Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

NHS Mental Health Service Inspection Unannounced

County Hospital

Talygarn Ward

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 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 County Hospital within Aneurin Bevan University Health Board on the evening of 9 September 2019 and following days of 10 and 11 September. The following sites and wards were visited during this inspection:

- Talygarn Ward - Adult Mental Health Acute Admission

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

2. Summary of our inspection

We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed that staff interacted with patients respectfully throughout the inspection.

Embedded systems and governance arrangements were in place which helped ensure that staff provided safe and clinically effective care for patients.

This is what we found the service did well:

- Patients we spoke with were complimentary of the care received
- Staff interacted and engaged with patients respectfully
- Established governance arrangements that provided safe and clinically effective care
- The application of the Mental Health Act
- Good team working and motivated staff

This is what we recommend the service could improve:

- Bedroom areas into single rooms
- Medicines are maintained at the correct temperature within the clinic
- Support for staff to access clinical supervision

3. What we found

Background of the service

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

Talygarn Ward is an acute mental health ward that provides admission and assessment for patients within the local authorities of Torfaen and north Monmouthshire and for the whole of Aneurin Bevan University Health Board between the hours of midnight and 9am.

Talygarn Ward is a stand-alone ward on the County Hospital site. The ward is located on the ground floor, with the Torfaen community mental health team located upstairs. The north Monmouthshire team is located in Abergavenny, approximately 10 miles from County Hospital.

The ward is mixed gender with 21 beds that comprised of two gender specific dormitories, with four beds in each, two gender specific dormitories, with two beds in each, and nine single bedrooms.

The staff team includes a ward manager and three deputy ward managers, who are link nurses to the three local community mental health teams. The ward has a number or registered mental health nurses and health care support workers. The multidisciplinary team includes three responsible clinicians who work at Talygarn Ward and their respective community localities, and input from psychology and Occupational Therapy (OT) teams. The ward has a designated Occupational Therapy Support Worker.

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 treated patients with dignity and respect. However, the shared bedroom accommodation impacts on the privacy and dignity of patients. It was positive to note that the health board are considering options to address this.

Patients were provided with the opportunity to maintain and develop skills through varied activity and therapy programmes.

Staying healthy

There was an emphasis to provide patients with a range of activities to help support their independence and aid recovery.

Throughout the inspection we observed that some patients to be regularly engaged in activities and therapies. These were facilitated by the ward's OT Support Worker.

The ward had developed an allotment area with Third Sector partners adjacent to the hospital grounds, which was led by the Occupational Therapy Support Worker. This provided patients with the opportunity to maintain this area and grow fruit and vegetables.

The input from the OT department helps provide an appropriate range of assessments activities, within the hospital and the community. This includes cinema and bowling trips, along with attending local shops and restaurants. There were strong links with external organisations that provided additional activates, such as dog therapy and walking groups.

The ward had a range of activities and facilities suitable to an acute admission ward. There was a communal lounge, and patients had access to a range of games, books and DVDs. There was also an OT room that was used to facilitate group and individual activities with patients. In addition, an OT kitchen was available, which provided patients with opportunities to practice and develop their skills.

Due to the busy nature of the ward, there was a reliance on the OT support worker to facilitate the ward activities. Whilst it was evident that the activity plan was flexible to adapt to patients' wishes, if patients were not involved with the OT facilitated activity, they often missed out on such activities, since the ward staff had limited opportunities to engage with patients, in ad-hoc activities. This was raised as an issue by some of the patients that we spoke with.

Improvement needed

The health board must consider how to support and facilitate additional ad-hoc activities on the ward.

Dignified care

Throughout the hospital, all the staff we observed interacted and engaged with patients appropriately, and treated patients with dignity and respect. Patients that we spoke with confirmed this and were complimentary about the care they received on the ward.

The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients.

We heard staff speaking with patients in calm tones throughout our inspection, and observed staff being respectful toward patients. When patients approached staff members, they were met with polite and responsive caring attitudes.

There were nine individual bedrooms, two of which each had an en-suite toilet, sink and shower. The remainder of the accommodation comprised of two gender specific dormitories, with four beds in each and two gender specific dormitories, with two beds in each. The bed areas within the shared dormitories were separated by curtains. This does not reflect modern mental health care provision because shared bedrooms can impact on the privacy and dignity of patients.

There were four toilets, three showers and a bath available for patients that did not have facilities in their own room. One of the showers required a replacement shower curtain, it was confirmed that this had been ordered, but not received.

Senior managers provided us with proposed options to reconfigure the ward environment, in to single en-suite rooms. A decision has yet to be made by the health board, however, providing single bedroom accommodation would provide patients with greater privacy and their dignity maintained whilst in hospital.

The ward had been refurbished and redecorated since our previous inspection, and it was positive to hear that patients' views on the decoration were considered. As a result, the ward had a range of pictures mounted throughout and additional colours to the communal areas, which made the ward appear less clinical. There was also a beverage area installed in to one of the communal rooms, where patients were able make their own hot and cold drinks.

Improvements had also been made to the enclosed court yard, with a large mural added to the perimeter wall and appropriate outside furniture. Staff confirmed additional outdoor recreational activities were to be implemented, to encourage patients to use the outside area.

We were also informed that outside exercise equipment was due to be installed, which would enable patients to take part in physical activity as an inpatient.

The building guttering above the enclosed garden was not clear of debris, and during the inspection we observed water overflowing directly into the garden area. This should be addressed, as water could fall directly on to a person in the garden, and also disturb a patient's sleep in a nearby bedroom area.

There were laundry facilities at the hospital that the patients were encouraged to use, with support from staff where required

Improvement needed

The health board must:

- Ensure that all shower curtains are in place
- Provide an update on reconfiguration to single bedrooms
- Provide an update on the provision of outdoor exercise equipment
- Ensure that building guttering is clear of debris and functioning.

Patient information

We saw information was available to help patients and their families understand their care, along with details about organisations that can provide help and support to patients affected by mental health conditions. Information on advocacy was also displayed.

Information was displayed on how patients and their families can provide feedback about their experiences of the care provided on the wards. There was

also information displayed on how patients can raise a concern about their care, which included the NHS Wales Putting Things Right[1] arrangements.

Information was available on healthy eating and other health promotion initiatives. The service also supported patients in accessing other agencies and charities, which included women's aid, and drugs and alcohol services.

There was no information available on the role of Healthcare Inspectorate Wales (HIW) and how patients can contact us. This is required by the Mental Health Act 1983 Code of Practice for Wales[2].

It was positive to note that both wards had a board which displayed photos of staff, these assist patients and visitors in identifying individual staff members.

Improvement needed

The health board must ensure that information is displayed on the role of HIW and how to contact the organisation.

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff ensured they communicated appropriately and effectively with patients. Staff took time to undertake discussions using words and language suitable to the individual patient. Where patients remained unclear, or were misunderstood, staff would patiently attempt to clarify what they had said.

[1] Putting Things Right is the process for managing concerns in NHS Wales. http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

[2] Mental Health Act 1983 Code of Practice for Wales (Revised 2016) provides guidance to professionals about their responsibilities under the Mental Health Act 1983. As well as providing guidance for professionals, the Code of practice also provides information for patients, their families and carers. https://gov.wales/topics/health/nhswales/mental-health-services/law/code-of-practice/?lang=en

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

There were regular patients meetings, these were scheduled to take place weekly. On reviewing the minutes, we saw evidence of this, or an appropriate reason was recorded, if they did not take place.

There was a You Said, We Did board, which displayed feedback by patients and what action the health board had taken in response. This was updated regularly by staff to ensure the information displayed was current.

Individual care

Planning care to promote independence

There was a clear focus on providing safe and effective care for patients. Care was individualised and focused on recovery, which was supported by the least restrictive practices. This was both in care planning and the 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.

There were strong links with local community teams and external organisations, which enabled patients to access these services and activities, as part of their care in hospital, and continued on discharge.

People's rights

We reviewed a sample of care records for patients detained under the Mental Health Act (the Act). We saw that documentation required by legislation was in place. This demonstrated that patients' rights had been promoted and protected as required by the Act

The use of mobile phones by patients was allowed, to maintain contact with family and friends. Access to mobile phones was managed on an individual patient risk basis. Patients and staff told us that ward telephones could also be used to contact relatives and there were payphones on the wards.

There was a family visiting room located off the ward, on the first floor of Talygarn unit. This had been recently decorated with new chairs and murals. If deemed necessary, staff were able to observe visits from outside the visiting room. The

room had a variety of children’s toys, which included a baby bouncer and play kitchen and a chalkboard-wall.

Listening and learning from feedback

As highlighted earlier, the health board had arrangements in place for patients and their families to provide feedback about their experiences and to raise a concern.

Senior ward staff confirmed that wherever possible they would try and resolve complaints immediately. Where this was not possible, they were aware that patients could escalate their concern via the health board's procedure.

Delivery of safe and effective care

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

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

The hospital environment was equipped with suitable furniture, fixtures and fittings for the patient group.

Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation

Safe care

Managing risk and promoting health and safety

The ward had implemented health board and local processes to manage and review risks, to maintain health and safety.. This enabled staff to continue to provide safe and clinically effective care.

Access to the ward was direct from the hospital car park, and provided suitable access for people who may have mobility difficulties. The ward was also secured to prevent unauthorised access.

On the whole the furniture, fixtures and fittings on each of the wards were appropriate for the intended patient group. The health board had undertaken significant anti-ligature refurbishment, to mitigate the risk of patient self-harm.

Since our previous inspection the health board had upgraded the staff personal alarm system and nurse call system. Both systems, when activated, would sound, and display panels throughout the ward, would indicate the location of the incident. Therefore, this provided staff with a clear indication of where to respond.

The alarm system was also linked to the community teams located on the first floor of the unit, and to another inpatient ward located on the County Hospital site. Therefore, if required, staff on Talygarn Ward would be supported from these areas. However, in one bedroom, the nurse call button was not located in reach of the bed therefore, a patient within this room may be unable to alert staff, if they

require assistance. A nurse call button within a bedroom should be accessible from the bed.

Strategies were described for managing challenging behaviour to promote the safety and well-being of patients. We were told that preventative techniques were used and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the physical restraint of patients was used, but this was rare and only used as a last resort. The ward did not have a specific area for staff to re-direct patients, to manage their challenging behaviours, neither were there areas available for seclusion[3].

There was limited space available, to easily allow staff to talk with patients in a quiet area, away from other patients. If verbal de-escalation was unsuccessful, staff described arrangements to protect the patient's privacy and dignity if physical intervention was required. , However, these interventions would generally be within communal areas, where other patients may be present. Not only does this impact negatively upon the dignity of the patient, it can also unsettle other patients within the area, witnessing the situation.

Senior managers confirmed that the health board would be reconfiguring two bedrooms in to an Extra Care Area (ECA). The ECA would enable staff to provide additional support to a patient, away from other patients on the ward.

Improvement needed

The health board must:

- Ensure nurse call buttons within bedrooms are accessible from the bed
- Provide an update on the provision of the Extra Care Area.

Infection prevention and control

[3] The supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. (The Mental Health Act 1983 Code of Practice for Wales (2016))

There were appropriate arrangements in place to safely manage infection prevention and control.

There was a regular audit of infection control in place. This was completed with the aim of identifying areas for improvement, so that appropriate action could be taken where necessary. This included ward based audits and the health board's infection prevention and control team audits.

Throughout the inspection, we observed the hospital to be visibly clean and free from clutter. Cleaning equipment was stored and organised appropriately. Whilst cleaning equipment was visibly clean, there was no record of when it was last cleaned or changed, keeping record of this would assist infection prevention and control arrangements.

The health board employed dedicated housekeeping staff for the wards. Cleaning schedules were in place to promote regular and effective cleaning of the hospital, and staff were aware of their responsibilities around infection prevention and control.

Staff had access to infection prevention and control and decontamination personal protective equipment when required.

There were hand hygiene products available in relevant areas of the hospital such as ward, clinic and food preparation areas; these were accompanied by appropriate signage.

There were suitable arrangements in place for the disposal of waste. Appropriate bins were available to dispose of medical sharp items, these were not over filled.

Nutrition and hydration

We found that patients were provided with a choice of food and drink, and additional snacks and drinks were available throughout the day.

We observed meals being served, and the dining room was clean and tidy and provided a suitable environment for patients to eat their meals. Patients appeared to enjoy the food provided, and during our conversations with patients were generally complimentary.

As stated earlier, there was an OT kitchen that patients could also access to prepare food, and we saw this being used during the inspection.

Medicines management

Overall, medicines management was safe and effective. The clinic room was secured to prevent unauthorised entry. Within the clinic medication was stored securely with cupboards and medication fridges locked; the medication trolley was also locked and secured within the clinic, to prevent it being removed by an unauthorised person. There were appropriate arrangements in place on both wards for the storage and use of controlled drugs and drugs liable to misuse.

There was evidence that there were regular temperature checks of the medication fridge to ensure that medication was stored at the manufacturer's advised temperature. However, as identified during our inspections elsewhere within the health board, there were no regular checks recorded, to monitor the clinic room temperature, to ensure that other medication remained within acceptable temperature ranges.

There was a regular pharmacy input, and audits were undertaken which assisted the management, prescribing and administration of medication.

The Medication Administration Records (MAR Charts)[4] reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages, their Mental Health Act legal status, or physical health measurements, such as body mass index, weight or height. Staff were consistently recording the administration of medication, or the reason why it had not occurred.

We spoke with staff about utilising the health board's self-medication policy, for some patients who would benefit from this as as part of their rehabilitative care. Such patients could take further responsibility for their own medication, in preparation for discharge to the community. Staff were receptive to developing this for the acute ward.

There was emergency resuscitation equipment available, and was easily accessible to staff, with evidence of nightly checks being completed. There were ligature cutters located throughout the ward, for use in the event of a self-harm emergency.

[4] 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.

Improvement needed

The health board must:

- Ensure that the temperature of ward clinic rooms containing medicines, are regularly monitored
- Consider implementing self-medication arrangements for appropriately assessed patients, in preparation for their discharge.

Safeguarding children and adults at risk

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

Effective care

Safe and clinically effective care

Overall, we found that systems and governance arrangements were in place, which helped ensure that staff provided safe and clinically effective care for patients. However, as detailed within the report the health board needs to address the deficiencies identified during the inspection and these are detailed, along with the health board's actions, in Appendix C.

Record keeping

Patient records were mainly paper files that were stored and maintained within the locked nursing office, and with some electronic documentation, which was password protected. We observed staff storing the records appropriately during our inspection.

On the whole, patient records we reviewed were well organised, however, some records were over-filled resulting in some documentation becoming loose and unsecured. Therefore there was a risk of this information becoming misplaced.

Staff completed entries that were factual, and entries regarding patient daily routine was documented in detail, which provided clear information regarding each patient's care.

Improvement needed

The health board must ensure patient records are not over-filled.

Mental Health Act Monitoring

We reviewed the statutory detention documents of two patients on Talygarn Ward. The statutory documentation verified that the patients were legally detained, and established audit arrangements were in place by the health board's Mental Health Act Administration Team to monitor the use of the Act.

We saw that the Mental Health Act Administration Team pro-actively supported the wards within the health board. This included dedicated trainer to provide ward staff with training and updates regarding the Act, with emphasis on relevant care law updates and the application of the Act to real life examples and scenarios.

There were monthly email updates in reference to Mental Health Act and the Mental Capacity Act sent to relevant personnel such as ward managers, lead nurses and medical staff.

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

We reviewed the care plans of three patients. Each patient had an up-to-date care and treatment plan in place.

Patient records contained detailed care plans that support staff in providing care for the patients. Care plans were supported by risk assessments that set out the identified risks and how to mitigate and manage them.

There was a range of standardised physical health documentation with in patient records, such as, NEWS[5], MUST[6], and mouth care documentation. On the whole the documents we reviewed were detailed and well completed, which evidenced that patients physical health was being monitored and cared for, whilst in hospital.

There was evidence of weekly reviews of care at the hospital, these reviews linked with the relevant community team to assist with the patient's discharge from hospital.

Patient records evidence that staff worked positively with external organisations to support individual social circumstances. This included Women's Aid, bereavement counselling, housing support and substance misuse services. These provided patients with link in the community that could be continued following discharge from hospital.

[5] The National Early Warning Score is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs such as, respiratory rate, oxygen saturation, temperature, blood pressure, pulse/heart rate, AVPU (alert, verbal, pain, unresponsive) response.

[6] MUST (Malnutrition Universal Screening Tool) is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan

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.

The ward had effective processes and audit arrangements to support staff in maintaining safe and effective care.

There was passionate leadership, strong team working and motivated staff, who provided dedicated care for patients. Staff were positive about the support they received from their colleagues and management teams.

On the whole there were strong links with community teams and external organisations to aid patient care. However, this was not as apparent with the North Monmouthshire community team.

Governance, leadership and accountability

There was a clear organisational structure for the hospital, which provided clear lines of management and accountability. These arrangements were clearly defined during the day, with senior management and doctor on-call arrangements in place for the night shift.

There were defined systems and processes in place to ensure that the service focussed on continuous improvement. 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.

There was dedicated and passionate leadership from the ward manager and deputy ward managers who were supported by committed a ward team and support from senior managers. We found that staff were committed to providing patient care to high standards.

Staff commented that team-working and staff morale on the wards was good. The ward was striving to provide high levels of care to the patient group, to expedite recovery and minimise the length of time in hospital. This was supported

by close and productive working with the respective community mental health teams.

The ward had detailed shift handover documents that clearly identified the essential information regarding each patient. This was a good reference document for staff on duty.

During the inspection we observed a number of multidisciplinary team meetings, which included members from the inpatient service and the community teams. During the meeting with north Torfaen community team and south Torfaen community team, there was inclusive and collaborative multidisciplinary discussions which focused on the individual patient care needs. It was evident that the inpatient team and the respective community teams had positive working relationship. However, during the meeting with the north Monmouthshire community team, the multidisciplinary joint working was not as evident, and there appeared to be disjointed working between the inpatient team and the community team.

It was positive to note that managers from the inpatient team and the community team had a daily handover meeting, so each service was aware of any changes to patient needs, both within hospital and in the community. This helped the teams plan together to help meet the needs of the patients within their service.

Talygarn Ward provided out-of-hours adult admissions (midnight to 9am) for the whole of Aneurin Bevan Health Board. During our inspection in 2017[7], it was evident that this arrangement had impacted significantly on the operation of the ward. Whilst out-of-hours adult admissions were still being undertaken at Talygarn Ward, increasing pressure on the ward staff at night, we were informed that as part of the health board's service review, this was being reconsidered, with alternative arrangements included in the proposals.

There was an established electronic system in place for recording, reviewing and monitoring incidents. There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Following this, reports were produced and reviewed at hospital and organisation level, review and analyse the data.

[7] https://hiw.org.uk/sites/default/files/2019-06/170418countyhospitaltalygarnen.pdf

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the service provided.

During our conversations with some ward staff, they percieved the investigation process for serious and untoward incident reviews, to be aimed at finding individual fault at ward level. This does not follow the health boards policy, and staff said they were willing to learn from incidents and felt supported by the ward team during such incidents, however, felt targetted by the investigation, and considered to be unsupported by senior managers during the difficult process. Whilst senior managers explained that this was not the case, the health board should give consideration on how to support staff during investigations, and how to aid staff's understanding of the process.

It was positive to note that throughout the inspection, all staff engaged openly and were receptive to our views, findings and recommendations.

Improvement needed

The health board must:

- Provide an update on the health board's out-of-hours adult admissions provision.
- Consider how to support staff further, during an incident investigation process.

Staff and resources

Workforce

The staffing levels appeared appropriate to maintain the safety patients within the hospital at the time of our inspection.

Staff evidenced strong team working and appeared motivated, to provide dedicated care for patients. Staff we spoke with were positive about the support they received from the colleagues, and leadership by their managers.

During the inspection there was one deputy ward manager post which had recently been vacated, and two registered nurse vacancies; these vacncies were in the recruitment process.. However, there had also been a number of absences due to sickness and extra staff had been required to provide additional support to some patients; this had caused difficulty in fulfilling the staff rota. Where

possible the ward utilised its own staff and regular staff from the health board's staff bank to fill these shortfalls.

It was positive to note that staff were undertaking additional shifts to assist in fulfilling rotas to maintain continuity of care. We reviewed staff rotas and spoke with the ward manager who confirmed that additional shifts were being monitored to prevent staff working excessive hours which may lead to fatigue.

The training information we reviewed, showed that staff were expected to complete mandatory training on a range of topics relevant to their roles. Training compliance was regularly monitored to ensure compliance was maintained. Staff also attended additional training and conferences relevant to their roles.

Staff completed annual performance appraisals and these were documented to evidence that these had been completed. Staff also had regular management supervision and regular team meetings.

Staff could access clinical supervision through the health board, however, we were informed that generally, the uptake was low. Senior managers confirmed that this was being reviewed with the aim to increase the clinical supervision uptake by ward staff.

Improvement needed

The health board must consider how to encourage and support ward staff in undertaking clinical supervision.

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
No immediate concerns were identified on this inspection.	Not applicable	Not applicable	Not applicable

Appendix B – Immediate improvement plan

Service: County Hospital

Ward: Talygarn Ward

Date of inspection: 9 – 11 September 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.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No immediate assurance issues.	Not applicable	Not applicable	Not applicable	Not applicable

Appendix C – Improvement plan

Service: County Hospital

Ward: Talygarn Ward

Date of inspection: 9 – 11 September 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 consider how to support and facilitate additional ad-hoc activities on the ward.	1.1 Health promotion, protection and improvement	The Health Board acknowledges that due to a high level of patient acuity and the requirement for nursing staff supporting patients during admissions to general hospitals, facilitating ad hoc activities has been more of a challenge. This has been further compounded as the ward is currently holding a vacancy for an Occupational Therapist which is being advertised. This role has been helpful in informing the wider team	Head of Occupational Therapy	January 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		around appropriate ad hoc activities to support recovery. The ward is keen to facilitate planned and ad hoc activities via a range of disciplines and agencies. The ward will continue to liaise with third sector organisations such as Hafal and will review the availability of equipment to support ad-hoc activities. The ward had been successful in recruiting volunteers, unfortunately the two volunteers are now no longer able to support the ward. Work is underway with the volunteer's manager to recruit further volunteers. The outdoor exercise equipment is scheduled to be installed in November 2019.	Ward Manager Ward Manager & Senior ward team Ward Manager	December 2019 February 2020 December 2019
The health board must ensure that all shower curtains are in place.	4.1 Dignified Care	The ward has re-ordered new shower curtains.	Ward Manager	October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must provide an update on reconfiguration to single bedrooms.	4.1 Dignified Care	An architect was commissioned to review the internal layout of Talygarn ward to provide options for single bedrooms, and how this would impact the bed numbers. The report has now been received and options are being reviewed by the Division in conjunction with similar issues for another ward. The architect now needs to undertake a review of the layout of the second ward. The options for both wards are being considered with reference to impact on patient experience and impact on acute bed provision across the area. Once both reports are received and collectively appraised, the preferred option/s will be presented to the Health Board Executive Team for consideration.	Divisional Director	February 2020
The health board must provide an update on the provision of outdoor exercise equipment.	4.1 Dignified Care	The outdoor exercise equipment has been purchased and is scheduled to be installed in November 2019.	Ward Manager/ Senior Nurse	December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that building guttering is clear of debris and functioning.	4.1 Dignified Care	A request has been logged with the Health Board's Works & Estates Department to complete this work.	Works & Estates Manager	November 2019
The health board must ensure that information is displayed on the role of HIW and how to contact the organisation.	4.2 Patient Information	The Health Board has requested posters from HIW. As soon as these have been received they will be displayed in all wards and mental health team bases.	Head of Quality & Improvement	November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The health board must ensure nurse call buttons within bedrooms are accessible from the bed.	2.1 Managing risk and promoting health and safety	Nurse call buttons are accessible from the bed. There are times when it is clinically indicated that the bed should be moved to facilitate clearer observation, in as unobtrusive a fashion as possible. During this time, the person would need to step from the bed to the call button. In this case, the person will be on continuous 1:1 or every 15 minutes observations and thus staff would be available very regularly. In the case of a person who was unable to move from their bed to activate the alarm, they would be moved to a different bedroom/ bed area. Once the clinical risk has been assessed as reduced, the bed is returned to the usual position. Citing of beds, call alarms and observation panels will be considered in any new build/ redesign in the future.	Ward Manager	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must provide an update on the provision of the Extra Care Area.	2.1 Managing risk and promoting health and safety	Capital funding has been agreed and approved. Work is due to commence in November 2019.	Ward Manager/ Senior Nurse	January 2020
The health board must ensure that the temperature of ward clinic rooms containing medicines, are regularly monitored.	2.6 Medicines Management	Ward staff will monitor the temperature of the clinic room regularly, and particularly during summer months. Wards have been instructed to contact Pharmacy for advice should the temperature rise to above 25°C.	Ward Manager	Immediate
The health board must consider implementing self-medication arrangements for appropriately assessed patients, in preparation for their discharge.	2.6 Medicines Management	The Health Board has a policy for self-medication. The Senior Nurse has arranged a meeting with the Pharmacist to discuss and review options to support this.	Ward Manager	November 2019
The health board must ensure patient records are not over-filled.	3.5 Record keeping	The Ward Clerk has reviewed all notes and created a new volume of notes where required. The ward clerk will continue to monitor this.	Ward Clerk	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The health board must provide an update on the health board's out-of-hours adult admissions provision	Governance, Leadership and Accountability	The Health Board is reviewing the acute care provision across the Adult Mental Health Directorate as part of a wider programme of transformational work with partners around crisis management. This includes the management of out-of-hours admissions. Part of this work includes the extension of the working hours of the Crisis Resolution Home Treatment Teams to 24 hours, with increased multi-disciplinary involvement. The teams commenced extended working patterns at the beginning of October and the impact of this on the patient experience and on out-of-hours admissions will be monitored.	Directorate Manager, AMH	April 2020
The health board must consider how to support staff further, during an incident investigation process.	Governance, Leadership and Accountability	The Health Board will canvass staff to understand how best to support staff at such times. Staff have reported that the debrief, offer of support from psychology colleagues, and well-structured and supportive	Head of Quality & Improvement/ Lead Nurse AMH	January 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		interviews by the reviewing officer have helped. The Division will take forward this learning in the training of reviewing officers		
The health board must consider how to encourage and support ward staff in undertaking clinical supervision.	7.1 Workforce	The ward has facilitated a project to test different methods of supervision with ward staff; particularly nursing staff. The project has been evaluated and findings will be presented to the Directorate's Quality & Patient Safety meeting in the first instance for recommendations to be heard, taken forward and replicated for other wards.	Senior Nurse, Lead Nurse AMH, Directorate Team	February 2020

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): **Dr Chris O'Connor**

Job role: **Divisional Director, MH & LD**

Date: **16 October 2019**