NHS Mental Health Service Inspection (Unannounced)

Royal Glamorgan Hospital

St David's Ward, Seren Ward, Admission Ward, Ward 21, Ward 22 and the Psychiatric Intensive Care Unit

Cwm Taf Morgannwg University Health Board

Inspection date: 8 - 11 July 2019

Publication date: 14 October 2019

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Digital ISBN 978-1-83933-335-4

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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 receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

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 Royal Glamorgan Hospital within Cwm Taf Morgannwg University Health Board on the evening of 8 July 2019 and the following days of 9, 10 and 11 July. The following sites and wards were visited during this inspection:

- St David's Ward - Older Person's Mental Health
- Seren Ward - Older Person's Mental Health
- Admission Ward - Adult Mental Health
- Ward 21 - Adult Mental Health
- Ward 22 - Adult Mental Health
- Psychiatric Intensive Care Unit - Adult Mental Health.

Our team, for the inspection comprised of two HIW inspectors, a HIW Clinical Specialist Advisor, five clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one lay reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

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.

Since 2015, HIW has conducted five mental health inspections within the Royal Glamorgan Hospital[1]. HIW uses a range of intelligence to inform its inspection programme and the frequency of mental health inspections at Royal Glamorgan over the last three years is notable, reflecting our ongoing raised level of concern. At our last follow-up inspection in June 2018, we visited Seren and St David's wards. We were disappointed to find that not only had previous actions not been completed, but we identified a number of new issues including immediate concerns in relation to the safety of medicines management.

Specific issues we have consistently identified since 2015 include the following:

- Ligature point risks and numerous environmental issues, including bathroom and bedroom facilities, furniture, fixtures and fittings
- Staffing levels and skill mix to ensure the appropriate numbers and skillset of staff in each ward/area
- Medicines management, including medicine storage, availability of ready-to-use suction equipment, medication administration records, prescription and administration of medicines
- Dignified care due to environmental issues and facilities, including dormitory areas and bathroom arrangements which impact on patients' privacy.

As a result of these concerns, HIW has continued to closely monitor these services including holding ongoing conversations with the health board around

[1] https://hiw.org.uk/sites/default/files/2019-06/180917royalglamorganen.pdf

https://hiw.org.uk/sites/default/files/2019-06/180425royalglamen.pdf

https://hiw.org.uk/sites/default/files/2019-06/170411royalglamen.pdf

https://hiw.org.uk/sites/default/files/2019-06/161014royalglamorganen.pdf

https://hiw.org.uk/sites/default/files/2019-06/Mental%2520Health%2520and%2520Learning%2520Disability%2520Inspection%2520Report%2520-%2520Royal%2520Glamorgan%2520Hospital%2520-%2520Mental%2520Health%2520Unit%2520-%252013-16%2520October%25202015.pdf

its approach to governance and risk management within mental health services in Royal Glamorgan Hospital.

The purpose of this inspection is to gain assurance on whether sufficient attention is being given by the health board to address the issues we have continued to find.

2. Summary of our inspection

Overall, given our findings, we could not be assured that there has sufficient progress made by the health board to address the issues we have repeatedly identified from our previous mental health inspections within Royal Glamorgan Hospital.

Whilst improvements had been completed in respect of the environment of care, there are recurring estates issues that impact on patient experience.

The design of the ward environments and lack of appropriate fixtures and furnishings impacts upon how staff are able to maintain the privacy and dignity of patients.

Unresolved plumbing and drainage issues impact upon the availability of toilet, shower and bath facilities across the mental health wards.

We were not assured that the provision of care was safe and effective in all instances.

We found significant concerns regarding medicines management, records management and the completion of mandatory training that resulted in the issue of a HIW immediate assurance letter to the health board.

We found areas of clinical documentation that were poorly completed and failed to address and monitor the needs of individuals including the management of their risks. This means that the patient would not receive adequate care and treatment.

The issues we identified highlight the inadequacy and ineffectiveness of audit processes as a means of checking that patient records were complete and up to date.

We observed a dedicated workforce however there were a number of staff working excessive hours, which may lead to risk fatigue and

could potentially affect their well-being and/or also compromise their professional judgements.

This is what we found the service did well:

- Staff interacted and engaged with patients respectfully
- Staff we met were committed to providing care
- Monitoring the use of the Mental Health Act
- Structural and decorative improvement to some of the environments of care since HIW's previous inspection

This is what we recommend the service could improve:

- Privacy measures to prevent wards being observed from public areas
- Record keeping and the completion of clinical documentation.
- Medicines management and clinic room arrangements
- Governance and audit arrangements
- Completion and monitoring of mandatory training.

We had some immediate concerns about patient safety which were dealt with under our immediate assurance process. This meant that we wrote to the service immediately after the inspection, outlining that urgent remedial actions were required. These were in relation to some aspects for the quality of patient experience and the delivery of safe and effective patient care.

Details of the immediate improvements we identified are provided in Appendix B.

3. What we found

Background of the service

Royal Glamorgan Hospital provides NHS mental health services at Ynysmaerdy, Llantrisant CF72 8XR, within Cwm Taf Morgannwg University Health Board.

The Adult Mental Health inpatient service has four mixed gender wards: Admission Ward with 14 beds, two treatment wards (Ward 21 & Ward 22) with 14 beds each and a Psychiatric Intensive Care Unit with six beds.

The Older Persons Mental Health inpatient service has two mixed gender wards: Seren Ward, a 19 bed organic[2] mental health assessment ward and St David's ward, a 10 bed functional[3] mental health assessment ward.

[2] An organic mental disorder is a dysfunction of the brain that may be permanent or temporary. It describes reduced brain function due to illnesses that are not psychiatric in nature. Organic mental disorders are disturbances that may be caused by injury or disease affecting brain tissues as well as by chemical or hormonal abnormalities. Exposure to toxic materials, neurological impairment, or abnormal changes associated with aging can also cause these disorders.

[3] Functional mental illness applies to mental disorders other than dementia, and includes severe mental illness such as schizophrenia and bipolar mood disorder.

Quality of patient experience

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

We observed staff interacting and engaging with patients appropriately and treating patients with dignity and respect. However, we did observe some staff entering dormitories without knocking.

It was positive that improvements had been made to the environment of care throughout the mental health wards since our inspections in 2018 and 2017. However, some improvements to privacy measures are still required to prevent ward areas being viewed from public areas of the hospital.

Dignified care

We observed staff interacting and engaging with patients appropriately and treating patients with dignity and respect. The staff we spoke with were committed to providing dignified care for the patients.

We heard staff speaking with patients in calm tones throughout our inspection. When patients approached staff members they were met with polite and responsive caring attitudes. On the whole we observed staff being respectful toward patients, we did, however observe on some occasions that staff entered occupied patient bedrooms without knocking the door beforehand.

It was positive to note that on Seren Ward there had been improvements to make the environment of care more dementia friendly. This was through the use of dementia friendly items and decoration, along with therapeutic spaces that were reminiscence orientated, such as the onward pub and nail salon areas. There was a range of equipment available that was suitable for patients with dementia, which included empathy dolls, pet therapy animals and electronic reminiscence interactive therapy activities.

At the time of our inspection there were temporary signs displayed identifying rooms, whilst the ward was awaiting delivery of dementia friendly signs.

Since our previous inspection, improvements had been made to the environment of care, which included the installation of anti-ligature fittings within communal and en suite toilet and shower areas. We were informed that due to the cognitive impairment of some patients on Seren Ward, some were unable to use these anti-ligature fitting as independently compared with more familiar traditional style fittings. This is because persons with cognitive impairments may have difficulty in adapting to use unfamiliar fixtures and items.

Services have to manage the balance in providing a safe environment of care and ensure that the environment does not impinge on patient's independence, and de-skill individuals whilst in hospital. The health board should keep this under review to ensure that patients are supported in being independent and kept safe.

A programme of work had been completed across the wards which improved the fixtures, fittings and furniture. The improvements provided a positive impact for patients throughout the environment of care. This included the installation of a patient laundry facility on St David's Ward, which was also used by Seren Ward. This facility was recommended by HIW on the previous two inspections undertaken on these wards.

As identified on previous inspections, it was disappointing to see that there were ward areas that did not have suitable screening in place to maintain the privacy of patients. This is because some areas on the wards were still visible to visitors accessing public areas and within the hospital grounds. In addition, the lack of appropriate screening to prevent light entering bedroom areas impacts upon patients' ability to sleep, which may negatively impact on healthy sleep patterns which are encouraged as part of their recovery and well-being.

It was positive to note that following our previous inspections, the child visiting room had been relocated from Ward 22 to an area that did not require visitors to enter onto the ward. However, within the visitor's room, we discovered a number of plastic bags which contained various patient items. This included soiled clothes and corded electrical items and toiletries. This was of concern to us, since these items could be misused by a patient, with the potential for self-harm. We raised this immediately to the nursing staff who removed these items to a safe location.

The staff were unable to identify who the items belonged to, or for how long they had been left within this area. During our conversations with staff they confirmed that staff on Ward 22 oversee the booking of the visitor's room, however, it was unclear who was responsible for the security and maintenance of the area.

The Psychiatric Intensive Care Unit (PICU) had six individual bedrooms. As highlighted during previous inspections, both St David's Ward and Seren Ward had a mix of single bedrooms and dormitory accommodation; Ward 21, Ward 22

and Admission Ward still had a mix of single bedrooms and two-bedded rooms. This does not reflect modern mental health care provision because shared bedrooms can impact on the privacy and dignity of patients.

However, we have additional concerns with the maintenance of privacy and dignity for patients that require transfer from wards located on the first floor, to the PICU on the ground floor. A patient would be escorted in the lift or down stairs, and then through a main thoroughfare of the mental health unit. Whilst this area is not directly open to the public, there may be visitors to the unit or non-mental health staff in this area. This may impact on patient privacy and dignity, particularly if being escorted in a safe-hold as a result of challenging physical behaviours.

Improvement needed

The health board must ensure that:

- Staff knock on bedroom and dormitory doors before entering
- The privacy and dignity of patients is maintained with the use of appropriate screening on external windows throughout the wards
- Arrangements are in place to maintain the cleanliness, tidiness and safety of the child visiting room
- Patient privacy and dignity is maintained when transferring patients from wards in to the PICU.

Patient information

There was a range of information displayed for patients throughout each of the wards. On the whole, this appeared up-to-date and relevant to the patient groups, and included information on health promotion. However, further information could be displayed on healthy eating, drug and alcohol support, and smoking cessation.

Information was also displayed on the wards, directing patients to external organisations such as advocacy services, charities and HIW. However, it was noted that the information displayed regarding HIW was in small print and would be difficult for patients with impaired vision to read.

Improvement needed

The health board must display information:

- On healthy eating, drug and alcohol support and smoking cessation
- That is suitable for patients with impaired vision

Communicating effectively

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

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

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

Individual care

People's rights

Legal documentation we saw to detain patients under the Mental Health Act (the Act) was compliant with the legislation. Information was displayed on the wards to inform patients, who were not restricted by the Act[4], about their rights to leave the wards; this is an improvement since our previous inspection.

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

[4] Commonly referred to as "informal patients", where the patient has capacity to agree to remain in hospital to receive care for their mental health.

services provide independent support to patients with specialist knowledge of each piece of legislation.

There were places for patients to meet with visitors in private. Appropriate arrangements were also in place for patients to make private telephone calls using their own mobile phones or the ward phones.

Listening and learning from feedback

There were opportunities for patients, relatives and carers to provide feedback on the care provided. Information on the NHS Wales Putting Things Right[5] process was displayed on the wards along with contact information for advocacy services and HIW.

A feedback post box with paper forms was also available within the unit reception area, along with an online survey that patients can access which they could access using their mobile phone. These provided opportunities to patients and their relatives or visitors, to give feedback on the service or care provided.

[5] Putting Things Right is the process for managing concerns when someone is unhappy about services provided by the NHS in Wales. www.wales.nhs.uk/sites3/home.cfm?orgid=932

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 were not assured that the provision of care was safe and effective in all instances.

We found that improvements were required with medicines management and the update of associated policies. We identified numerous omissions and inaccuracies in patient records and found that adequate audit processes were not in place to check that patient records were complete, up to date and care plans were being followed by staff.

Staff training compliance required significant improvement, with particular emphasis on prevention and management of violence and aggression training.

Safe care

Managing risk and promoting health and safety

Access to the mental health unit and wards was secure to prevent unauthorised access. Staff could enter the wards with their health board identification cards, and visitors rang the buzzer at the ward entrances.

The Admission Ward, Ward 21 and Ward 22 were located upstairs from the main entrance; these were accessed either via the staircase or lift, so that there was accessible entry for all.

There were nurse call points around the wards, but not within patient bedrooms. During our previous inspection, we raised this as a concern with the health board. We were informed that the use of nurse call bells for adult wards was considered, but that the decision made was that it would not be appropriate for this group of patients. We were informed that all patients' whereabouts and well-being are checked regularly throughout the shifts.

The health board's response does not provide us with assurance, because if a patient was in difficulty or distress within their bedroom, then they could not attract the attention of staff promptly. We advised staff that this issue must be reviewed

again, to provide clear reasoning on how a patient can call for assistance, if a nurse call system is not available.

Staff had access to personal alarms to call for assistance if required.

The training records[6] for the Prevention and Management of Violence and Aggression (PMVA) were unsatisfactory for all wards inspected, and require significant improvement. Our concerns regarding this were dealt with under our immediate assurance process.

The training compliance did not provide us with assurance that there would always be a sufficient number of staff on duty, having completed the appropriate training to manage escalating patient behaviours. This is a particular concern during the night shift, when staffing levels are overall reduced, with fewer members of staff present within the departments and mental health unit overall. This could be compounded further with bank staff working at the hospital, who may also have not received training for PMVA.

The health board was unable to confirm that all bank staff working on the mental health wards had received training for PMVA. It is essential that in addition to permanent staff, bank staff are suitably trained for PMVA.

We spoke with staff, and following discussions and reviewing relevant information provided to us, we found that the current provision of training no longer reflects the most recent Restraint Reduction Network Guidance[7]. We were advised that the current training provision of an initial four day course and an annual two-part 12 hour refresher course, does not provide sufficient time to encompass all the new theory advocated within the Restraint Reduction Network Guidance.

We were also informed that the restraint training currently provided, focuses primarily on reactive approaches, such as physical restraint, and provides insufficient emphasis on human rights, meeting patient needs, prevention and

[6] During the inspection the health board provided the following statistics: 56.41% Seren Ward / 42.86 % St David's Ward / 50.79% Admission Ward / 58.73% PICU / 61.54% Ward 21 / 79.63% Ward 22. The health board's immediate assurance response provided updated figures these are detailed in Appendix B.

[7] The British Institute of Learning Disabilities 2019 Restraint Reduction Network guidance

de-escalation of challenging behaviours, and recovery following restraint. Due to the necessity to train staff in physical restraint, there was insufficient time to adequately explain the traumatic nature of restraint. If training places insufficient emphasis on restraint prevention and de-escalation, staff will understandably be more likely to use restrictive interventions in the first instance, rather than as a last resort, resulting in an over reliance on restraint. The PMVA training must follow the principle of the least restrictive intervention.

As noted earlier, the health board has undertaken significant anti-ligature refurbishment throughout the mental health wards; this has reduced the risk of patient harm by use of ligatures. It was also positive to note that the PICU environment had been updated to reduce the risk of patients absconding from this area. This included the installation of an airlock[8] on entry and exit of the ward, and increasing the height of perimeter anti-climb fence of the secure garden.

Within the PICU, there was an Extra Care Area (ECA) which comprised of a reasonably large room, with seating for patients and an adjoining toilet area. The ECA was used to provide additional support to a patient away from other patients on the ward if necessary. The flooring of the ECA had soft matting, however, this was poorly fitted, with gaps and overlaps, and the perimeter of the floor also had sharp edges around base of the wall. This issues therefore must be addressed.

Improvement needed

The health board must ensure that:

- Patients can alert staff that they require assistance from their bedrooms
- Staff, including bank staff, who work on mental health wards complete their PMVA training

[8] An airlock comprises of two doors that cannot be opened simultaneously. This aids in preventing a person leaving the ward unauthorised whilst the inner door is opened to allow access to the ward as the outdoor will remain locked.

- PMVA training, initial and refresher, follows the principle of least restrictive intervention
- There is suitable flooring within the ECA
- There are no sharp corners or edges within the ECA.

Infection prevention and control

Throughout the inspection we observed that the hospital was mostly clean and free from clutter. The main exception to this was the outside designated smoking areas, which were poorly kept with overfilled cigarette bins and a large amount of cigarette debris present.

Cleaning equipment was stored and organised appropriately. Each ward had dedicated housekeeping staff that maintained the cleanliness of the ward throughout the morning until 2pm. As noted during our previous inspections, after 2pm there were limited housekeeping staff available across the mental health wards. This reduction in staff after 2pm impacted upon ward staff time with patients, as they had to take on some domestic duties through the afternoon and evening.

Staff had access to infection prevention and control and decontamination Personal Protective Equipment when required. Hand hygiene gel dispensers where suitably placed on Seren Ward and St David's Ward. On the adult wards hand hygiene gel was available to staff and locked away to prevent the risk of ingestion by patients. It was positive to note that following our previous inspection, a hand hygiene gel dispenser was installed outside the entry point to the adult wards.

Appropriate bins were available to dispose of medical sharps items. These were dated when assembled to help ensure that they were disposed of within the required time frame if not filled within that period. However, it was noted that the safety lids on the sharp bins were not always used.

Improvement needed

The health board must ensure that:

- Cleaning schedules are in place, to maintain the outside areas, particularly smoking areas
- Housekeeping arrangements are sufficient, to minimise the impact on ward staff after 2pm

- Safety lids are appropriately assembled on all sharps bins.

Nutrition and hydration

Patients were provided with meals at the hospital, making their own choices from the hospital menu. Menus were displayed on the wards, and pictorial menus were available and seen to be used on Seren Ward and St David's Ward, to assist some patients in choosing their meals. There was a wide and varied menu available to patients on all wards, containing vegetarian and healthier options.

We were also informed that the food provided on St David's Ward and Seren Ward can be suitable for patients with difficulty swallowing.

The wards operated protected mealtimes so that patients were not interrupted during their meals. Patients also had access to fruit and snacks along with hot and cold drinks throughout the day.

It was positive to hear that the reminiscence pub on Seren Ward was also regularly used for some patients to sit and have their meals, as an alternative to the main dining room on the ward.

We reviewed a sample of fluid balance (input/output) charts. For one patient on Seren Ward there was inadequate monitoring and actions taken over an eight week period since admission, and a weight loss of over six kilograms were noted since admission. Daily fluid balance charts were not always completed for this patient, with significant gaps of a month within their records. There was also a two week gap between discussing nutritional supplements with the dietician and the prescribing of the supplements.

We also saw incomplete and inadequate monitoring of fluid balance with another patient on Seren Ward. Daily totals were not completed for this patient, and documentation was very brief. There was also no evidence recorded of what actions were considered or taken, to improve fluid intake.

These examples demonstrate that fluid balance monitoring was inadequate for some patients when it was required. There was also a lack of audit and governance in place to identify these deficiencies in patient care.

When fluid intake requires close monitoring, this should be reflected in the individual patient's risk assessment, documented in the patient’s care plan, and

regularly reviewed by the teams. This is because dehydration can lead to further physical and mental complications, along with personal discomfort or pain.

Improvement needed

The health board must ensure that:

- When required, fluid balance charts are used and completed correctly
- Patient records include detailed entries that accurately reflect patient fluid balance where applicable
- When required, staff act upon insufficient fluid input, and that the actions are documented within patient records
- There is a regular audit of fluid balance monitoring charts.

Medicines management

We identified areas for improvement with medicines management across all wards inspected. Our concerns with this were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

Overall, we noted that medication was securely stored. All clinic rooms were locked to prevent unauthorised access, as were medication cupboards. Medication trolleys were also secured to the clinic room, to prevent them being removed by an unauthorised person. Medication fridges were locked when not being accessed, with the exception of Ward 21, where we noted that the fridge had been left unlocked when we entered the clinic on one occasion.

The temperatures of medication fridges and clinic rooms were being monitored and recorded, to check that medication was stored within the appropriate temperature range. However, only the clinic room on Ward 22 had an effective way of reducing the room temperature. In some instances, temperatures were documented at or above 25 degrees Celsius, with no record of what action, if any, was taken. We therefore, were not assured that medication stored within these rooms remain viable for use, if exceeding the manufacturers recommended temperature limit.

We also identified that on Seren Ward there was a large amount of personal medication that was no longer required. There was also medication being stored

past the expiry date. The personal medication and expired medication should have been returned to pharmacy as per health board policy.

We found numerous Medication Administration Record[9] (MAR) charts that were incomplete across all wards. Staff were omitting essential patient details on the front page of the MAR chart such as, Mental Health Act legal status, weight, height and date of birth.

There were also incomplete records of administration on the charts. We saw blank boxes for administration signatures, therefore, it was not evident if medication had been administered or not, and if not, the reason why the medication had not been administered had not been recorded, as required, within the All Wales Medication chart.

Within another MAR chart, we saw medication was prescribed, but did not specify the route of administration. In addition, another chart had medication prescribed that had not been authorised by an accompanying consent to treatment certificate, as required under the Mental Health Act. Furthermore, we noted another chart that was accompanied by the wrong patient's consent to treatment certificate.

There were appropriate arrangements for the storage and use of controlled drugs and drugs liable to misuse. Controlled drug cupboards were kept locked when not being accessed. However, we noted on Ward 22 that there was medication remaining in the controlled drug cupboard that was no longer required and which had not been appropriately removed as per health board policy. In addition, the cupboard was being used to store inappropriate items, such as alcoholic beverages and a bag of unidentified powder, which had been placed in the cupboard in October 2018. This should have been dealt with in line with the health board's policy, and not stored for a prolonged period.

There was a controlled drugs log book within each clinic, and all medication was accounted for. However, it was noted on Ward 21 that one administration of methadone was only signed by one registered nurse, and therefore not in line

[9] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

with the requirement for a two registered nurse check, as per the health board's controlled drugs policy.

On three wards the controlled drug index page within the log book did not refer to the correct page numbers. Therefore, there was a risk that registered nurses could update the log book incorrectly.

Only the PICU had a schedule of controlled drugs that staff could refer to, and this should be available in all clinics.

We observed on one occasion a registered nurse who was about to check and count controlled drug tablets from a container by hand, and not use a tablet counter as a non-touch technique; we intervened to prevent them from handling the tablets. We discussed this further with the registered nurse who stated that they were unfamiliar with the tablet counter, therefore we were not assured that staff would maintain appropriate infection prevention and control when checking tablets stored in a container.

We requested to view a selection of clinic room polices on each of the wards. We were provided with a range of policies, however, most had passed their review date. On three wards we were given a rapid tranquilisation policy that had a review date of January 2008. When we requested an updated version, the health board were unable to produce this during the inspection. Therefore, we were not assured that staff were obtaining or being provided with the most up to date guidance to direct their professional practice.

We observed a number of medication rounds, and saw that staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

Improvement needed

The health board must ensure that:

- Medication fridges are locked when not being accessed
- Arrangements are in place to promptly return or dispose of unrequired medication
- MAR charts are completed accurately and in full, including all patient details, route of administration and record of administration
- Prescribed medication is authorised by the corresponding consent to treatment certificate

- The most recent consent to treatment certificate is held with the corresponding MAR chart
- Controlled drugs cupboards are not used to store inappropriate items
- The administration of controlled drugs are recorded in line with health board policy
- The index page in controlled drugs logs are correctly completed
- A schedule of controlled drugs is available in each clinic room
- Staff use non-touch technique when counting tablets stored in a container
- Policies relevant to the use of medication and clinic rooms are up to date, and that staff can access these easily within each of the clinics.

Safeguarding children and adults at risk

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

Medical devices, equipment and diagnostic systems

There were regular checks of resuscitation equipment. Staff had documented when these had occurred to ensure that the correct equipment was present and in date. It was noted that the oxygen within the clinic room on Ward 22 was not set up ready to use, this could cause unnecessary delay for the use of oxygen in an emergency. It is recommended that oxygen cylinders are always ready for use, this was actioned by ward staff during the inspection.

The ward emergency equipment check included checking that the oxygen cylinder was present, however, it is also recommended that this includes checking the volume of oxygen remaining in the cylinder, to ensure there is adequate oxygen available for high flow delivery, in the event of an emergency.

The emergency equipment on Seren Ward included an electrical aspirator[10], this wasn't included on the emergency checklist. However, following our discussions with staff during the inspection, the checklist was updated to include this.

There were ligature cutters located throughout the hospital in case of an emergency.

On Ward 22 there was a hypostop box[11] for the emergency treatment in cases of hypoglycaemia (low blood sugar) in diabetic patients, however, when the contents was checked, there were items missing. We raised this with staff during the inspection.

Improvement needed

The health board must ensure that hypostop boxes are fully stocked and that the contents are in date.

Effective care

Safe and clinically effective care

Throughout the report, we have identified areas for improvement. The health board must ensure that audit and governance arrangements are embedded to support staff in providing continual safe and effective care.

The health board has set out its actions in Appendices B and C.

Record keeping

We found that patient records were a combination of paper and electronic documentation. The paper records that were used by staff contained copies of the electronic documentation. However, the paper records did not always contain the most up-to-date information that was stored electronically therefore, we could

[10] A suction device used to remove bodily fluids from a patient.

[11] Hypostop box provides a range of glucose products for use in cases of hypoglycaemia in diabetes patients.

not be assured that staff would be referring to the correct version of the treatment plan. In addition, we found examples where:

- There were no care plans in place for the management of patients who had been identified with specific risks
- Where patient care plans were in place, these were not being accurately followed by staff.

As highlighted earlier, we were not assured that there were established audit processes in place to ensure that patient records were complete, up-to-date and followed by staff. Our concerns regarding record keeping were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B. Specific care planning issues that we identified are detailed elsewhere within this report.

Mental Health Act Monitoring

We reviewed the statutory detention documents of five patients across three wards, which included the Admission Ward and Ward 22 at Royal Glamorgan Hospital and Ward 14 at the Princess of Wales Hospital[12]. In addition, we reviewed the community treatment order for one patient. The statutory documentation we reviewed, verified that patients were legally detained.

Staff that we spoke with were positive about the revised structure of the Mental Health Act administration team, since our previous inspection. Staff commented favourably on the improved staffing resources, and also the support for developing the team systems for managing the implementation of the Act within the health board.

Copies of Mental Health Act documentation were available to the adult mental health wards electronically via the computerised patient record system. This means that the Mental Health Act administration team could ensure that these documents are available for ward staff to reference as and when required.

[12] Ward 14 at Princess of Wales in Bridgend provides mental health care for patient and is part of Cwm Taf Morgannwg University Health Board. Patients may be moved between hospitals in line with Mental Health Act legislation.

However, the electronic system was not in place on Seren Ward and St David's Ward and therefore paper copies were required to be maintained for ward staff reference. However this impacts upon ward staff time and documents were not always kept up to date.

The health board should consider expanding the electronic system to all mental health wards.

As detailed earlier in the report, improvements are required in the availability of consent to treatment certificates alongside the MAR charts, to ensure that registered nurses can refer to these, to ensure that medication is administered legally.

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

We reviewed the care plans of nine patients.

As stated earlier we found examples where:

- There were no care plans in place for the management of patients who had been identified with specific risks
- Where patient care plans were in place, these were not being accurately followed by staff.

All wards were expected to undertake risk assessment reviews, using a unit wide review framework. It was noted that while this is adequate for the wards, the frequency of formal risk assessment reviews did not reflect the patient group cared for in the PICU. The risk assessment review process was too infrequent to meet the needs of the patients on PICU due to the potential for more rapid change in patient acuity and their presentation on this ward. This means that patient risk assessments may not accurately reflect the risk posed by the individual patient since the last review.

One patient record indicated that the patient was on hourly general observations, however, the actual patient observation level was 15 minute intervals. Therefore, the patient records had not been updated to reflect the correct frequency of observations, to ensure the patient's safety was maintained.

A review of patient admission documentation concluded that physical monitoring records, including body maps[13], were not always completed, and was no evidence to indicate that these were declined by the patient.

Where patients were previously known to services prior to their admission in hospital, copies of the care and treatment plans were not always available in a timely manner. It was also noted that it was common that the care and treatment plan was not updated to reflect that the patient had been admitted to hospital, but remained to reflect the latest update when the patient was receiving care within the community. Whilst staff would develop inpatient management plans to reflect the care provided as an inpatient, the patient's care and treatment plan must reflect the most up-to-date situation for the patient.

The unmet needs of patients were not identified within their care and treatment plan. It is important that any unmet needs are documented, so that these can be regularly reviewed by the multidisciplinary team to consider options for meeting the needs; this may mean identifying an alternative placement.

It was positive to note within a patient record who had a terminal diagnosis, that the family were fully included in the patient's future care and plans.

Improvement needed

The health board must ensure that:

- Risk assessments are reviewed regularly to accurately reflect the risk posed by the individual patient, particularly for those patients being cared for on the PICU
- Care and treatment plans are updated to reflect that the patient had been admitted to hospital, and that these are available to ward staff in a timely manner
- Patient's unmet needs are documented.

[13] A blank schematic diagram of the front and back of a generic person used clinically to document the location of lesions, lacerations, bruises, rashes, etc. for future reference.

Mental Capacity Act and Deprivation of Liberty Safeguards

We reviewed three patient records that were identified as patients subject to Deprivation of Liberty Safeguards (DoLS).

Two of the records evidenced that staff had referred to the local authority to apply for a DoLS, and that these were in place. It was evident that the process was being applied appropriately.

Another patient record had an alert sticker, which identified the person as being subject to DoLS. A copy of the application was filed, however, there was no authorisation in place to enact the DoLS. Staff members we spoke with stated that the patient was not subject to DoLS, and subsequent to the DoLS application being submitted, the patient had capacity to make decisions regarding their care. However, this was not documented within the patient's record.

If a patient is no longer subject to a DoLS, the alert on the patient's record must be amended to reflect this, to ensure that DoLS restrictions are not illegally in place. Any changes must be recorded within the patient record.

Improvement needed

The health board must ensure patient records clearly demonstrate any changes in Deprivation of Liberty Safeguards.

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.

It is of significant concern that we have identified recurring issues during this inspection, and those previous, in relation to mental health wards at Royal Glamorgan Hospital. This includes areas of clinical practice such as medicines management and recordkeeping.

Whilst there are arrangements for clinical audit in place, we found areas where these were poorly completed or where deficiencies were identified and there was insufficient action taken.

We again found that the design of the mental health wards persist, in not maintaining patient privacy and dignity. This is in addition to recurring maintenance issues that impact upon the facilities available for patients, which have a negative effect on patient experiences.

Throughout the inspection, staff demonstrated their commitment to provide care for patients within the hospital. However, we are concerned that some staff may be working excessive hours, which could affect staff well-being and impact upon professional judgements, due to fatigue.

Improvements are also required in the completion of mandatory training, along with the current monitoring system to ensure that training statistics are up-to-date and readily available.

Governance, leadership and accountability

There was dedicated and passionate leadership from the ward managers, who were supported by deputy ward managers and committed ward teams. On the

whole, staff spoke positively about the leadership and support provided by the ward managers on each ward, along with good support between wards. We found that staff were committed to providing patient care to high standards. However, as highlighted earlier, we identified significant improvements required in the delivery of safe and effect care, which evidence a lack of embedded governance and audit arrangements. Whilst there are arrangements for clinical audit in place, we found areas where these were poorly completed or where deficiencies were identified, there were insufficient actions taken.

It is concerning that during this inspection, and those previously conducted within the mental health wards at Royal Glamorgan Hospital, we have repeatedly identified the need for improvement in relation to medicines management and record keeping. On each occasion, this has resulted in our concerns being dealt with under our immediate assurance process.

We have raised our concerns regarding the design of the mental health unit in previous inspection reports and acknowledge the challenges in redesigning the mental health unit to improve patient experience at the hospital. However, all wards (apart from the PICU) have some shared bedrooms or dormitories, and these do not reflect modern mental health care provision. The shared bedroom areas only afford the basic level of privacy for patients and the health board must review this.

Following all of our inspections, we have identified and reported to the health board the impact that environment is having on privacy and dignity of patients. This is usually due to the lack of curtains between beds within shared bedrooms and the lack of appropriate screening for bedroom and communal room windows. The health board has previously taken appropriate actions to address some of our concerns, however, there are areas that still need to be improved and maintained.

We were previously informed that there are ongoing drainage and sewage issues at Royal Glamorgan Hospital. These cause regular problems with toilet, shower and bath facilities across the mental health wards. This often results in these facilities being out of order to patients and therefore limiting their availability for use. This issue must be addressed and rectified urgently.

It was positive to hear that since our previous inspection, regular ward manager meetings had recently been established to review and share action plans from both internal and external reviews. We were also provided with examples of governance structures which reviewed some, but not all clinical outcomes associated with the delivery of patient care. However, the health board must ensure that its governance processes ensure that there is adequate scrutiny and

oversight of issues arising from internal audit and external review, such as HIW inspections, and that wider learning from these is applied, actioned and maintained.

Improvement needed

The health board must:

- Ensure that governance and audit arrangements are adequately embedded throughout the mental health services
- Review its mental health service provision to ensure the environments of care are developed, to reflect current and future provision of mental health care.

Staff and resources

Workforce

There was a staff organisational structure for the mental health service and wards. Whilst there were a number of registered nurse vacancies, there was evidence that the health board was attempting to recruit to the vacancies. At the time of the inspection six registered nurse posts had been recruited in to, with further efforts in place to fill the remaining 5.3 whole time equivalent (WTE) vacancies. There was also a shortfall in health care assistants of 11.5 WTE which required to be filled.

Where there were shortfalls in fulfilling a rota, such as due to vacancies or absences, the health board's bank staff would be used; this could include staff form the wards inspected, working additional shifts to their contracted hours.

It was positive to note that staff were undertaking additional shifts to assist in fulfilling rotas to maintain continuity of care. However, we noted that there were a number of staff working excessive hours, which may lead to fatigue and could potentially affect their well-being and/or compromise their professional judgements and impact on patient safety.

Senior managers confirmed that there was an automatic notification, issued via the electronic staff roster, when staff members worked 60 hours within a one week period. This is to alert and to limit staff exceeding this. However, we were not assured that this would restrict staff regularly working above the contracted hours.

We were also aware that ward staff were involved in duties, such as cleaning, serving patient food, and completing patient laundry. This impacted upon ward staff time to engage with patients. Whilst these are essential duties, the health board should review the staffing on the wards, to ensure that there is no impact on the time ward staff can spend with patients, to the detriment of patient care and recovery.

There were no clear mental health unit management arrangements in place during the night shift. By night, there was no designated nurse in charge of the unit, this therefore impacted negatively on leadership and management of issues which may occur out of hours. We witnessed this issue during the first night of our inspection, where the members of staff we spoke with were unable to verify the number of staff, patients and bed numbers on the other mental health wards. A designated nurse in charge of the mental health unit during the night shift could assist in the oversight of the overall unit, and provide clear nominated onsite support for ward staff, prior to using the established on-call arrangements.

The inspection team considered the staff training compliance for mental health wards. Whilst it was evident that this was being monitored by the ward managers, there were areas which required significant improvement with compliance. There was also non-compliance with up-to-date resuscitation training, and due to the unpredictable nature of the environment, the health board must ensure that staff complete their required resuscitation training.

It is also a concern that the training records seen during the inspection were not accurate. This was due to discrepancies with ward establishments within the Electronic Staff Record[14] (ESR). The ESR was used to record training and to monitor staff training compliance.

Whilst the revised training figures evidenced higher compliance rates, this remained unsatisfactory. This does not always provide the service with the required information, to ensure that staff are sufficiently trained to maintain a safe environment of care.

[14] The Electronic Staff Record is a computerised human resources programme used throughout the NHS in England and Wales. www.electronicstaffrecord.nhs.uk

Improvement needed

The health board must:

- Ensure that vacant posts are filled
- Ensure that staff do not work excessive hours
- Ensure that arrangements are in place so that ward staff are not required to undertake additional duties that impact on patient care
- Consider arrangements for a designated nurse in charge of the mental health unit during the night shift and out of hours
- Ensure that all staff complete mandatory training
- Ensure that ESR provides accurate training monitoring information.

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, measurable, 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
Soiled clothes, corded electrical items and toiletries were left in the child visiting room.	This meant that patients, visitors and staff were exposed to contaminated items and therefore a risk of infection. Patients also had access to items that could be used to hard themselves or others.	We raised this with the staff present.	Staff removed the items to a safe location.
The oxygen within the clinic room on Ward 22 was not set up ready to use	This meant there could be unnecessary delay for the use of oxygen in an emergency resulting in increased harm or death.	We raised this with the staff present.	Staff ensured that the oxygen cylinders were made ready for use.

The electrical aspirator on Seren Ward's emergency equipment checklist was not included.	This meant that staff were not checking it was present and in working order. A missing or non-functioning electrical aspirator could result in increased harm or death.	We raised this with the staff present.	Staff added the electrical aspirator to the checklist.

Appendix B – Immediate improvement plan

Service: Royal Glamorgan Hospital

Wards: Admission Ward, Ward 21, Ward 22, Psychiatric Intensive Care Unit, Seren Ward and St David's Ward

Date of inspection: 8 – 11 July 2019

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.

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The health board must provide HIW with details of the action take to ensure that medication is stored within the required temperature range on every ward.	Standard 2.6	Following established daily checks by ward staff, when the temperature of the refrigerator is lower than 2 degrees and higher than 8 the pharmacy will be contacted and the medications quarantined. In instances when the temperature of the treatment room is noted to be at or above 25 degrees centigrade the nurse in charge will be informed and remedial action will be taken if required. All wards have access to portable air conditioning unit which will be used to control the temperature if required. The incident will be recorded via the DATIX system for reporting and Service Group review purposes.	Ward Manager Ward Manager Locality Head of Nursing	Completed Completed Completed

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
The health board must provide HIW with details of the action taken to ensure that all Medication Administration Records are completed accurately.	Standard 2.6	The Head of Nursing will reiterate to all registered staff (via email) their responsibility to appropriately and accurately record administration and all medications in line with Health Board policy and NMC guidelines. This will be reinforced by ward managers during handovers and will be further enhanced through ward meeting minutes. The pharmacy department will undertake quality assurance of Medication Administration Records weekly as a core function of the inpatient Pharmacist role with immediate effect. On the admissions unit all Medication Administration Records will be reviewed daily (weekdays) and compliance with documentation standards monitored by the ward	Head of Nursing Ward Based Pharmacy /Ward Manager Ward Based Pharmacy/ Ward Manager	Completed Completed Completed

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
		manager and pharmacist with immediate effect On wards 21 and 22, Medication Administration Records will be reviewed twice weekly and the results monitored by the ward manager/ deputy ward manager with immediate effect. Routine audit of the Medication Administration Records will be added to the quarterly Audit schedule	Ward Based Pharmacy/ Ward Manager Locality Head of Nursing	Completed September 2019
The health board is required to provide HIW with details of the action taken to ensure that patient records are complete, up to date and followed as planned, by staff.	Standard 3.5	Ward management team will undertake weekly review of all care plans for inpatients, to ensure timeliness and completeness and record evidence of this taking place Supervision with registered and unregistered Nursing staff will focus on delivery of care as planned. A clinical audit process involving peer review by ward managers with support	Ward Manager Ward Manager Care & Treatment	Complete Complete September 2019

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
		of Senior Nurses and Care & Treatment Planning lead will be instigated to review quality of care planning on a three monthly cycle. . Directorate CTP team will deliver update training on outcome focused care planning for all inpatient teams.	Planning Lead CTP Lead	October 2019
Quality of management and leadership				
The health board must provide HIW with details of the action taken, to improve the compliance rates for Violence and Aggression training, to ensure that there is an adequate number of staff trained in each ward.	Standard 2.1 and 7.1	Reported Violence & Aggression training compliance was inaccurate due to poor Electronic Staff Record processes. This has been addressed through temporary redistribution of the administrative process to ward managers. Actual compliance at time of report is: • St David's Ward 72% • Seren Ward 81.5% • Admission Ward 50.76% • Psychiatric Intensive Care Unit 95%,	Senior Nurse/ Directorate Support Manager	Completed

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
		• Ward 21 64.54% • Ward 22 90% There is a training schedule in place across the Directorate with 12 Management of Violence & Aggression sessions across the year. In order to address the low rate of training in the Admission unit there will be two training sessions in September (in order to enable rosters to support attendance). All inpatient units will have at least 85 % compliance after that point Training records will be reported on at monthly Locality based governance meeting for review and action as appropriate. In the interim training compliance is reported at Service group wide governance forum.	Senior Nurse Locality Head of Nursing	September 2019 October 2019

Appendix C – Improvement plan

Service: Royal Glamorgan Hospital

Wards: Admission Ward, Ward 21, Ward 22, Psychiatric Intensive Care Unit, Seren Ward and St David's Ward

Date of inspection: 8 – 11 July 2019

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

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that staff knock on bedroom and dormitory doors before entering.	4.1 Dignified Care	All staff will be reminded of necessity for all staff to treat people with respect and dignity at all times. Introduction of Safety Briefing on all inpatient wards will provide mechanism for dissemination of significant information related to quality, health and safety. This will become embedded into handovers practices across all areas within the month.	Deputy Head of Nursing.	30th September
The health board must ensure that the privacy and dignity of patients is maintained with the use of appropriate screening on external windows throughout the wards.	4.1 Dignified Care	Procure and fit appropriate black out blinds / curtains for older adult ward bedrooms. All ground floor clinical areas will have appropriate screening on windows.	Business Support Manager Older Adult Senior Nurse |	31st October 30th September

The health board must ensure that arrangements are in place to maintain the cleanliness, tidiness and safety of the child visiting room.	4.1 Dignified Care	Responsibility for management of child visiting room sits with ward manager for ward 21 who will ensure structures are in place to ensure safe and effective use. The visiting room is now part of routine inpatient ward cleaning schedules	Ward manager, ward 21	Complete Complete
The health board must ensure that patient privacy and dignity is maintained when transferring patients from wards in to the PICU.	4.1 Dignified Care	Message in respect of privacy and dignity for all patients reiterated to staff via safety briefing process outlined earlier. Review Standard Operating Procedure for PICU admission process to consider transfer of patients around the unit	Deputy Head of Nursing. Ward manager, PICU	30th September
The health board must display information on healthy eating, drug and alcohol support and smoking cessation.	4.2 Patient Information	Mental health directorate will engage with public health advisors in respect of making every contact count training and relevant and updated information for all wards.	Deputy Head of Nursing.	30th November

The health board must display information that is suitable for patients with impaired vision.	4.2 Patient Information	All wards now display recommended bilingual HIW information. All other display information will be reviewed and updated accordingly when implemented.		Complete
Delivery of safe and effective care				
The health board must ensure that staff, including bank staff, who work on mental health wards complete their PMVA training.	2.1 Managing risk and promoting health and safety	Staff training programme in place as per immediate assurance plan Directorate will work alongside nurse bank to ensure bank staff are provided with opportunities for PMVA training	Deputy Head of Nursing.	30th November 30th December
The health board must ensure that PMVA training, initial and refresher, follows the principle of least restrictive intervention.	2.1 Managing risk and promoting health and safety	Directorate will request training department to undertake review of training programme against best practice guidance and amend accordingly. Subsequently an impact assessment will be undertaken in relation training and duration full impact of any changes will take	Deputy Head of Nursing/PMVA training. Business Support Managers	31st March 2020 30th April 2020

The health board must ensure that there is suitable flooring within the ECA.	2.1 Managing risk and promoting health and safety	Scope options available to achieve safe and appropriate environment. Flooring will be procured and fitted to meet identified need	Business Support Manager Locality manager	30th September 30th November
The health board must ensure that there are no sharp corners or edges within the ECA.	2.1 Managing risk and promoting health and safety	Scope options available to achieve safe and appropriate environment. Appropriate alterations will be completed to environment	Business Support Manager Locality manager	30th September 30th November
The health board must ensure that cleaning schedules are in place, to maintain the outside areas, particularly smoking areas.	2.4 Infection Prevention and Control (IPC) and Decontamination	Management team to establish detail of current cleaning schedule and review whether it is sufficient to meet demand. Cleaning services will be amended to reflect demand	Business Support Manager	30th September 30th September

The health board must ensure that housekeeping arrangements are sufficient, to minimise the impact on ward staff after 2pm.	2.4 Infection Prevention and Control (IPC) and Decontamination	Management team establish detail of current cleaning schedule and review whether it is sufficient to meet demand. Cleaning services will be amended to reflect demand	Business Support Manager	30th September 30th September
The health board must ensure that safety lids are appropriately assembled on all sharps bins.	2.4 Infection Prevention and Control (IPC) and Decontamination	Introduction of Safety Briefing on all inpatient wards to remind staff of the importance of maintaining acceptable standards of health and safety.	Deputy Head of Nursing.	30th September
The health board must ensure that when required, fluid balance charts are used and completed correctly.	2.5 Nutrition and Hydration	A training package will be developed to increase awareness of importance of accurate fluid balance practice and recording Wards will develop “training boards” to provide opportunity for on-going promotion of good practice	Deputy Head of Nursing Ward managers.	31st October 30th September

The health board must ensure that patient records include detailed entries that accurately reflect patient fluid balance where applicable.	2.5 Nutrition and Hydration	A training package will be developed to increase awareness of importance of accurate fluid balance practice and recording Review of recording fluid in/output will added to inpatient audit/review programme	Deputy Head of Nursing Senior Nurse	31st October 30th September
The health board must ensure that when required, staff act upon insufficient fluid input, and that the actions are documented within patient records.	2.5 Nutrition and Hydration	A training package will be developed to increase awareness of importance of accurate fluid balance practice and recording Review of recording fluid in/output will added to inpatient audit/review programme	Deputy Head of Nursing Senior Nurse / Care and treatment planning lead	31st October 30th September
The health board must ensure that there is a regular audit of fluid balance monitoring charts.	2.5 Nutrition and Hydration	Review of recording fluid in/output will added to inpatient audit/review programme	Senior Nurse	30th September
The health board must ensure that medication fridges are locked when not being accessed.	2.6 Medicines Management	Introduction of Safety Briefing on all inpatient wards will provide mechanism to remind staff of the importance of maintaining locked medication fridges.	Deputy Head of Nursing.	30th September

The health board must ensure that arrangements are in place to promptly return or dispose of unrequired medication.	2.6 Medicines Management	The medicines management storage and administration checklist will be updated to include and audit of the return of surplus medication. Introduction of Safety Briefing on all inpatient wards will provide mechanism to inform staff of the importance for return of surplus medication and disposal of contraband substances	Mental Health Pharmacist/ Senior Nurse Deputy Head of Nursing.	30th September 30th September
The health board must ensure that MAR charts are completed accurately and in full, including all patient details, route of administration and record of administration.	2.6 Medicines Management	All prescribing practitioners (medical and nursing) will be informed of responsibilities in relation to accurate completion of MAR charts. Pharmacy will review MAR charts routinely as part of their work on all wards and address themes and patterns in the medication management group	Clinical director Ward pharmacist	Completed 30th September

The health board must ensure that prescribed medication is authorised by the corresponding consent to treatment certificate.	2.6 Medicines Management	MHA admin team will devise training resources to raise awareness of need for accurate administration of consent to treatment process Review of consent to treatment records will be added to inpatient audit/review programme	Mental Health Act admin lead Senior Nurse/Care and Treatment Planning lead	30th September 30th September
The health board must ensure that the most recent consent to treatment certificate is held with the corresponding MAR chart.	2.6 Medicines Management	MHA admin team will devise training resources to raise awareness of need for accurate administration of consent to treatment process Review of consent to treatment records will be added to inpatient audit/review programme	Mental Health Act admin lead Senior Nurse/Care and Treatment Planning Lead	30th September 30th September
The health board must ensure that controlled drugs cupboards are not used to store inappropriate items.	2.6 Medicines Management	Pharmacy and directorate will review arrangements for return of surplus medication and disposal of contraband substances	Mental Health Pharmacist/ Senior Nurse	30th September

The health board must ensure that the administration of controlled drugs are recorded in line with health board policy.	2.6 Medicines Management	Mental Health directorate will establish a multidisciplinary medication management group to monitor and address areas of concern and develop best practice across all inpatient areas	Mental Health Pharmacist / Clinical director	31st October
The health board must ensure that the index page in controlled drugs logs are correctly completed.	2.6 Medicines Management	Mental Health directorate will establish a multidisciplinary medication management group to monitor and address areas of concern and develop best practice across all inpatient areas	Mental Health Pharmacist / Clinical director	31st October
The health board must ensure that a schedule of controlled drugs is available in each clinic room.	2.6 Medicines Management	Mental Health directorate will establish a multidisciplinary medication management group to monitor and address areas of concern and develop best practice across all inpatient areas	Mental Health Pharmacist / Clinical director	31st October

The health board must ensure that staff use non-touch technique when counting tablets stored in a container.	2.6 Medicines Management	All registered nurses have received refresher training on Non touch medication counting techniques and appropriate non touch aids procured Mental Health directorate will establish a multidisciplinary medication management group to monitor and address areas of concern and develop best practice across all inpatient areas	Mental Health Pharmacist / Clinical director	Complete 31st October
The health board must ensure that policies relevant to the use of medication and clinic rooms are up to date, and that staff can access these easily within each of the clinics.	2.6 Medicines Management	Mental Health directorate will establish a multidisciplinary medication management group to monitor and address areas of concern and develop best practice across all inpatient areas	Mental Health Pharmacist / Clinical director	31st October
The health board must ensure that hypostop boxes are fully stocked and that the contents are in date.	2.9 Medical devices, equipment and diagnostic systems	Mental Health directorate will establish a multidisciplinary medication management group to monitor and address areas of concern and develop best practice across all inpatient areas	Mental Health Pharmacist / Deputy Head of Nursing	31st October

The health board must ensure that risk assessments are reviewed regularly to accurately reflect the risk posed by the individual patient, particularly for those patients being cared for on the PICU.	Monitoring the Mental Health Measure	The directorate risk assessment / training group will undertake a review of the inpatient risk management process to identify a proportionate and prudent process that will meet the needs of all clinical areas.	Deputy Head of Nursing	30th November
The health board must ensure that care and treatment plans are updated to reflect that the patient had been admitted to hospital, and that these are available to ward staff in a timely manner.	Monitoring the Mental Health Measure	CTP lead will develop training materials to reiterate the organisational standards in relation to CTP documentation A clinical audit process involving peer review will be instigated to review quality of care planning	CTP lead Deputy Head of Nursing / CTP lead	31st October 30th September
The health board must ensure that patient's unmet needs are documented.	Monitoring the Mental Health Measure	CTP lead will develop training materials to reiterate the organisational standards in relation to CTP documentation	CTP lead	31st October
The health board must ensure patient records clearly demonstrate any changes in Deprivation of Liberty Safeguards.	Mental Capacity Act and Deprivation of Liberty Safeguards	Directorate will undertake review of documentation processes and standards with DoLS team Documentation will be added to weekly documentation review and 3 monthly documentation audit	DoLS team leader/Deputy Head of Nursing Deputy Head of Nursing	31st October 31st October

Quality of management and leadership				
Ensure that governance and audit arrangements are adequately embedded throughout the mental health services.	Governance, Leadership and Accountability	Governance and audit arrangements is a key priority for the newly established Locality Management Team and a program to develop structures to support this is under development with a view to full implementation.	Locality manager/Deputy head of Nursing	31st December
Review its mental health service provision to ensure the environments of care are developed, to reflect current and future provision of mental health care.	Governance, Leadership and Accountability	Scoping document setting out case for the redevelopment of inpatient areas in Royal Glamorgan Hospital to be completed and submitted to Welsh Government	Assistant Director of Operations	30th January 2020
The health board must ensure that vacant posts are filled.	7.1 Workforce	Management team will actively recruit into all vacant posts and review vacancies at monthly nursing staffing meeting	Deputy Head of Nursing	30th September
The health board must ensure that staff do not work excessive hours.	7.1 Workforce	Management team will undertake a monthly review of staff rosters to identify patterns and areas of potential excessive hours. This will be reported into the monthly Locality performance meeting	Senior Nurse Locality manager	30th September 30th September

The health board must ensure that arrangements are in place so that ward staff are not required to undertake additional duties that impact on patient care.	7.1 Workforce	Management team to establish detail of current cleaning schedule and review whether it is sufficient to meet demand.	Business Support Manager	30th September
The health board must consider arrangements for a designated nurse in charge of the mental health unit during the night shift and out of hours.	7.1 Workforce	Management team will review present out of hours provision and identify options for alternative arrangements to provide leadership. In the interim all out of hours ward nurses have a clear understanding of escalation pathway and process for sharing information across units.	Deputy Head of Nursing Ward managers	31 October Complete
The health board must ensure that all staff complete mandatory training.	7.1 Workforce	Training compliance is a key priority for the newly established Locality Management team and will be addressed in monthly performance meetings.	Locality Manager	30th September
The health board must ensure that ESR provides accurate training monitoring information.	7.1 Workforce	Senior Nurses will validate ESR information for accuracy with ward managers initially and then quarterly.	Senior Nurses	31st October

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): **Alan Lawrie**

Job role: **Director of Primary, Community and Mental Health**

Date: **13 September 2019**