Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

NHS Mental Health Service Focussed Inspection (Unannounced)

Heddfan Psychiatric Unit

Betsi Cadwaladr University Health Board

Inspection date: 7-9 July 2020

Publication date: 7 October 2020

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Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-80082-298-6

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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 focussed inspection of Heddfan Psychiatric Unit within Betsi Cadwaladr University Health Board on the evening of 7 July and the following days of 8 and 9 July 2020. The following sites and wards were visited during this inspection:

- Gwanwyn - Older Persons Mental Health
- Hydref - Older Persons Mental Health

Our team, for the inspection comprised of two HIW inspectors and one clinical peer reviewer. The inspection was led by a HIW inspection manager.

The purpose of this inspection was to gain assurance on whether sufficient attention is being given by the health board to address issues that have been raised through concerns reported to HIW.

The inspection focussed specifically on

- Patient Care
- Governance and leadership
- Safeguarding
- Staffing
- Infection prevention and control.

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.

There was evidence of strong and supportive leadership on both wards.

We found the service provided safe and effective care. However the health board must ensure staff are suitably skilled and trained to care for the ward's specific patient group.

This is what we found the service did well:

- Established and effective clinical processes in place to maintain patient safety
- Care and Treatment plans were completed in line with the Welsh Measure
- Established and effective governance arrangements that provided safe and clinically effective care
- Strong leadership on both wards.

This is what we recommend the service could improve:

- Areas of the environment to help maintain patient safety
- Communication and involvement with staff around potential strategic changes in the unit
- Recruitment into vacant posts.

3. What we found

Background of the service

Heddfan Psychiatric Unit provides NHS mental health services at Heddfan Unit, Wrexham Maelor Hospital, Croesnewydd Rd, Wrexham LL13 7TD, within Betsi Cadwaladr University Health Board.

In response to the COVID – 19 pandemic, the Heddfan Unit became designated as a regional admission unit for older persons care. Clywedog and Dyfrdwy wards transferred from Adult Mental Health wards into Older Persons Mental Health Wards. At the time of our inspection the Psychiatric Intensive Care Unit[1] (PICU) was closed.

Heddfan currently has four mixed gender Older Persons Mental Health wards:

- Clywedog ward, a 13 bed organic[2] mental health assessment ward
- Dyfrdwy ward, a 19 bed functional[3] mental health assessment ward
- Gwanwyn, a 13 bed organic mental health ward

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[1] A Psychiatric Intensive Care Unit is an in-patient mental health ward that provides greater support and lower risk for patients with a more restrictive environment and increased staffing levels than an acute ward. PICUs are designed to look after patients who cannot be managed on acute psychiatric wards due to the level of risk the patient poses to themselves or others. The aim is for the patient's length of stay to be as short as possible to manage the increased challenging behaviours and then returned to an acute ward as soon as their mental state has stabilised to what can be safely managed there.

[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.

- Hydref, a 16 bed functional ward.

This inspection focussed on Gwanwyn and Hydref ward. Each ward employs a staff team which includes a ward manager and deputy ward manager, and a team of registered nurses and health care support workers. The multidisciplinary team includes professionals from psychiatry, psychology, and occupational therapy.

The unit is supported by the health board's clinical and administrative structures.

Quality of patient experience

We found a dedicated staff team that were committed to providing a high standard of care to patients.

The ward environment on Gwanwyn and Hydref was well maintained, clean, tidy and free from obvious health and safety hazards.

Staying healthy

There was a wide range of relevant information leaflets for patients, families and other visitors available in the reception areas of the unit and on the individual wards. These areas contained information on mental health issues, guidance around mental health legislation and physical wellbeing such as healthy eating. There was also information on organisations that can support patients, their families and carers.

Heddfan had a team of occupational therapists that provided a wide range of activities for patients within the unit. Both wards had their own designated garden area, both of which provided a pleasant outdoor space. Both ward environments were well maintained, clean, tidy and free from any health and safety hazards.

Dignified care

On first night of the inspection we noted that staff interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients. Most staff we spoke to also demonstrated a good level of understanding of patients they were caring for.

On both wards there were communal areas which provided sufficient space for patients to have personal quiet time away from their rooms. Each patient had their own en-suite bedroom which included a toilet, sink and shower. The bedrooms provided patients with a high standard of privacy and dignity.

Bedroom doors had observation panels so that staff could undertake observation on patients without opening the door and potentially disturbing the

patient. Patients were able to close the observation panels from inside their bedroom.

There were bathrooms available on each ward that patients could utilise if they wished to have a bath. There were appropriate aids available to provide additional support for patients if required.

There was a patient status at a glance board[4] in the nurse's office displaying confidential information regarding each patient being cared for on the ward. The boards were designed in such a way that confidential information could be covered when the boards were not in use. This meant that the staff team were making every effort to protect patient confidentiality.

Due to the Coronavirus (COVID – 19) pandemic no visitors or family members were allowed at Heddfan. There were ward mobile phones available for patients to contact friends and families, however these facilities were poor. It was positive to hear that the health board were looking to reintroduce visitors and were putting together plans for visits to take place safely. However in the meantime, the health board needs to make improvements for patients to receive virtual communications with family members.

There was the opportunity for patients, relatives and carers to provide feedback on the care provided via the NHS Putting Things Right[5] process. Senior ward staff confirmed that wherever possible they would try and resolve complaints immediately.

Improvement needed

The health board needs to make sure that patients have access to technology to see and speak to family members.

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

[5] Putting Things Right is the integrated processes for the raising, investigation of and learning from concerns regarding treatment within the NHS

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 provide safe and clinically effective care.

We found that staff were completing clinical processes and documentation as required. However, the skill mix should to be reviewed and the development of staff working with new patient group requires investment to help meet the needs of the patients at the unit.

A review of the environment on Clywedog and Dyfrdwy must take place to ensure the environment is made suitable for older persons care.

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.

There were processes in place to manage risk and maintain health and safety on both wards. Gwanwyn was located on the ground floor with Hydref on the first floor of the unit. There was a lift available to the first floor which ensured accessible entry to Hydref ward.

There were nurse call points around the ward and within patient bedrooms so that patients could summon assistance if required. Both Gwanwyn and Hydref had bedroom sensors that would alert staff to patients rising from their beds so that staff could provide the required level of support for patients. On the first night of the inspection we observed staff responding in a timely manner to alarms that activated.

There were up-to-date ligature point risk assessments in place for both wards. These identified potential ligature points and what action had been taken to remove or manage these.

The furniture, fixtures and fittings on both wards were, on the whole, appropriate to the respective patient groups. On Hydref ward we noted an arm rest missing from a semi-circular seat. The health board must make sure this arm rest is fixed or replaced to ensure it does not present a risk to patient safety.

During the inspection we did not visit Clywedog or Dyfrdwy wards, however staff we spoke to told us that these wards were not suitable for older adult care, as they had not been repurposed from adult acute wards into older adult care wards. Examples provided by staff were that the bathroom floors had raised levels which placed older patients at greater risk of falls and the bedrooms did not have appropriate beds and fixtures for older adult care. We were also told that patients could not alert staff when they require assistance from their bedrooms. This was brought to the attention of senior management during the inspection, who assured us that a review of the environment in both these wards was being undertaken. Additional high-low profiling beds to assist in maintaining the safety of patients with reduced stability and mobility had been ordered for both wards. The health board must ensure this review is completed and relevant actions taken in a timely way.

Some staff told us they did not feel adequately trained to care and support a new patient group with differing risks and needs to previous patient groups they had worked with. Senior management informed us that additional training and support was being developed for staff, and a shadowing programme was being implemented.

Staff also told us that they would benefit from training on subjects such as restraint and manual handling techniques when dealing with older person's care, due to staff having limited experience in dealing with a different type of patient group where different techniques may be required. The health board must make sure that all staff are suitably trained to deal with older person's care to ensure the safety of patients and staff is maintained.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the health board's incident reporting system (DATIX) that included the names of patient(s) and staff involved, a description, location, time and length of the incident. Any use of restraint was documented.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed so that the occurrence of incidents could be reviewed and analysed. Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the unit and the wider organisation.

We reviewed records and confirmed there was evidence of incidents being recorded. These included issues raised by staff regarding the environment of care on Clywedog and Dyfrdwy, and staff shortages. It was reassuring to see that staff felt confident in reporting and raising these issues, which demonstrated professional integrity. This culture of reporting should be encouraged and supported by the health board so that staff feel valued in contributing to change and are confident in reporting issues that affect staff and patient safety.

Improvement needed

The health board must ensure that:

- The arm rest is fixed or replaced on Hydref Ward
- A review of the environment on Clywedog and Dyfrdwy is completed to ensure patient safety
- Patients have access to appropriate beds and fixtures to aid patient independence and safety
- Patients can alert staff that they require assistance from their bedrooms
- Staff, including bank staff, receive training and support to feel confident in caring for the current patient group.

Infection prevention and control

There were hand hygiene products available in relevant areas on both wards and these were accompanied by appropriate signage. Staff also had access to Personal Protective Equipment (PPE) when required.

There were laundry facilities for the wards which were well maintained and we found that laundry rooms and linen cupboards were well organised.

There were cleaning schedules undertaken by health board housekeeping staff across both wards. Ward staff stated that they undertook additional cleaning in clinical areas and we observed staff cleaning clinical areas on the first night of our inspection. Staff were also observed washing hands frequently.

We spoke with the infection, prevention and control staff to determine how the health board had responded to the COVID – 19 pandemic. They told us that at the start of the pandemic a number of deficiencies were identified within Heddfan unit and as a result a plan was put in place to go back to basics, where hand hygiene and environmental hygiene adjustments were implemented.

Some difficulties were initially experienced with the use of PPE. Issues highlighted included identifying single use versus sessional use of PPE, however this has since been resolved. Internal audits demonstrated that learning and improvements had been made following a difficult period at the start of the pandemic and we observed good practice being undertaken by staff during the inspection. We also noted that there was a good supply of PPE on both Gwanwyn and Hydref wards.

Staff we spoke to were aware of infection control obligations and clear on isolation processes. Each ward had areas set aside where if a patient became symptomatic they could be isolated and barrier nursed on the ward within a protected area. None of these areas were in use at the time of inspection.

Infection prevention and control staff also visited the wards on a daily basis. Throughout the inspection we observed the unit to be visibly clean and free from clutter.

Nutrition and hydration

We reviewed care records and confirmed that assessments of patients' eating and drinking needs had been completed. Patient records documented specific individual dietary needs to maintain sufficient nutrition and fluid consumption, and monitoring documentation we reviewed was appropriately completed.

Medicines management

Medication was stored securely in cupboards and medication fridges which were locked and secure. Medication trolleys were also secured to the clinic room, to prevent them being removed by an unauthorised person.

There were appropriate arrangements in place on the ward for the storage and use of Controlled Drugs and Drugs Liable to Misuse. The temperatures of

medication fridges and clinic rooms were being monitored and recorded, to check that medication was stored within the appropriate temperature range.

The Medication Administration Records (MAR Charts)[6] 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.

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.

Both wards provided care to adults only. Ward staff had access to the health board's safeguarding procedures via its intranet. Senior ward staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff they were able to demonstrate the process of making a safeguarding referral.

There was good corporate safeguarding oversight by the health board within Heddfan. When the patient group changed to all older persons the health board situated one of its corporate safeguarding team members on-site as it expected an increase in referrals and incidents. The increase did not happen, however the team member remains there to provide advice and guidance and to quality assure all referrals.

There is also a best interest assessor based at Heddfan, this assessor carries out all the DoLS assessments at the unit.

All safeguarding training is delivered within the health board, however some of the training figures were quite low, and this is detailed further in the next section of the report.

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[6] 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.

Safe and clinically effective care

Within the sample of patients' care records viewed, we saw a number of completed patient assessment tools based upon best practice guidelines and national initiatives. This was with a view to helping staff provide safe and effective care. Examples we saw included those in relation to preventing pressure sores and nutrition.

Record keeping

Patient records were mainly paper files that were stored within the locked nursing office. We observed staff storing the records appropriately during our inspection.

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.

We reviewed a sample of patient records for both wards. It was evident that staff from across the multidisciplinary teams were writing detailed and regular entries which provided a live document on the patient and their care.

We saw evidence to show that extensive efforts were being made to seek the best possible outcomes for patients. Physical health assessment as well as mental health assessments were robust and had been carried out to a high standard. However we did note that the unmet needs were not documented in one set of care plans we viewed. It is important that unmet needs are documented so that these can be regularly reviewed by the multidisciplinary team to look at options for meeting those needs.

Improvement needed

The health board must ensure that unmet needs are documented within patient care plans.

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

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

We reviewed a sample of care files and found that they were generally maintained to a good standard. Entries were comprehensive and recognised assessment tools were used to monitor mental and physical health. The patient

records we viewed were well organised and easy to navigate. There was clear evidence of multidisciplinary involvement in the care plans which reflected the domains of the Mental Health (Wales) Measure 2010.

The majority of patient records we examined contained comprehensive needs and risk assessments throughout the patient admission which directly linked to the plan of care and risk management strategies implemented on the wards.

COVID – 19 patient care plans were in place, these plans were individualised, detailed and well developed. These plans demonstrated that both wards had processes in place that maintained the safety of staff and patients. As highlighted in the earlier part of this report, due to the layout of the wards there was opportunities to place symptomatic patients into segregated areas to prevent and protect others from becoming infected with COVID - 19.

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.

We found that staff were committed to providing patient care to high standards. Throughout the inspection staff were receptive to our views, findings and recommendations.

The health board should consider how staff are kept informed of the future strategy of Heddfan and what implications there may be for staff and their roles.

Improvements are required in the completion of mandatory training, along with IT systems which can support the completion of training.

Governance, leadership and accountability

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

There was dedicated and passionate leadership from the ward managers who were supported by committed ward multidisciplinary teams and senior health board managers. We found a friendly, professional staff team who demonstrated a commitment to providing high quality care to patients. Staff were able to describe their roles and appeared knowledgeable about the care needs of most patients they were responsible for.

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.

Senior managers of the health board engaged openly during the inspection, and acknowledged that some processes had been implemented since being notified of the concerns raised with HIW. The health board openly provided details of improvements that had been made. Each morning there was a meeting to review the immediate operation of the hospital and any emerging risks or issues that required attention. Staffing resources were reviewed daily and were planned in advance to help ensure sufficient staff numbers were on shift to meet the care needs of the patients at the hospital.

During our discussions with staff it was clear that staff had been affected by the changes made to the wards in response to the COVID 19 pandemic. Staff we spoke with raised concerns around the quality of communication during this time and also in relation to the phase 2 plan which sets out the health board’s intentions of transitioning into a new service model of care. Staff stated that there had been no consultation with them over the proposed plans. Some staff we spoke to indicated that experienced staff were intending on leaving the health board due to the uncertainty and lack of communication around the changes taking place in the next phase.

Staff would benefit from clarity of the health board's future strategy and what implications there are for staff and their roles. It is important that the health board have ongoing transparent communication with staff about the changes they are planning.

The health board must encourage staff to feel confident in sharing ideas, demonstrating that staff are valued and are supported to contribute to any proposed changes.

Improvement needed

The health board must make sure that staff feel consulted and involved in decisions that affect them, and that staff feel confident in sharing ideas and contributing to change.

Staff and resources

Workforce

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

Staff told us that the unit management team were approachable and visible. During interviews with staff they told us they had confidence to speak with management if they needed to raise issues or concerns.

Staff evidenced strong team working and appeared motivated to provide dedicated care for patients.

We noted a number of registered nurse vacancies, which the health board was attempting to recruit into. Where possible the ward utilised its own staff and regular staff from the health board's staff bank to temporarily fill these shortfalls. Daily meetings on staffing levels and patient flow and demand took place to immediately resolve any shortfalls. The health board must continue to ensure it has sustainable and sufficient capacity to provide safe and effective care to patients.

Staff told us that the current system of recruitment was very resource intensive on ward managers, and due to the competing demands of the wards there were delays in submissions of paperwork for vacancies on the wards. The health board should look at alternative ways of supporting staff in the administration recruitment to ensure there are no unnessecary delays in the recruitment and appointment of new staff.

The unit had a clear policy in place for staff to raise any concerns and staff we interviewed had knowledge of the policy.

There was a programme of training so that staff would receive timely updates on what training required completion. The electronic records provided the

senior managers with details of the course completion rates and individual staff compliance details.

We reviewed the mandatory training and clinical supervision statistics for staff at the unit and found that completion rates were generally high. Whilst reviewing records we identified that safeguarding training completion rates were low. It was acknowledged that due to the difficulties surrounding the pandemic with staff shortages, this had impacted upon the ability to release staff for training. It was reassuring to see that the completion rates for training had already been identified and the health board were in the process of arranging this training. The health board also needs to make sure that staff have access and availability to additional IT systems which can support the completion of their training.

There were good systems in place to support staff welfare. The unit's clinical psychologist was providing ongoing support to staff, the psychologist had met and spoken with all staff and it was reassuring to see that support had also been considered for the clinical psychologist. The health board must continue to monitor, promote, and invest in staff welfare and wellbeing.

Improvement needed

The health board must ensure that:

- Staff vacancies are filled and future initiatives are explored to encourage recruitment into the unit.
- Staff are supported to avoid preventable delays incurred during recruitment and pre-employment checks.
- Safeguarding mandatory training rates are improved, along with IT systems which can support the completion of training.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, 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			

Appendix B – Immediate improvement plan

Service: Heddfan Psychiatric Unit

Ward/unit(s): Gwanwyn and Hydref Wards

Date of inspection: 7 – 9 July 2020

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				

Appendix C – Improvement plan

Service: Heddfan Psychiatric Unit

Ward/unit(s): Gwanwyn and Hydref Wards

Date of inspection: 7 – 9 July 2020

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 needs to make sure that patients have access to technology which allows patients to see and speak to family members	1.1 Health promotion, protection and improvement	The health board have purchased an additional 4 IPADS, making 6 in total, which are solely to facilitate contact between patients and families. 'How to use' Guides will be made available for patients, staff and relatives to enable them to use the apps to access different forms of social media.	Head of Nursing Business Manager	30 August 2020 30 August 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Ward managers will monitor the use of I PADS for patients to have contact with family members. The audit will be completed on a weekly basis The Health Board is undertaking an evaluation of the use of technology and MHLD services will be part of this evaluation.		
Delivery of safe and effective care				
The health board must ensure that the arm rest is fixed or replaced on Hydref ward.	2.1 Managing risk and promoting health and safety	The fault for this specialist seating equipment has been reported to estates and awaiting repair.	Clinical Operations Manager	30 August 2020
The health board must ensure that a review of the environment on Clywedog and Dyfrdwy is	2.1 Managing risk and promoting	The Health Board will undertake a full environmental review for all OPMH wards	Clinical Operations	30 September

Improvement needed	Standard	Service action	Responsible officer	Timescale
undertaken to ensure patient safety.	health and safety	at the Heddfan Unit this will include: Shower area and bedrooms and accessibility. The environmental review team will include estates, IPC and Health and Safety.	Manager	2020
The health board must ensure that patients can alert staff that they require assistance from their bedrooms	2.1 Managing risk and promoting health and safety	There is currently a patient call system in each bathroom which is not fit for purpose. However, an additional and appropriate wireless patient call system is required for those patients with mobility issue. This system has been ordered and awaiting delivery.	Inpatient Operations Manager	30 September 2020
The health board must ensure patients have access to appropriate beds and fixtures to aid patient independence and their safety.	2.1 Managing risk and promoting health and safety	All patients have access to an appropriate bed and any specialist bed requirements raised at the daily Older Adult Acute Care Meeting for action to ensure the patient is in an appropriate bed. Specialist fixtures to ensure independence and safety in relation to the appropriate bed is currently being reviewed as part of the equipment review.	Clinical Operations Manager	30 August 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Specialist fixtures will then be procured for use in the bedrooms.		
The health board must ensure staff, including bank staff, receive training and support to feel confident in caring for a different patient group.	2.1 Managing risk and promoting health and safety	A refreshed training needs analysis will be undertaken to review the gap in skill set in caring for a different patient group	Training and Development Lead	31 October 2020
		A training plan will be put in place to address gaps in Restrictive Physical Interventions, Manual Handling specifically directed towards caring for older people		
		An Advanced Nurse Practitioner will be recruited to support the physical health care and training in older persons nursing	Head of Nursing	30 August 2020
		Each ward manager will have opportunity to shadow a ward manager in Care of the Elderly to increase confidence and skill	Head of Nursing	30 August 2020
		Additional support package from Practice Development Nurse to support the wards in caring for a different patient group	Assistant Director of Nursing	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		A plan to be in place for one of the former adult wards in Heddfan Unit to return to its adult function. Thus reducing the gap in caring for a different patient group to one ward in Heddfan.	Head of Nursing	30 August 2020
The health board must ensure that unmet needs are evidenced and documented within patient care plans.	3.5 Record keeping	Teams have been reminded by a memo to ensure unmet needs are documented within the Mental Health Measure documentation. There is a daily Acute Care Meeting (Mon-Fri) where any identified unmet needs have clear actions for resolution. A weekly audit will include a monitoring question on unmet needs captured in the Mental Health Measure documentation and gaps immediately rectified.	Head of Nursing Inpatient Clinical Operations Manager Inpatient Clinical Operations Manager	Complete Complete 30 August 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The health board must make sure that staff feel consulted and involved in decisions that affect them, and that staff feel confident in sharing ideas and contributing to change.	Governance, Leadership and Accountability	Engagement event with senior leaders to gather views on the way forward	Deputy Director Strategy	30 September 2020
		Staff suggestion boxes have been insitu across the Heddfan Unit for staff to provide feedback	Inpatient Operations Manager	Ongoing
		Implement 'You said, we did' Notice Boards.	Business Manager	30 September 2020
		Implementation of Safety Culture Survey to collect views from front line staff on the Heddfan Unit	Head of Nursing	September 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that staff are supported to avoid preventable delays incurred during recruitment and pre-employment checks	7.1 Workforce	A dedicated Business Support Manager has been aligned to the recruitment process to support ward managers and reduce avoidable delays with recruitment. Delays in recruitment will be monitored through the operational group	Business Support Manager Head of Operations	Completed Ongoing
The health board must ensure that staff vacancies are filled and future initiatives are explored to encourage recruitment into the hospital.	7.1 Workforce	All current vacancies have been identified and progressing through recruitment exercise Early identification of leavers and support with TRAC recruitment	Head of Nursing Business Manager	30 October 2020 30 September 2020 Ongoing
The health board must ensure safeguarding mandatory training rates are improved, along with IT systems which can support the completion of training.	7.1 Workforce	A training plan will be put in place to address areas of low compliance (less than 85% completed compliance) with safeguarding training for each ward A review of IT equipment and accessibility will be undertaken to support easier	Inpatient Operations Manager Business Manger	30 September 2020 30 September

Improvement needed	Standard	Service action	Responsible officer	Timescale
		access to E-Learning		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): **Mike Smith**

Job role: **Interim Director of Nursing MHLD**

Date: 18 August 2020