of noteworthy practice), cookery, watching television / DVD's, and spending time in the courtyard. There was a narrow, high walled concrete courtyard which was bleak and unwelcoming. This was highlighted in the last report. Patients could sit at the far end with relatives however, this area was not covered by CCTV and therefore was a "blind spot" with regards to safety. The manager needs to ensure that there are sufficient staff on duty to observe patients in the courtyard at regular intervals. The courtyard would benefit from raised areas with flower beds, a decked area or an artificial grass area where patients could get involved in growing flowers or vegetables and take responsibility for the day to day maintenance of the area. The occupational therapists told us that they were hoping to bring some of the allotment work to the courtyard. We noted that the designated smoking areas were overflowing with cigarettes ends.

There was no gym facility available although patients mentioned a preference for one. Staff told us that they were in the process of confirming arrangements to use the local authority facilities subject to acceptable prices.

Most of the patients told us the difficult part of their stay on the ward was boredom. This is not conducive to effective treatment or promoting the wellbeing of patients

Improvement needed

The ward manager needs to develop a wider activity programme to relieve the boredom described by patients

The health board needs to ensure that the courtyard is a pleasant, safe environment for patients and relatives which is free from rodents.

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 limited designated male and female areas, only bedrooms and toilets. All other areas such as lounges and bathrooms were not gender specific. This did not offer patients a choice in where and with whom they wished to sit and relax.

There were only two individual bedrooms with ensuite toilet and washing facilities. The remaining rooms were a mixture of single, double, four or six bed communal dormitories. This does not promote patients' privacy and dignity. We suggested that the Health Board consider making cubicles in the 4 and 6 bedded rooms so that each has a door and therefore more privacy (in the absence of single en-suite rooms) however senior staff told us that there were no plans to change the provision to individual bedrooms at present.

Patients told us that they could personalise their rooms with their own belongings depending on their mental state at that time, although they were prohibited from hanging anything on the walls. However we did not see any rooms which had been personalised. We saw and patients confirmed that staff knocked their bedroom doors before entering which maintained patients' privacy to some degree.

The bedroom door observation panels were covered with curtains which patients could close for privacy. However, in the communal bedrooms if one patient was under observation due to their mental state, it meant that all patients in that room were denied the privacy of closing the curtain. This means that other patients and staff could look in to the bedrooms at any time and therefore did not promote dignity and respect.

Individual space was very limited on the unit with no quiet rooms or less stimulated rooms for patients who were very unwell. This meant that patients in the communal bedrooms could possibly be in a position where they do not have any individual space to themselves.

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

Improvement needed

The health board should consider making a quiet room / less stimulated room for patients who require or wish to have time to themselves away from other patients.

Patient information

There was some written information displayed on the ward for patients and their families. We saw that posters displayed information about advocacy services smoking cessation, visiting times and the locked door policy. There was no information regarding how patients could provide feedback on the care they received on the ward or the Putting Things Right NHS complaint process. However this was in place before the end of the inspection.

We saw that there was clear signage within the unit in both Welsh and English. However there was no signage to advise patients and relatives that there were CCTV cameras in the smoking area of the courtyard. The health board must review their policy of CCTV use to ensure that it follows the Information Commissioner's Office guidance set out in their 2018 CCTV Code of Practice[1].

There was a "meet the team" ward board with photographs of the team members including the occupational therapists and consultants. It would be beneficial if the psychologists were added to this board. This means that patients and their relatives can identify the staff members and what their roles are.

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.

There was a multidisciplinary handover meeting every morning where pathway decisions for each patient were discussed. There was a good working relationship with the social workers who attended this meeting. They were co-located upstairs.

Timely care

We found that patients were generally 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 alarm bells were not available in communal areas nor in all bedrooms. This meant that should a patient or member of staff require assistance in an emergency situation the response may not always be in a timely manner.

Improvement needed

The health board need to ensure that patients and relatives area aware of the areas where CCTV are in place and ensure that it follows the Information Commissioner's Office guidance set out in their 2018 CCTV Code of Practice.

The health board should consider placing nurse call / alarm bells in areas throughout the unit.

Individual care

Planning care to promote independence

Care was individualised and on the whole focused on treatment and recovery that was supported by least restrictive practices, both in care planning and ward or hospital practices.

Each patient had their own programme of care based on their individual needs such as medication, therapy sessions and activities. These included individual and group sessions, based within the hospital and the community (when required authorisation was in place).

People’s rights

We looked at the information booklet offered to patients and their relatives on admission to the ward and saw that the information regarding admission status was ambiguous and vague. The information regarding informal patients needs to be re-written in more supportive and less intimidating manner. This was an improvement in last year's report which has not been fully addressed.

Additionally, there was no family room for visitors with books and toys for younger family members. Visitors have to share the ward facilities with patients when visiting relatives. This is not dignified for patients who are unwell or want privacy whilst on the ward. Staff told us that there was a room upstairs used for children to visit which meant that they did not have to enter the ward. This is good practice, however this room was not designated and therefore staff would have to ensure the room was available before the visit could go ahead. It was not child friendly and there were no books or toys available. This again was an improvement identified in the last report.

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.

Currently the system for making a call is that staff dial from the office and put it through to the payphone on the wall in the reception area. Or when a patient receives a call, staff again put it through to the payphone on the wall. This means that patients have to talk in a public thoroughfare. When we spoke to staff regarding privacy we were told that patients could also use the telephone in the doctor's office but staff would have to oversee the call. This means that patients can not make or receive a private telephone call if they do not have their own mobile phone.

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 small 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.

Improvement needed

The ward manager needs to ensure that the wording on informal admission in the information booklet is less intimidating.

The health board should consider using a room upstairs as a designated family /professional visitor's room. This could contain books and toys for children.

The health board should consider purchasing a cordless phone to enable patients to have private telephone conversations.

Listening and learning from feedback

We did not see information displayed for patients and their families on how they could provide feedback or raise a concern (complaint), although this was

available in the information booklet given on admission. Additionally we did not see suggestion boxes 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. However this information was not easily available when we arrived on the ward. During the inspection visit one of the deputy ward managers had printed out the relevant information and made it available on the information area in reception.

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 three times a week and was available via telephone at other times. We spoke with the advocacy representative who confirmed that staff on the ward were proactive in accessing the service on behalf of patients.

Improvement needed

The ward manager needs to ensure that patients and their relatives have a means to feedback their experiences of the service.

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 health board's arrangements to manage risk and promote staff and patients' safety and wellbeing were always effective specifically; the ineffective alarm system, blind spots in the garden and the transfer arrangements of patients to other hospitals.

There were effective procedures for the safe management of medicines and infection prevention and control.

Written care plans were in place however these need auditing and reviewing. This was highlighted in last years report and has not been addressed.

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, we did find some areas regarding information on medication and section 17 leave which was not in place. The section 17 leave was highlighted last year and had not been addressed.

Safe care

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.

We saw that some staff were issued with 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 fit for purpose. The alarms were similar to "walkey

talkey" type handsets. Staff would have to speak into the handset to ask for assistance and also to respond to colleagues requesting help. This was not always possible depending on the presenting emergency situation. There were no visual warning lights on the ward to notify staff where to respond. 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 across the health board as it is a re-occurring theme within the Mental Health and Learning Disability inspections.

Our concerns regarding the personal alarm system was 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 Talygarn ward:

HIW found that the current personal alarm system used in the building to alert staff to emergency situations was not fit for purpose, in as much as;

- There were not sufficient numbers of hand held alarms
- The system requires staff to speak into the hand set (similar to a walkey talkey device) to notify colleagues where the incident is occurring. There is the potential that staff may not be in a position to access the handset to speak into in an emergency situation
- The system does not give visual warning of where the emergency is located
- This system is not timely and does not provide a safe environment for staff or patients.

Improvement needed:

The health board urgently need to provide a safe system for alerting staff of when and where there is an emergency situation.

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

We were also concerned that there was a "blind spot" at the bottom of the outside courtyard where patients, relatives or staff could not be viewed from the main building. Additionally staff told us that there was a problem with contraband (usually prohibited drugs) being thrown over the fence around the courtyard. There were CCTV cameras at the smoking area at the top of the courtyard but these did not extend to the sitting area at the bottom.

Talygarn is an adult acute assessment ward and consists of a two storey building with most facilities located on ground level. There is level access to the main entrance from the car park. Entry is via an intercom system to deter unauthorised persons from entering the building. Information regarding visiting times and the locked door policy is visible at the main entrance. The crisis team and psychologists are based on the second level and patients have escorted access to these areas. There is also direct entry to this level form the rear of the building and it is where children access for visiting relatives.

Overall, the ward appeared well maintained and systems were in place to report environmental hazards that required attention and repair. There had been refurbishing of the bedrooms with anti-ligature measures such as specific beds, wardrobes and radiator covers. However this work had not been well planned as the radiator covers now obscured all the electrical points and subsequently the domestic staff had to remove the radiator cover to access the sockets to plug in the cleaning equipment. Additionally, the wardrobe design in one bedroom involved moving the bed to the other side of the room. This meant that the patient had to get out of bed and cross the room to access the light switch.

We discussed with the maintenance team representative issues regarding the overflow pipe from the hot water boiler and the earth cable for the electricity in the kitchen. We were assured that both issues would be dealt with the following week when the appropriate items had been ordered.

There was a fire door which was wedged open for the duration of our inspection. This enabled staff to observe the whole length of the ward. For safety reasons the health board must place magnetic door holders on fire doors which are permanently open.

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. However we did not see unmet needs being recorded, such as appropriate visiting for children.

We saw that storage rooms and cupboards were locked to prevent unauthorised and accidental access by patients and visitors.

Improvement needed

The health board needs to ensure the safety of patients, relatives and staff in all areas of the courtyard

The health board needs to address the concern regarding contraband being thrown over the fence surrounding the courtyard

The health board needs to review the access to electrical sockets in the bedrooms

The health board needs to look at the location of the light switch in the identified bedroom

The ward manager needs to ensure that the maintenance team complete the outstanding work in the kitchen

The health board must ensure fire doors have magnetic closures in the case of a fire.

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. However we saw that there were areas where refurbishment work had been commenced but not completed, for instance the bathroom. This meant that there were areas where maintaining effective cleanliness was difficult. These works needs to be completed as soon as possible.

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

We were also told that the patients' laundry machine often overflowed on to the floor because the outlet pipe would either block or water would empty from the machine quicker that it could enter the outlet pipe. The health board need to ensure that this is addressed.

There were gender specific toilets in the communal areas. Staff told us that these were new and often blocked. This occurred during our inspection and domestic staff unblocked the toilet. When asked why the maintenance team had not been called we were told the ward couldn't be without a gender specific toilet whilst waiting for the maintenance team to come because that could be days. The cause of the continual blockages needs to be addressed.

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

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.

Improvement needed

The health board need to ensure that the outlet pipe for the patients' washing machine is in good working order

The ward manager needs to make a list of outstanding refurbishment work and request completion by the appropriate maintenance team

The health board need to ensure that the toilets are in good working order.

Nutrition and hydration

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.

At present patients did not have access to a kitchen area to make hot or cold drinks. However we saw that there was a dedicated room already identified and was in the process of being furnished.

Medicines management

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

There was a medicines management policy available however this was out of date (Oct 2017).

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. 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. The pharmacist visits the ward twice weekly and participates in the ward round, stock checks, speaks with patients and offers training for junior /new staff.

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. However not all the drug charts we looked at had the MHA 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.

There were appropriate tools available to measure the efficacy of any medications administered such as NEWS[1] charts.

[1] The national early warning score (NEWS) is a guide used by medical services to quickly determine the degree of illness of a patient.

Improvement needed

The health board needs to ensure that all wards have up to date policies and procedures.

The ward manager needs to ensure that the MHA legal status of the patient is recorded on the MAR sheet.

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.

Talygarn 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.

As detailed earlier, the health board should provide a designated child friendly visiting room.

Effective care

Safe and clinically effective care

During the course of our inspection, we found that (with the exception of the personal alarms and CCTV cameras in the courtyard) 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.

Staff had received training in de-escalation techniques for challenging behaviour. Although restraint is not used routinely staff are trained and medication is prescribed on individual MAR sheets should it be required.

There was no seclusion room and as suggested earlier in the report the unit may benefit from a high care / less stimulated room to support distressed patients.

Record keeping

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

Patients' care records were paper based and were well structured and easily navigated.

Mental Health Act Monitoring

We reviewed the statutory detention documents of one patient across Talygarn ward. This is because there was only one patient detained during the visit. All other patients were informal. The application for detention in hospital had been made in accordance with the requirements of the Act. This demonstrated that the patient's rights had been promoted and protected as required by the Act.

The ward files were organised and contained most of the required information. Areas for improvement were;

- Rights for medication letter to nearest relative is not currently being undertaken
- All expired section 17 leave forms should be clearly marked as are no longer valid and should not be retained in the statutory folder
- A copy of the medical scrutiny forms need to be included.

The MHA manager came to the ward to speak with the inspection team and the above areas were discussed in detail.

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 available on the ward.

Improvement needed

The ward manager and the MHA manager need to ensure the bullet pointed areas are addressed.

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

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

Although we saw full and thorough mental and physical health assessments, risk assessments and the case notes were detailed, generally when there was a current Care and Treatment Plans (CTP) the information was minimal. We found;

- Objectives and interventions were quite general (i.e. usually around medication)
- We did not see evidence that patient's strengths were being identified and used to plan care and treatment
- CTP's were not focussed on rehabilitation and recovery (in two files there was no CTP plan)
- Unmet needs were not always identified
- Mental health capacity assessments were not undertaken
- Patients signature for agreement and involvement in planning care were not visible
- The Care Co-ordinator was not clearly identified
- No dietary needs assessment or weekly monitoring of weight
- No evidence of advocacy support.

Improvement needed

The ward manager needs to audit and review patients' records, especially the CTP and ensure that these are in place, detailed and up to date.

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 all ward staff were up to date with Mental Capacity Act / Deprivation of Liberty Safeguards training.

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 evidence of good management and leadership at Talygarn. 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.

We saw good cohesive team working with evidence of clear succession planning.

Completion of mandatory training has improved since last year.

Staff told us that senior management were often seen in the building and were familiar with the staff and service provided at the unit.

Governance, leadership and accountability

Aneurin Bevan 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. 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 three deputy managers a committed ward team and a small multi-disciplinary team which included three consultants who, we were told, were supportive and engaged well with the unit.

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. Although we were disappointed that there had been very few actions completed from last year's improvement plan.

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 staffing was almost at full capacity. There was a relatively new nursing team who were working very well together and this was supported with a full team (although small) medical and therapeutic team.

Observations made during the course of our inspection indicated that nursing staff had the right skills and knowledge to meet the needs of patients.

We saw from nursing shift rotas that numbers were at appropriate for the number of patients currently on the unit. There was also a "driver" who was employed to transfer patients to various hospitals within the health board. When this person was not driving they were utilised as extra health care support workers on the unit. This is a pilot at present and we heard that if it becomes a substantive post there needs to be further health and safety risk assessments to the vehicle to ensure the safety of all concerned in the transfer of patients.

All staff had received an appraisal of their work within the last year.

We reviewed staff training. It was evident that this was being monitored by the ward manager and there had been a significant improvement on last years report. From our findings within this report we saw that there was a shortfall in Mental Health Act and Deprivation of Liberty Standards training.

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
There was no Putting Things Right (the health board process for raising a concern / complaint) information or leaflets available for patient or relatives to read.	Patient / relatives would not know the process for raising a concern / complaint.	HIW highlighted this with the deputy ward manager on the second day of the inspection.	Leaflets were printed and places in the information stand by the front door before the inspection was completed.

Appendix B – Immediate improvement plan

Service: County Hospital Mental Health

Ward/unit(s): Talygarn Ward

Date of inspection: 1,2 and 3 May 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
Finding: HIW found that the current personal alarm system used in the building to alert staff to emergency situations was not fit for purpose, in as much as; There were not sufficient numbers of hand held alarms The system requires staff to speak into the hand set (similar to a mobile phone) to notify	2.1 Managing risk and promoting health and safety	As an immediate assurance the Division can confirm: Sufficient hand held alarms are in situ on the ward and all staff on duty are provided with Walkie Talkies. The lack of a more specific personal alarm systems across all Mental Health Inpatient facilities across the Division has already been placed on the risk register, with an addition to	Directorate Manager/ Lead Nurse	June 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
colleagues where the incident is occurring. There is the potential that staff may not be in a position to access the handset to speak into in an emergency situation. This system is not timely and does not provide a safe environment for staff or patients. **Improvement needed:** The health board urgently need to provide a safe system for alerting staff when and where there is an emergency situation.		expedite and prioritise Talygarn Ward. (A copy of the risk assessment item has been included for reference). Over the next 2/3 weeks the Health and Safety Department will be conducting an audit of personal safety on all of the mental health and learning difficulties wards. This will establish what current measures are in place, their efficacy, identify areas for improvements and research current best available systems. As part of the review we will be identifying opportunities for alarms systems that work across sites to enable site wide responses to emergency situations (i.e. adult wards supporting older adult wards).		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		With specific regard to the Talygarn alarm system: • A quote with firm costings will be provided, by the supplier, on the 1st June 2018.	Works and Estates	1st June 2018
		• A capital bid application will be completed, signed off by the Mental Health & LD Division and submitted to the Corporate Capitol Team by 10th June 2018.	Directorate & Divisional Management Teams	10th June 2018
		• Decision on approval for the works will be made by the Executive Team on the 11th June 2018.	Executive Team	11th June 2018
		• Subject to financial approval by the Executive Team, the alarm system will be ordered. From this point it is expected that it	Works and Estates	September 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		would take approximately 3 months for the system to be fully fitted, which would include time to order parts and fit the system		

Appendix C – Improvement plan

Service: County Hospital Mental Health

Ward/unit(s): Talygarn Ward

Date of inspection: 1,2, and 3 May 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 to relieve the boredom described by patients	1.1 Health promotion, protection and improvement	The Senior Nurse/Ward Manager is engaged with the Exercise and Well-being officer to in reach into the ward to develop a programme to increase activity opportunities for patients. Volunteers starting imminently will provide an alternative engagement with the patients to health board staff. The ward and OT staff will continue to develop their programme of	Senior Nurse/Ward Manager/ OT	September 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board needs to ensure that the courtyard is a pleasant, safe environment for patients and relatives which is free from rodents.		engagement. This will include Psychological group work undertaken by Psychology assistants and Psychological therapist. The Senior Nurse has escalated these matters to : the Facilities Manager to address the issue of rodents. the works and estates department to look at the options of painting / cleaning the court yard walls the third sector service Growing Space who will work with patients to develop the courtyard	Senior Nurse/Facilities Manager	June 2018
The health board should consider making a quiet room / less stimulated room for patients who require or wish to have time to themselves away from other patients.	4.1 Dignified Care	The Ward Manager/Senior nurse have identified a room that can be utilised as a quiet room.	Senior Nurse/Ward Manager	July 2018
The health board need to ensure that patients and relatives area aware of the areas where	5.1 Timely access	CCTV signs have been ordered and will be installed on receipt. In the meantime	Ward Manager	July 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
CCTV are in place and ensure that it follows the Information Commissioner's Office guidance set out in their 2018 CCTV Code of Practice.		laminated notices will be displayed		
The health board should consider placing nurse call / alarm bells in areas throughout the unit.		A Health and Safety audit is currently being carried out on all acute units to scope call/alarm bells. Costings will be undertaken and a report prepared for full consideration by the Health Board	Ward Manager/Health & Safety Officer	September 2018
The ward manager needs to ensure that the wording on informal admission in the information booklet is less intimidating.	6.2 Peoples rights	An information leaflet has been developed across all adult inpatient units and will be ratified at the Adult Directorate Planning meeting.	SIM/Lead Nurse	July 2018
The health board should consider using a room upstairs as a designated family /professional visitor's room. This could contain books and toys for children.		A room has been identified on the unit and child friendly equipment has been ordered.	SIM/Senior Nurse Ward	July 2018
The health board should consider purchasing a cordless phone to enable patients to have		The ward has a mobile phone which will be made available to patients to have	Manager/Senior Nurse	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
private telephone conversations.		private telephone conversations		
The ward manager needs to ensure that patients and their relatives have a means to feedback their experiences of the service.	6.3 Listening and Learning from feedback	The ward currently run weekly Carers groups. A Carer's clinic was established but was not well attended. Therefore a Carer's group has been developed at Talygarn to provide support to relatives and Carers. The groups run over 6-7 sessions. The sessions will include advice on the following- Crisis management Physical Health Housing and Benefits Psychology Any concerns or suggestions from these meetings will be feedback to the ward manager	Ward manager/Senior Nurse	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Carers enlight.docx A suggestion box has been introduced. The ward has weekly patient community meetings. This allows the team to explore and explain activities for the forthcoming week and to let patients know any changes that may be happening on the ward, as well as listening to any complaints or concerns raised by patients The ward has a 'You said we did board' to capture patient feedback and to make patients aware of what action was taken and is displayed on the main corridor.		
Delivery of safe and effective care				
The health board needs to ensure the safety of patients, relatives and staff in all areas of the courtyard	2.1 Managing risk and promoting health and safety	Costings have been submitted to extend the scope of the current CCTV.	SIM/Senior Nurse	July 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board needs to address the concern regarding contraband being thrown over the fence surrounding the courtyard		Health & Safety have completed a safety audit across all inpatient units- awaiting report. The Quality and Patient Safety department will monitor DATIX reports for the next 3 months to identify the extent of the problem to support action planning	Health & Safety Lead/SIM/Lead Nurse/QPS Lead QPS Lead/Concerns Manager	September 2018 July 2018
The health board needs to review the access to electrical sockets in the bedrooms The health board needs to look at the location of the light switch in the identified bedroom		This has been reported to works and estates and awaiting completion of the work.	SIM/Senior Nurse/Works and Estates.	July 2018
The ward manager needs to ensure that the maintenance team complete the outstanding work in the kitchen		This has been reported to works and estates and awaiting completion of the work. Work on the kitchen is now completed.	SIM/Ward Manager/Senior Nurse	July 2018 Complete
The health board must ensure fire doors have magnetic closures in the case of a fire.		A request for Costings have been submitted for this work		July 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board need to ensure that the outlet pipe for the patients' washing machine is in good working order	2.4 Infection Prevention and Control (IPC) and Decontamination	The washing machine is now in good working order.	Ward Manager/Senior Nurse	Complete
The ward manager needs to make a list of outstanding refurbishment work and request completion by the appropriate maintenance team		The ward manager has a list of outstanding refurbishment and this will be escalated for completion.	Ward Manager/Works and Estates/SIM/Senior Nurse	July 2018
The health board need to ensure that the toilets are in good working order		The toilets are now in good working order.	Ward Manager	Complete
The health board needs to ensure that all wards have up to date policies and procedures.	2.6 Medicines Management	The ward Manager has e mailed all staff to ensure that they are aware of the relevant policies and procedures on the ABUHB intranet and how to access these.	Ward Manager	Complete
The ward manager needs to ensure that the MHA legal status of the patient is recorded on the MAR sheet.		The ward Manager has raised this with all staff and has introduced a weekly checking process to audit compliance.	Ward Manager	Complete
The ward manager and the MHA manager need	Application of the	This has now been addressed	MHA Manager	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
to ensure the bullet pointed areas are addressed.	Mental Health Act			
The ward manager needs to audit and review patients' records, especially the CTP and ensure that these are in place, detailed and up to date.	Monitoring the Mental Health Measure	The MH & LD Division carry out 6 monthly rolling audits- the next one for Talygarn is July 2018. The ward Manager will introduce a weekly checking process of documentation.	QPS Lead Nurse Ward Manager	July 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): Ana Llewellyn

Job role: Divisional Nurse

Date: 14 June 2018