NHS Mental Health Service Inspection (Unannounced)

Ysbyty Gwynedd

Hergest Unit

Betsi Cadwaladr University

Health Board

Inspection date: 6 – 8 September 2021 &

20 – 22 September 2021

Publication date: 23 December 2021

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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 978-1-80391-531-9

Contents

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 two unannounced mental health inspections of Ysbyty Gwynedd, Hergest Unit within Betsi Cadwaladr University Health Board. The first starting the evening of 6 September 2021, the second starting the evening of 20 September. The following sites and wards were visited during these inspections:

- Aneurin - Female acute mental health admission ward
- Cynan - Male acute mental health admission ward
- Taliesin - Psychiatric Intensive Care Unit (PICU)

Our team, for the inspection comprised of two HIW inspectors and two clinical peer reviewers. A HIW inspection manager led the inspection.

The first unannounced visit took place on the evening of Monday 6 September 2021. Shortly after arriving at the hospital, HIW were advised of a patient and two staff members who had tested positive for COVID - 19. As a result, the remaining two days of this inspection took place remotely and focussed on the following concerns:

- Management of Coronavirus (COVID-19)
- Staffing levels
- Staff welfare.

HIW completed a second unannounced inspection on the evening of the 20 September and the following days of 21 and 22 September 2021. This inspection focussed on what improvements had been made since our inspection on the 6 September 2021. In addition, we also inspected the following areas:

- Infection Prevention Control
- Patient Care Plans
- Environment of care
- Governance and staffing.

HIW explored how the service met the Health and Care Standards (2015).

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

During our inspection commencing 6 September, we identified a number of areas of concern particularly around Infection Prevention and Control, and Governance and Leadership. Due to concerns about patient safety, we issued an immediate assurance letter, where we write to the service immediately after our inspection with our findings requiring urgent remedial action. We then returned to undertake a further unannounced inspection on 20-22 September to ensure the Hergest Unit was providing safe and effective care.

Overall, we found evidence that the Health Board had started to implement systems and processes to address areas identified in the immediate assurance issued. However, further improvements were identified in the inspection on the 20-22 September 2021.

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

A number of environmental issues, a lack of infection prevention and control measures relating to COVID-19 procedures, and staffing issues were escalated during both inspections.

Improvements are required in completion of patient care plans and in maintaining accurate staff rota records.

Improvements in communication and engagement between senior managers and ward staff is required to develop a trusting relationship.

This is what we found the service did well:

- We observed that staff interacted and engaged with patients respectfully
- Good team working and motivated staff

- Established governance arrangements.

This is what we recommend the service could improve:

- The maintenance of the hospital facilities
- The capacity of its older adult inpatient mental health service
- Organisation and completion of care plans
- Improvements in welfare and morale of the hospital workforce
- A more stable and consistent senior management team
- Management of staff rota records.

Following the inspection on the 6 September 2021, HIW had some immediate concerns, which were dealt with under our immediate assurance process. This meant that we wrote to the Health Board immediately after the inspection, outlining that urgent remedial actions were required.

Details of the immediate improvements that were required are summarised below and the actions the provider has/is taking to address them are provided in Appendix B:

- We were concerned that some staff were working excessive hours and were regularly working beyond the end of their shift
- Staff informed HIW that they were not always having meal breaks during 12-hour shifts
- Staff were being used from Psychiatric Liaison Teams to fill rota gaps on the wards to cover sickness and staff long-term leave. As a result, this impacted upon the capacity of the Psychiatric Liaison Team to undertake their role
- Staff rotas we reviewed highlighted a number of unfilled shifts
- There is no evidence of a ward acuity assessment to identify if current staffing levels were suitable for the current patient demands on the unit.
- HIW were not assured that all staff were aware of COVID-19 cases on the unit or that correct reporting mechanisms were in place

- As visitors on the unit HIW inspectors were not advised to adhere to COVID-19 protocols, such as hand hygiene compliance

- Staff were not always following infection control protocols, for example, Security Guards were observed coming onto the unit from another area of the hospital. They were not wearing their masks correctly and went straight onto a ward without complying with hand hygiene protocols

- Staff were being utilised from other areas of the hospital and across the Health Board to assist with staffing issues on Hergest unit. It was unclear what procedures were in place to prevent any potential transmission of infection.

These are serious patient safety issues and we issued an immediate assurance letter to the health board following the inspection. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

No new areas requiring immediate assurance were identified during the inspection on 20 September 2021.

3. What we found

Background of the service

The Hergest Unit provides NHS mental health services at Ysbyty Gwynedd, Penrhosgarnedd, Bangor, LL57 2PW, within Betsi Cadwaladr University Health Board.

The service has three wards:

- Aneurin, a 17 bed female acute mental health admission ward
- Cynan, a 17 bed male acute mental health admission ward
- Taliesin, a 6 bed mixed gender Psychiatric Intensive Care Unit (PICU).
- A dedicated Section 136 Suite[1].

At the time of our inspection, bed capacity had been reduced to help support social distancing measures required due to COVID -19. Aneurin and Cynan Wards bed capacity was 14 and Taliesin remained at 6.

The service employs a staff team, which includes a team of registered mental health nurses and healthcare support workers. The multi-disciplinary team consists of consultant psychiatrists and occupational therapists.

Dedicated teams of administration staff, maintenance, catering and domestic staff support the day-to-day operation of the hospital.

The hospital is overseen by the health board's clinical and administrative structures.

[1] Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. A Section 136 Suite is a designated place of safety.

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.

Patients we spoke to told us they were receiving good care at the hospital.

The health board needs to review the inpatient service provision for older adult mental health care, to ensure it has sufficient capacity and appropriate care to meet the needs of older adult mental health patients.

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 well-being such as healthy eating. There was also information on organisations that can support patients, their families and carers.

Hergest Unit had a team of occupational therapists that provided a wide range of activities for patients within the unit. Each ward had their own designated garden area, which provided outdoor space for patients.

The unit had a therapies area, which included an activities area with a pool table and cardio exercise equipment, an arts therapy room, and a crafts room. However, at the time of the inspection we were informed that the gym equipment was not being used by patients due to restrictions relating to the COVID-19 pandemic.

Dignified care

We noted that all employees; ward staff, senior management and administration 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. We observed most staff taking time to speak with patients and address any needs or concerns the patients raised, this demonstrated that staff had responsive and caring attitudes towards the patients.

We noted locked doors and an intercom system on the entrance to the wards to prevent any unauthorised access. Taliesin was a Psychiatric Intensive Care Unit (PICU)[2] that had six individual bedrooms. Aneurin and Cynan were both designated as 17 bed acute admission wards; both were a mix of individual bedrooms and dormitory areas. At the time of the inspection, both wards were operating at 14 beds due to COVID–19 restrictions. Most patients had access to their own bedroom. However, there was one shared cubicle area on Cynan and Aneurin Ward. The three bedded cubicles had curtains between them, which only afford the basic level of privacy for patients and do not reflect modern mental health care provision.

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. On the first night of the inspection, we were told that the bath on Cynan Ward had not been working correctly. This matter was immediately brought to the attention of the health board and resolved during the inspection. There was also a blocked toilet on Aneurin Ward, which was also brought to the attention of the health board during the inspection.

Some of the bathroom areas on Aneurin and Cynan Ward were being used for storage, a number of boxes were positioned in corner areas of the bathroom. The health board must ensure that all items are stored in appropriate areas. In addition, three unused hospital beds were being stored in the reception area of

[2] PICUs are designed to look after patients who cannot be managed on open (unlocked) psychiatric wards due to the level of risk the patient poses to themselves or others.

Cynan Ward. This was brought to the attention of the health board and the beds were immediately removed.

There was a patient status at a glance board[3] in the nurse's office displaying confidential information regarding each patient being cared for on the ward. The boards are 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.

Hospital policies and the staff practices we observed, contributed to maintaining patient dignity and enhancing individualised care at the hospital.

Improvement needed

The health board must ensure that

- The blocked toilet on Aneurin Ward, and the bath on Cynon ward are fixed
- Bathroom areas are not used for storage.

Patient information

We saw advocacy posters that provided contact details about how to access the service. Due to Welsh Government restrictions associated with COVID-19 legislation, Advocacy services were no longer visiting patients, however patients were able to contact a representative of the statutory advocacy service by telephone to speak to a representative.

Across all wards, we saw information relating to patient feedback and posters were displaying QR codes for patients to scan in order to provide feedback directly to the health board. Wi-Fi was available to facilitate this. In addition, there

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

was the opportunity for patients, relatives and carers to provide feedback on the care provided via the NHS Putting Things Right[4] process.

Communicating effectively

Patients we spoke with stated that they felt safe and able to speak with a staff member should they need to. Patients told us they were happy at the hospital and that staff were kind and helpful. There was clear mutual respect and strong relational security between staff and patients.

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

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

Timely care

Each morning there was an Acute Care Meeting involving all ward managers, multi-disciplinary team members, and representatives from the community services. Each patient being cared for at the hospital was discussed in turn.

Hergest Unit has a designated Section 136 suite where the police could bring people for a Mental Health Act assessment. This unit was closed on the 6 September, and patients were being re-directed to an alternative Section 136 suite in the health board. We were advised that the Section 136 facility had been on divert to Ablett and Heddfan units from 25 August 2021 – 7 September 2021. This had been agreed following discussion with North Wales Police.

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

The reason for the divert was staffing challenges arising from the COVID-19 positive patient requiring 2:1 nursing in an isolated ward next to Aneurin Ward. We were told that this is the contingency plan for all the Section136 facilities and it is not usual practice for Hergest to divert due to staff shortages. The health board must ensure that there are always sufficient staffing numbers on duty to deal with any Section 136 admissions. Transporting a person further to a different Section 136 Suite within the health board is detrimental to the person's well-being.

The Section 136 suite was available for use on the unannounced inspection that took place on the 20 September and there were sufficient staff available to deal with a Section 136 admission.

The Section 136 Suite was adequately equipped to provide comfort and safety for a person awaiting and undergoing an assessment. There was a toilet available within the Section 136 Suite, however, there was no door or screen within the toilet entrance to afford privacy to a person using the facility. This had been highlighted as an area that needed improvement during our last inspection in 2018 but remains a significant dignity issue. The health board must ensure that this work is carried out.

The suite complied with the National Institute for Health and Clinical Excellence (NICE) standards, and the hospital ward and police had an agreed protocol on the use of the suite.

We were told meetings took place between the police and ward staff to evaluate admissions and frequency of use of the suite. It was positive to hear that any lessons learnt and organisational feedback would be discussed during these meetings. Close partnership working with the police and effective use of the Section 136 suite is essential to ensure that people presenting with mental health issues are getting the right care at the right setting.

Due to capacity demands across the health board older person's mental health service, there were occasions when older persons mental health beds were unavailable and therefore a person would be admitted to the adult acute admission wards where there was a bed available. Staff told us that there were also occasions when older persons with a diagnosis of dementia were admitted to the adult acute admission wards. The environment of care on acute mental health wards are not the most appropriate environment to meet the specific needs of those patients, lacking visual and orientation aids that are commonplace on dementia wards. Staff on acute mental health wards may also lack the skillset and be unfamiliar with providing care to patients with a diagnosis of dementia, in meeting their needs and managing their behaviours.

Staff spoken to raised concerns regarding the suitability of the environment of care and the complex challenges that present with older patient care. They described situations where some patients would require enhanced observations and different levels of physical care which staff may be unfamiliar with providing.

Improvement needed

The health board must ensure that:

- Section 136 suite remains open and there are sufficient staff available to cover admissions
- There is appropriate privacy measure for the toilet located in the Section 136 Suite
- A pathway is developed in the health board for older adult care.

Individual care

People's rights

Patients could also utilise the Independent Mental Health Advocacy (IMHA) service where a representative could be contacted via telephone or when they attended the hospital. We were told that advocacy were not currently attending the wards, however were available by telephone for patients to make contact.

During the course of reviewing patient records, we noted that there were no capacity assessments being recorded. Therefore, there was no record to determine if the patient had capacity to make informed decision around:

- Administration of medication within the ward environment
- Understanding the inherent restrictions of being admitted onto a locked ward.

Established hospital policies and systems ensured that patients' equality, diversity and rights are maintained. Information was displayed on the wards to

inform patients, who were not restricted by the Act[5], about their rights to leave the ward.

Due to Welsh Government restrictions associated with COVID-19 legislation, visitors were not allowed on to the unit. However, some patients could meet with family and friends within the hospital grounds. Other patients could maintain contact with family and friends by telephone and video calls.

There was a designated area for children and families visiting which was off ward. This meant that patients could meet with younger family members away from the ward environment.

Improvement needed

The health board must ensure that capacity assessments are completed and recorded in patient records.

Listening and learning from feedback

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

There was no evidence of regular patient meetings taking place, where patients would have the opportunity to discuss any improvements or patient initiatives.

It was positive to note that there was a large display of thank you cards on display in the nurse's office.

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

Improvement needed

The health board must put a system in place for patient meetings with ward staff.

Delivery of safe and effective care

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

Whilst overall the physical environment at Hergest Unit was maintained to a good standard, we identified a number of areas that require action.

We also identified areas for improvement concerning staff practice, in particular around completion of care plans to evidence in detail the care being provided.

Safe care

Our concerns regarding management of COVID-19 and staffing issues from the inspection on 6 September 2021 were dealt with under our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

No immediate assurances were identified when we return to Hergest on the 20-22 September 2021.

Managing risk and promoting health and safety

There were established processes in place to manage and review risks, and to maintain health and safety at the hospital. This assisted staff to provide safe and clinically effective care.

The Hergest Unit is located within the grounds of Ysbyty Gwynedd with its own entrance and staffed reception during the day. During the evening and night, the entrance to Hergest Unit is secured to prevent unauthorised entry, during these times the wards can be contacted via the intercom located at the entrance. However, when the inspection team arrived unannounced on the first evening on 6 September 2021 we were let through the locked doors on to the ward without being asked for identification. Staff must act with vigilance and ensure that the identity of visitors is confirmed prior to allowing their access on to the ward. It was positive to note that on the second unannounced visit, identification was requested.

The inspection team considered the hospital environment during a tour of the hospital on the night of 20 September 2021 and the remaining days of the inspection. We identified a number of decorative and environmental issues that required attention, these included:

- Sticky tape residue marks where items had been stuck to doors and windows. This unfortunately left the wards, in parts, looking scruffy and a unkempt
- Plaster flaking on walls both sides of garden entrance door to Cynan Ward
- Plaster flaking and dampness near the external entrance door to 136 suite
- Cluttered and disorganised storage cupboards
- Hot water tap not working in kitchen on Aneurin Ward
- Patient bathrooms being used as additional storage areas.

These issues were brought to the attention of the health board and the estates team were notified. The health board must ensure that the environmental and decorative issues are resolved.

We told that some of the wards on Hergest had high-low profiling beds to assist in maintaining the safety of patients with reduced stability and mobility. We were told that risk assessments were in place for individuals who use these beds; however, it was unclear if risk assessments had been completed for other individuals on the wards that could gain access to these beds. Staff had access to personal alarms to call for assistance if required, there were also nurse call points around the hospital so that patients could summon assistance if required.

There were established systems in place for assessing and monitoring patients' level of agitation, and staff were trained in recognised Restrictive Physical Intervention (RPI) techniques for managing patient behaviours. Senior staff confirmed that the physical restraint of patients was used, but this was rare and only used as a last resort.

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 patients 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 with regular incident reports produced and reviewed so that occurrence of incidents could be monitored and analysed.

We attended a Putting Things Right meeting. Incidents, safeguarding, staffing and Infection Prevention Control were among the items discussed. It was reassuring to see and hear senior management discussing issues during this meeting, however, no members of the ward staff were available at this meeting. It would be beneficial if ward staff were provided with an opportunity to represent the themselves at these meetings. This would ensure that ward staff have an opportunity to contribute to discussions and improvements made with the senior management team.

There were up-to-date ligature point risk assessments in place for the wards. These identified potential ligature points and what action had been taken to remove or manage these. We reviewed records and confirmed there was evidence of audits.

Improvement needed

The health board must ensure that:

- Staff confirm the identity of visitors prior to allowing access on to the ward
- Sticky residue is removed from windows
- Re-plastering is completed on Cynan Ward and Section 136 suite
- Storage cupboards on all wards are organised
- Patient bathrooms are not used as additional storage areas
- Hot water tap on Aneurin Ward is fixed
- There are regular environmental audits to identify any unreported damaged areas
- Representation from ward staff at meetings.

Infection prevention and control

We found that the arrangements for the prevention and control of infection within Hergest Unit did not protect potential transmission of COVID-19 to other patients and visitors. During the unannounced visit on 6 September, the inspection team

questioned if there were any COVID -19 cases on the ward. We were told that one positive patient was being nursed in isolation. However, the inspection team were later advised by another member of staff that two members of staff had tested positive across the unit. We were not assured that all staff were aware of the cases on the unit or that the correct reporting mechanisms were in place.

In addition, as visitors on the unit, we were not advised to adhere to COVID-19 protocols, such as hand hygiene compliance. We also observed security guards coming onto the unit from another area of the hospital. They were not wearing masks correctly and went straight onto one of the wards without complying with hand hygiene protocols. We also identified that staff were being utilised from other areas of the hospital and across the health board to assist with staffing issues at Hergest. It was unclear what procedures were in place to prevent any potential transmission of infection from other areas of the hospital.

Our concerns regarding management of COVID-19 and staffing issues from the inspection on 6 September 2021 were dealt with under our immediate assurance process.

Following the unannounced inspection on the 6 September 2021, HIW were provided with evidence to confirm that the health board conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands of the COVID-19 pandemic. We also examined COVID-19 documents, which supported staff to ensure they remained compliant with policies and procedures.

When we returned unannounced on 20 September 2021, we noted improvements. Staff were checking that we had complied with COVID-19 protocols such as hand hygiene and wearing and changing of face masks. Staff were also aware of the COVID-19 status of the unit.

On the 20 September 2021, two patients were being nursed in the isolation suite. We were unable to inspect this area but through glassed doors, we were able to observe staff donning PPE in an area outside the isolation suite The PPE was being stored on a table outside the isolation suite. The acute manager told us of further improvement plans she was implementing in the isolation area. This included separating a room into designated donning and doffing areas and estates were fitting a cupboard in this area to store supplies of PPE. The health board must provide an update on the further improvements the health board are making to the isolation suite.

Staff we spoke to were aware of infection control obligations. We were told by staff and saw evidence of staff policies relating to self- isolation, and COVID-19

workforce risk assessments. We were also told that any staff who tested positive were discussed at safety huddles, and Datix incidents would be completed. In addition, a 72-hour review would be undertaken to ensure that appropriate safeguards were in place to protect staff and patients. Regular communication via emails ensured everyone has up to date advice and guidance on COVID-19.

Weekly cleaning audits and daily hand hygiene audits were carried out on the unit. The acute care manager also completes a daily walkabout with the senior leadership team on a weekly basis. Any breaches or issues are addressed directly with staff and with ward/team managers. In addition, external audits are undertaken by external health board staff to ensure compliance. The nursing team were very complimentary of the domestic staff and we were told that they all worked well together as a team.

Cleaning equipment was stored and organised appropriately. There were suitable arrangements in place for the disposal of clinical waste. Bins were available to dispose of medical sharp items and these were not overfilled.

Improvement needed

The health board must ensure that:

- All staff check visitors compliance with COVID-19 procedures
- Isolation suite has suitable storage for PPE
- HIW are provided with details of improvements made to the isolation suite.

Nutrition and hydration

Patients were provided with meals at the hospital making their choice from the hospital menu, and had access to drinks and fresh fruit on the wards. The patients we spoke with were positive about the food provided.

We were told that specific dietary requirements were accommodated and if patients missed mealtimes, they would be provided with sandwiches. Staff said patients make their food choices in advance and stated if a patient changes their mind, they can usually be accommodated with another option.

The dining room was clean and tidy and provided a suitable environment for patients to eat their meals. We were also told that patients could also eat meals in their rooms to help with social distancing measures.

Medicines management

Overall, we noted that medication was securely stored. Staff locked the clinic room and medication cupboards to prevent unauthorised access. The automated medication dispensing cabinet was not working correctly on Aneurin ward, however staff were still able to dispense medication. This issue had been reported and was resolved whilst the inspection was ongoing.

Staff locked medication fridges when not being accessed. There was evidence of regular temperature checks of the medication fridge to monitor that medication was stored at the manufacturer's advised temperature. However, we saw that on both Aneurin and Taliesin wards, the fridge temperatures recorded were outside the required range but staff had not escalated this. This was immediately raised by HIW and both fridges were fixed. The health board must ensure that fridge temperatures are in the required range to ensure that medication is stored at the correct temperature.

Staff told us that since the installation of the automated mediation dispenser unit, the temperature of the clinic in the summer months could be high. We noted that no ambient room temperature checks of the clinical room were routinely monitored or recorded on Aneurin Ward. It is important that temperature checks of the clinical room are taken and recorded to ensure that medication is not affected by temperatures outside of the manufactures' stated temperature range.

There were regular stock checks of medication, including Controlled Drugs and Drugs Liable to Misuse, to ensure that the correct amounts were present. A number of liquid medicines on Taliesin Ward were reviewed, these were appropriately stored, however they were not labelled with a date of opening. It is important that dates of opening are recorded on liquid medication as this may affect the shelf life and quality of the medication.

There was a regular pharmacy input, and audits were undertaken, which assisted the management, prescribing and administration of medication. We observed a number of medication rounds, and saw that staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

The majority of Medication Administration Records (MAR Charts)[6] reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages and their Mental Health Act legal status. However, on one patient chart the allergy section stated ‘as per GP record’. This would require the nurse to look at the GP records, when all allergies should be recorded on the drugs chart to prevent any drug induced allergic reactions. It is important that any allergies and information are documented on patient charts.

A Medication Management Policy was not available in the clinic and staff were unable to demonstrate where the policy was kept. The heath board must make sure that all staff understand the policy, are familiar with the content and that a copy of the policy is available in the clinical area.

Staff had access to all relevant medicine management policies at the hospital along with the current British National Formulary (BNF)[7].

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.

Improvement needed

The health board must ensure that:

- Staff record fridge and clinical room temperatures
- Any fridge or clinic room temperatures outside the required range are addressed

[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.

*7 British National Formulary is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about individual medicines.

- Management investigate the raised temperature in clinical room
- Dates of opening liquid medications are recorded
- Allergies are clearly specified on drug charts
- Staff are aware of the location and content of the medication management policy.

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.

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 knowledge of the process of making a safeguarding referral. As highlighted above all safeguarding referrals are discussed during the putting things right meeting where the health boards safeguarding lead would be present.

Medical devices, equipment and diagnostic systems

There were regular audits of resuscitation equipment undertaken on each of the wards when required, which documented that all resuscitation equipment was present and in date.

There were a number of ligature cutters located on each of the wards, for use in the event of an emergency. During the inspection, all staff we spoke with were aware of the location of ligature cutters.

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 Appendices A, B and C.

Record keeping

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

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

We reviewed the Care and Treatment Plans of four patient records provided to us after the unannounced inspection on 6 September 2021, and five patient records were viewed during the unannounced return on the 20 September 2021.

We highlighted a number of errors in the care plans reviewed from both inspections.

The unmet needs of patients were not identified. It is important that any unmet needs are documented, so that these can be regularly reviewed by the multidisciplinary team. It is important to consider options for meeting all needs, as this may result in identifying an alternative placement.

We also noted a number of missing observation recordings in observation recording forms. Signatures of observing staff were missing and forms contained gaps with no entries. During one set of patient notes the fluid balance (input/output) charts, had some discrepancies where the charts had been poorly completed or were incomplete. The charts inspected did not provide sufficient information to document the patients' consumption over a period of time and it was difficult to establish if this patient had access to appropriate amount of fluids. In addition, the care plans did not adequately cover the following areas:

- No date of review was recorded on some care plans
- No evidence of physical assessments taking place
- No entries to show if patient had capacity to agree to treatment plan
- COVID–19 care plans were signed but not fully completed.
- Care co-ordinators were unnamed and just recorded as nursing staff.

The health board must ensure it addresses all the deficiencies with care plans to ensure that accurate and historical data is captured and recorded.

Improvement needed

The health board must ensure that:

- Unmet needs are evidenced and documented within patient care plans.
- Observation record sheets are accurately completed
- Food and fluid charts are completed in full and accurately recorded
- Review dates are recorded in care plans
- There is evidence of physical assessments taking place
- That capacity assessments are completed
- COVID–19 care plans are fully completed
- Care co-ordinators are identified and named.

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.

Throughout the inspections and at the feedback sessions, staff and management at Hergest Unit were receptive to our views, findings and recommendations.

Throughout the inspections, staff demonstrated their commitment to provide care for patients within the hospital. However, we are concerned that some staff may be working excessive hours and not taking their required breaks. Fatigue may affect staff well-being and impact upon professional judgements.

Improvements are required in relation to maintaining accurate staff rota records.

We also noted that findings from other inspections within the health board were replicated at Hergest. This identifies a lack of joint learning by the health board on the outcomes of inspections.

Governance, leadership and accountability

The significance of the areas of improvement identified in the below Workforce section, along with Infection Prevention and Control, and Care Planning sections of this report, highlights the need for improvement in audit and governance regarding these areas to support patient safety.

Throughout interviews with staff, it was clear that working relationships built on trust had not yet been fully developed between the ward staff and health board senior management teams. This was partly due to a number of significant changes to the management and multi-disciplinary team. In addition, staff we spoke to raised concerns around the quality of communication from senior leaders around recent staff movements on Hergest Unit. The health board must

ensure it has a communication strategy in place to brief staff when any changes are made.

During interviews with staff, we were told that changes in the senior management teams made it difficult to build up working relationships that allowed them to raise confidential issues or concerns. There was a clear lack of trust in senior management from the ward staff who described working in a culture of blame; this feeling amongst staff was having a significant impact on staff morale and well-being.

Some staff described being ‘petrified’ of making mistakes and were fearful that they would be redeployed or suspended from duties. However all staff spoke positively about their immediate line managers and described working in resilient and supportive teams.

We spoke to ward staff and were told that they escalated some environmental and patient care issues to management. They also told us they were not confident these issues would be dealt with. However, senior staff informed us that they were unaware of these issues. It is unclear if this difference is due to a lack of structured escalation procedures, or a lack of confidence from ward staff in the senior team. The health board must provide a system for escalation of issues for staff to follow, including regular updates of actions taken by management. This system should be clearly communicated to all staff.

The health board have appointed a Clinical Operations Manager, along with a Head of Nursing and Clinical Acute Care Manager. Discussions held with these individuals and the Interim Director of Mental Health highlighted that they were aware of issues on Hergest Unit that require improvement. They indicated they had a commitment to addressing these to raise the standard of the environment and treatment and support to patients and staff.

Senior staff advised us of initiatives they were developing to try to support staff well-being. In order to bridge the gap between senior management and ward staff, senior managers were ensuring that they were a visible presence on the ward and were making efforts to build up confidence and trust between ward staff and senior management. However it was evident through interviews with staff that they did not feel valued or supported by senior management. The health board must ensure that its senior leaders encourage professional integrity, inclusive and supportive relationships so that staff feel valued, respected and confident to report concerns. In order to achieve this the health board needs to provide a stable and consistent senior management team for staff on Hergest Unit.

At the time of the inspection there was no permanent consultant psychiatrists nor psychologists in post, the health board had arranged cover for these positions. However, this had been sporadic and had not provided consistency of care. Ward staff we spoke to told us that they did not feel involved in decisions around patient care and treatment that were being made by the consultant psychiatrists.

As a result there was a lack of collaboration between the disciplines, and whilst there was also occupational therapy input, there was no evidence of cohesive multi-disciplinary team working. The lack of an established multi-disciplinary team impacts negatively on patient care and safety. Patients were not getting timely access to the range of care and support they need. The lack of MDT collaboration also prevents ward staff, including newly qualified nurses, developing clinical judgement skills.

It is vitally important that the health board ensure that the staff at the hospital work together and become a more cohesive team who communicate, consult, and make decisions together to optimise patient care.

A key finding from our our last Mental Health Inspection of Wrexham Maelor Heddfan Unit in July 2020 was a lack of communication and consultation between senior management and ward staff. This highlights a lack of shared learning from other inspections within the health board.

Improvement needed

The health board must ensure that:

- Senior management and ward staff work together to build up confidence and trust
- Senior management improve communication with staff
- MDT work collaboratively with ward staff
- Consistent and stable senior management team is maintained.

Staff and resources

Workforce

During the unannounced inspection on the 6 September 2021, we were given conflicting information on the staffing numbers and the observation needs of the patient group. The health board subsequently provided us with accurate data on the staff who were working on the night of the inspection and the observational levels required. This data reflected that there were sufficient staffing levels to meet the needs of the patient group. However, this was only because staff were not taking their breaks and some staff were working extra hours after their rostered shift to support their team members. Details on the health boards' response are included in Appendix B.

Further examination of previous rotas indicated unfilled gaps. The health board told us that these gaps had been filled with staff, however, this was not reflected on the rotas we examined. The health board must ensure that staff rota records are robustly managed and that any changes or amendments to staffing are accurately recorded, and historical data on resources is captured.

Staff told us that they would often work beyond their rota'd shifts to support colleagues due to staffing shortages. Staff indicated that there were occasions where they felt staffing levels were too low, in particular at night-time and on weekends. In addition, we were told that staff were working through their breaks as they felt it was unsafe to take a break and they were fearful of leaving colleagues short staffed on the unit. This type of working environment will lead to fatigue and affect staff well-being, compromise their professional judgements and impact on patient safety.

Senior management confirmed that they were encouraging staff to have breaks by discussing breaks during morning meetings and arranging coverage on the wards for staff to have breaks. In addition, senior management had developed a weekly accountability meeting where they look at hours staff worked to try and alleviate staff working excessive shifts and becoming fatigued. However, staff told us that even though management were telling them to have breaks they did not always feel that the unit would still be safe if they went on break. This was due to the acuity of patients and staffing levels. The health board must ensure there are sufficient staff to meet the demands of the patients.

During conversations with senior management, it was unclear when the most recent review of safe staffing numbers had taken place on Hergest Unit. This should be based on the current acuity levels and changing demands on the unit. Safe staffing is a fundamental part of good quality care and it is important that the health board undertake a review of its staffing establishment on Hergest Unit, including the S136 suite.

Senior staff confirmed that there were a number of registered nurse vacancies and recruitment had been ongoing for these posts. There were also a number of staff who had been temporarily redeployed or absent due to sickness. Therefore, additional resources were required to fulfil staff rotas. Where possible the ward utilised its own staff and regular registered nurses from the health board's bank staff.

There was a lack of staff break facilities on the unit, and those available were small and cluttered. In addition, due to limited storage space across the unit, staff rooms for the unit included items that should be stored elsewhere. This meant that there were limited suitable places where staff could take their breaks.

Staff told us that team meetings were not taking place. This was something the acute care manager told us she was looking to improve upon. The health board must ensure that regular team meetings can take place, this should be planned in order to make this a more meaningful, supportive and valuable process for staff.

The training statistics reviewed identified low compliance with some modules on Aneurin Ward. For example, the compliance rates for fire safety was 44%, Information Governance was 51% and Moving and Handling was 48%. In addition, compliance with staff appraisals was only at 68%. We have recognised that the figures on Aneurin Ward may be due to staff absences and that face-to-face training has been difficult due to the pandemic, however, improvements are still required in these areas.

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

Improvement needed

The health board must ensure that:

- Staff do not work excessive hours
- Staff have breaks and feel confident leaving the ward for breaks
- There are appropriate areas where staff can take their breaks
- Staff rota records are robustly managed and that any changes or amendments to staffing are accurately recorded.

- That there are adequate staffing levels to maintain a safe environment at all times including additional staff to cover observation times
- Mandatory training figures are improved
- Regular team meetings take place for staff.

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
We found the bath was not working on Cynan Ward	Patients were unable to use the bath	We raised this concern with the health board during the inspection and requested this was immediately resolved.	The health board immediately resolved this issue during the inspection
We found that the toilet was blocked on Aneurin Ward	Patients were unable to use the toilet	We raised this concern with the health board during the inspection and requested this was immediately resolved.	The health board immediately resolved this issue during the inspection.
We found that the temperature on the fridges in both clinical rooms were not within the required temperature ranges	Medication may not have been stored correctly	We raised this concern with the health board during the inspection and requested this was immediately resolved	Both fridges were fixed and medication was being stored safely on the ward

Appendix B – Immediate Improvement plan

Service: Ysbyty Gwynedd

Area: Hergest Mental Health Unit

Date of Inspection: 6 – 8 September 2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of patient experience				
No immediate concerns identified at this time.				
Delivery of safe and effective care				
HIW were not assured there was sufficient staffing to provide appropriate clinical care to support and maintain the safety of the ward. The health board must ensure the wards have a sustainable staffing model with the required levels of expertise to meet the clinical needs of all patients.		A Divisional Inpatient Establishment review has recommenced, which was stood down in 2020 due to Covid-19 pandemic priorities. This will enable an understanding of staffing requirements across the Division and a model to be agreed to ensure safe delivery of care in all Divisional inpatient settings.		**24/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Action: 1. Local Senior Leadership (SLT) to review and submit their inpatient staffing establishment template to inform the overall Divisional inpatient establishment review. 2. Reaffirm the staffing escalation process across the unit and the Division as a whole. 3. Information sessions to be held with all Hergest unit/ward leads to ensure a strengthened understanding of the Hergest Standard Operational Procedure (SOP), to enable consistent implementation.	**Head of Operations (HON)/Head of Nursing (HOP)** **Director of Operations (DOP)/ Director of Nursing (DON)** **HOP/HON** **DOP/DON** **DOP/DON**	**20/09/21** **15/10/21** **31/12/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
We talked to staff throughout the inspection and examined staff rotas. We identified significant staffing issues on the unit, these were:		4. Continue to progress with the "Stronger Together" Discovery phase across the Division, to give staff the opportunity to work together to shape how the organisation works. This will include attendance at workshops. 5. Progress with a Divisional communication campaign aligned to the "Speak out safely" initiative, so staff are aware and are supported in raising any concerns across BCUHB. This will enable staff to use a confidential and anonymous platform to raise any concerns. 6. Raising awareness with the Respect and Resolution policy as part of developing health working relationships in the workplace.	**Divisional Head of Workforce (DHOW)** **DHOW** **DOP/DON**	**30/10/21** **31/11/21** **15/09/22**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Staff were working excessive hours and were regularly working beyond the end of their shift. Staff informed us they were not always having meal breaks during 12 hour shifts. They had notified management of this but the situation had not changed.		7. Progress with the Maturity Matrix approach to track improvement across the Division. **<u>Current position</u>** When the ward rosters are initially completed and signed off, staff are not rostered to work excessive hours. For any additional hours worked this is in addition to contracted hours which staff have agreed to undertake through either bank or overtime. **Action:** 8. Local arrangements to be implemented to ensure a robust system is in place to closely monitor, review and address timely any issues in relation to staff working	**HOP/HON** **DHOW**	**30/09/21** **15/10/21** **17/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Staff were being used from Psychiatric Liaison Teams to fill rota gaps on the wards to cover sickness and staff long term leave. As a result this had impacted upon the capacity of		excessive hours and with regularity working beyond their shift, to ensure staff wellbeing in work. 9. A Divisional standard template to be developed to inform decision making regarding authorisation of additional shifts for staff. **<u>Current position - Meal Breaks</u>** The interim SLT have recently been made aware regarding this issue and have commenced renewed focus to ensure that staff are taking their breaks appropriately. **Action:**	**Acute Care Site Manager (ACSM)** **DON/DOP** **ACSM**	 **15/10/21** **18/10/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
the Psychiatric Liaison Team to undertake their role.		10. Strengthen the escalation and action in the daily Acute Care Meeting (ACM) for any issues regarding staff breaks. 11. Through an agreed cycle of business and through a range of communication means i.e. Memo, Staff Briefing, visit to units, staff forums, including the Joint Partnership Forum with staff side partners and Wellbeing Hubs, highlight the importance of staff wellbeing in work and to limit working excessive hours, the importance of staff taking their breaks and reaffirm the appropriate escalation processes. 12. To ensure the importance of working reasonable hours and meal breaks are included in the Staff Induction Pack within	**HOP/HON** **ACSM**	**15/10/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Staff rotas we reviewed highlighted a number of unfilled shifts, for example the shifts for the 6th of September showed that there were 5 unfilled HCA night shifts on Aneurin Ward and 2 HCA night shifts on Taliesin Ward. Similar gaps were highlighted from rotas provided to us for week commencing 6th-11th September 2021 with no staff allocated to some shifts.		the staff Wellbeing Section and also include as part of the checklist for staff supervisions. **<u>Current position regarding utilisation of Psychiatric Liaison staff</u>** In order to provide safe staffing on inpatient environments, there has, on occasion, been the need to use Psychiatric Liaison staff overnight for duty nurse purposes. However, this is considered in relation to the number of liaison nurses on duty to ensure there is a psychiatric liaison service available to the District General Hospital (DGH). In addition, to ensure continuity of service, the doctor on duty will hold the Psychiatric Liaison bleep to be able to support any assessments required.	**HOP/HON** **DON/DOP** **HOP**	**17/09/21** **Completed** **23/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Action: 13. Review of the current SOP and the Business Continuity Plan to ensure clarity of the mitigation plans to support continuity of services. 14. The Interim Hergest SLT to ensure discussions are routinely taking place regarding safe staffing levels in daily ACM and Safety Huddles, and that appropriate mitigation and/or escalation is in place where required. 15. To continue to ensure a member of the SLT, or the duty nurse at the weekends, routinely attend the ACM and Safety Huddles and escalate any issues to the Divisional Huddle or Bronze on-call at weekends.	**HOP/HON**	**30/10/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
It was not evident that up to date ward acuity assessments had been completed to identify the required staffing levels. It is unclear if the current staffing levels were suitable for the current acuity and patient demands on the unit.		16. Reaffirm the requirement aligned to the MH&LD Staffing Escalation Policy across the Division. 17. To monitor and review key performance indicators aligned to Psychiatric Liaison to address any issues where required. **<u>Current Positon regarding unfilled shifts</u>** Unfilled shifts were covered via redeployment of staff from other areas. These were additional staff to the rostered numbers on the E-Roster system e.g. the Duty Nurse was based on the ward. Likewise, other staff were deployed from other areas to enable safe staffing, again these staff would not show on the Hergest E-Roster as they were on the E-Roster for other areas.	**ACSM**	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Staff were unclear what the escalation arrangements were and how to contact an on-call doctor.		The current agreed staffing establishment for the three wards in Hergest unit is:- Aneurin 5/5/3 - 17 established beds (also one escalation bed). Cynan 5/5/3 - 17 established beds (also one escalation bed). Taliesin 5/5/4 - 6 beds. Having reviewed the staffing positon, none of wards on the evening of 06/09/2021, at the time of the inspection, were below the staffing template. Further to this, the staffing template is based on 18 patients for both Aneurin and Cynan, and the bed occupancy at the time of the inspection was 14. Also to note, both Cynan and	**Ward Manager**	**25/09/21** **17/09/2021**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Taliesin on 06/09/2021 were over establishment for HCSW's * **Action:** 18. Through communication and engagement with key unit managers, ensure that there is – a. Clear understanding of the E-Roster processes. b. Timely E-Roster sign-off to enable all additional shift requirements identified to be processed to bank office. c. Putting in place scrutiny on E-Roster controls reporting through to HON and HOP. 19. Reaffirm the requirement for Ward manager to escalate any unallocated shifts within the agreed timeframe to daily ACM huddle for discussion and agreement of any	**DOP** **HOP/HON** **HOP** **DHOW**	**25/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		action/mitigation to be put in place. **Current position aligned to ward acuity assessments** The ACM discuss and agree staffing levels required based on patient acuity. Ward managers/ representative for the ward provide an overview of their ward staffing requirements to ACM, which feeds into the daily Safety Huddles. **Action**: 20. To ensure the bed flow twice weekly meeting includes ward acuity assessments to plan safe staffing levels for the forthcoming days. **<u>Current position aligned to escalation arrangements</u>** Current on-call arrangements include a unit bleep holder, bronze		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		on-call, silver on-call and medical on-call. A rota is circulated on a monthly basis for all these positions, and more frequently if changes or gaps occur. The silver on-call was established at the beginning of the Covid pandemic to provide additional advice and support to the bronze on-call due to the increase in activity across the Division. Bronze and silver on-call communicate on a regular basis as required, and bronze on-call attend local area Safety Huddles and site meetings during their on-call period. There is a Consultant on-call rota and junior doctor on-call rota, with contact details. The rotas are communicated, there is a pan-Division distribution list and this is		**25/09/21** **25/09/21** **15/10/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		evident in the duty nurse room and on the ward areas*. 21. Divisional memo to be circulated to reaffirm the escalation procedure for on-call arrangements. 22. To include this issue in the communication and engagement session with the ward/unit leads. 23. To ensure this is included in the Hergest SOP. 24. Review the current staff mapping undertaken during the second surge of Covid-19 for all staff within the Division for options of deployment.		**15/10/21**
HIW were not assured that there were established Infection Prevention and Control measures in place to manage and mitigate		The safe management of Covid-19 in the MH&LD Division has incorporated a Covid-19 Social		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
the risks posed by Covid-19. The health board must ensure that all internal and national Covid-19 policies and measures are complied with to ensure the safety of patients, staff and visitors. On arrival the inspection team questioned if there were any Covid-19 cases on the ward and were told of one positive patient being nursed in isolation. However, the inspection team were later advised by another staff member that two further members of staff had tested positive across the unit. We were not assured that all staff were aware of the cases on the unit or that correct reporting mechanisms were in place.		Distancing Action Checklist and Action Card which provides assurance the Covid-19 guidance has been applied across the Division. An escalation, communication and cascading process is in place with ACM, Daily Safety Huddles, Divisional Huddles, MH&LD Briefings and BCUHB announcements. Daily submission of SITREP including PPE audits, monthly Infection Prevention and Control (IPC) audits and walk around of IPC in all inpatient areas. MH&LD Division has the highest compliance in BCUHB for Covid-19 risk assessments.* **Current position aligned to Covid-19 Cases** A patient tested Covid-19 positive on admission on 24/08/2021. In line with policy, the patient was		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
As visitors on the unit we were not advised to adhere to Covid-19 protocols, such as hand hygiene compliance.		isolated and nursed for the incubation period, returning to the ward once this had ended and advice sought from our IPC team. There were two patients who were considered contacts; one with this particular patient and another who had a socially distanced visit outside with her father, under staff supervision. Her father subsequently tested positive for Covid-19, and following advice from our IPC team the patient was considered to be a contact as a precaution. Both patients were nursed individually in their rooms as per guidance by the IPC team and the unit Covid-19 Standard Operating Procedure (SOP). Neither patients have subsequently tested positive for Covid-19 and the patients are now able to utilise the ward area, with the 2:1 support arrangements to manage the situation, ending on Monday 06/09/2021. This		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		corresponds with the reported daily SITREP position.* No staff were working at the time of the inspection who were Covid-19 positive. **Current position aligned to visitors to the Unit** Covid-19 Guidance posters are clearly visible which are displayed at the Hergest entrance and within the foyer. Each ward entrance also has posters aligned to hand washing and mask wearing. An IPC station is immediately noticeable upon entering the Hergest unit at the foyer, with a stock of hand sanitizer and masks. Aligned to current guidance all visits to the MH&LD are prearranged with agreement by the staff on the unit. A visiting record is completed by the staff and visitors and the visitor log		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		updated. Corporate Covid-19 signage and posters have been provided to all units to advise visitors of the IPC requirements in place when visiting units. There is a requirement that all visitors to the unit are booked in advance.*	**HON**	**31/10/21**
		Guidance on visitors to wards has been shared with staff via the MH&LD Staff Briefing, BCUHB announcements and email to all Ward managers.	**HOP**	**30/09/21**
		The SLT undertakes a 3 monthly self-assessment of 40 standards related to Safe Clean Care and progress against assurance standards reviewed.	**DOP**	**Completed**
		The SLT provides an exception report on IPC to the monthly Divisional IPC meeting. Key metrics requiring improvement and renewed focus is on ensuring	**HOP**	**15/09/21**
Security Guards were observed coming onto the unit from another area of the hospital.			**HOP/HON**	**17/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
They were not wearing their masks correctly and went straight onto a ward without complying with hand hygiene protocols. Staff were being utilised from other areas of the hospital and across the health board to assist with staffing issues on Hergest unit. It was unclear what procedures were in place to prevent any potential transmission of infection.		daily Covid-19 and hand hygiene audits are consistently undertaken and mandatory IPC training Level 1 and 2 is increased throughout the unit. **Action** 25. To achieve required improvements aligned to IPC key metrics. 26. To review the Covid-19 Action Card and update aligned to the MH&LD Winter Plan. 27. To liaise with the IPC Associate Director in relation to any additional IPC advice, guidance or support to the unit. 28. Recirculate memo, via Safety Huddle, regarding completion of the Visiting Record Checklist and Visitors' Log.	**ACSM** **HOP/HON**	**17/09/21** **21/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		29. All staff to be reminded when receiving visitors into units, that BCUHB IPC guidance is followed at all times, inclusive of hand hygiene. **Current position -** The issues aligned to lack of hand hygiene protocols and inappropriate wearing of face masks by the security guards has been escalated to the appropriate BCUHB department. A Datix has been raised and a 'Make It Safe+' is being progressed aligned to this incident. This will identify any additional learning from this episode**.** **]Action**	**HOP**	**15/10/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		30. PTR process to be fully implemented to enable the MIS+ to be completed. 31. Scrutiny of MIS+ investigation to identify any learning from this episode by the West SLT. **Current position regarding Staff utilised from other areas** Any staff who are redeployed across the Division are deployed in accordance with the health board staffing escalation policy and the latest IPC Covid-19 guidance. 32. Local SLT to have monitoring and review arrangements in place to ensure the IPC Covid-19 guidance is consistently implemented aligned to staff deployment.		

Improvement needed Quality of management and leadership	Regulation/ Standard	Service action	Responsible officer	Timescale
No Immediate concerns identified at this time.				

Service / health board Representative:

Name (print):	**Carole Evanson**
Role:	**MH&LD Director of Operations (interim)**
Date:	**17/09/2021**

Appendix C – Improvement plan

Service: Betsi Cadwaladr University Health Board

Ward/unit(s): Hergest Unit

Date of inspection: 6 – 8 & 20 – 22 September 2021

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 the bath is fixed on Cynan Ward.	4.1 Dignified Care	The bath within Cynan was LOLER inspected and Planned Maintenance checked by Caretech on 11/08/21, with no faults noted. Additional check of bath on 21/09/21 during HIW Inspection, and no faults noted. Review the need for this bath in the ward area, and progress with informed decision.	Head of Operations	15/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that the blocked toilet on Aneurin Ward is fixed.	4.1 Dignified Care	Toilet was unblocked during the HIW visit	Head of Operations	Completed
The health board must ensure that the bathrooms are not used as storage areas.	4.1 Dignified Care	Site review to be completed to ensure appropriate storage facilities identified for any mobility aids and equipment on site	Head of Operations	30/11/21
The health board must ensure that the Section 136 suite remains open and there are sufficient staff available to cover admissions.	5.1 Timely access	To ensure effective E-roster planning, aligned to KPI's. To ensure efficient planning to known absences through allocation of duties locally, bank, overtime or agency where required. To continue with a daily review of staffing through the Acute Care Meetings and Safety Huddles to support resolution of any staffing issues locally. To ensure any outstanding staffing issues are escalated into the Divisional Huddle for resolution/mitigation For out of hours, escalation to MH&LD Divisional Bronze/Silver on call for resolution/mitigation	Head of Operations/ Head of Nursing	Completed and reviewed daily

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that there is appropriate privacy measure for the toilet located in the Section 136 Suite.	5.1 Timely access	Ensure dignity screens are in place at all times to enable appropriate privacy	Head of Operations	Completed
The health board must ensure that a pathway is developed in the health board for older adult care.	5.1 Timely access	OPMH Pathway: Divisional meetings have commenced with clear terms of reference. Second meeting held 26/10/21. Options appraisal to be completed based on the qualitative baseline data for the area. Project plan to be developed and progressed via monthly OPMH meetings. OPMH service model development to be identified and progressed through the Clinical Strategy Group.	OPMH Pathway Lead OPMH Pathway Lead Head of transformation OPMH Pathway Lead	Completed and monthly meetings 30/11/2021 30/12/2021 30/06/2022
The health board must ensure that capacity assessments are completed and recorded in patient records.	6.2 Peoples rights	Bulletin to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of capacity assessments.	Head of Operations	15/11/21 15/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		MH&LD Staff Briefing to include above correspondence. Further development of the patient notes audit checklist to ensure inclusion of all necessary standards, including capacity assessments. Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation. Copies of the bulletin are displayed on ward notice boards and discussed at handovers.	Head of Operations Head of Nursing Head of Nursing Head of Operations	15/11/21 30/11/21 16/11/21
The health board must put a system in place for patient meetings with ward staff.	6.3 Listening and Learning from feedback	Develop fortnightly group meetings between patients and staff, using the model developed by Rehab Services.	Head of Operations	30/11/21
Delivery of safe and effective care				
The health board must ensure that staff confirm the identity of visitors prior to allowing access on to the ward.	2.1 Managing risk and promoting health and safety	Email circulated to all service areas on 14/09/21 reaffirming guidance for any visitors to units.	Head of Operations	Completed 14/09/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Review Visitor Logs and Visitor Record Checklist to ensure correct completion weekly. Reaffirm visitor process and procedures in MH&LD Staff Briefing. Include email in staff handover document.		Completed and ongoing 15/11/21 15/11/21
The health board must ensure that sticky tape residue marks where items had been stuck to doors and windows is removed.	2.1 Managing risk and promoting health and safety	Domestic supervisors emailed on 27/10/21 to support full review of all doors and windows, to ensure rectified.	Head of Operations	15/11/21
The health board must ensure that the plaster flaking on walls both sides of the garden entrance door to Cynan Ward is resolved.	2.1 Managing risk and promoting health and safety	Identified during estates senior walk about on 21/09/2021 and is included in full estates plan for the Hergest site, which is currently going via tendering processes. Continued progress to be monitored via Local Area Estates monthly meetings.	Head of Operations	30/11/21
The health board must ensure the plaster flaking and dampness near the external door to the 136 suite is resolved.	2.1 Managing risk and promoting health and safety	Identified during estates senior walk about on 21/09/21 and is included in full estates plan for the Hergest site, which is currently going via tendering processes.	Head of Operations	30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Continued progress to be monitored via Local Area Estates monthly meetings.		
The health board must ensure that the cluttered storage cupboards are organised.	2.1 Managing risk and promoting health and safety	Full site mapping of all identified storage cupboards that require organising Delegate task of organising cupboards to named member of staff. Ensure spot checks of storage cupboards are incorporated in monthly Matron unit walkabout.	Head of Operations	15/11/21 22/11/21 30/11/21
The health board must ensure that the hot water tap is fixed on Aneurin Ward.	2.1 Managing risk and promoting health and safety	Fixed on 24/09/21.	Head of Operations	Completed
The health board must ensure that the patient bathrooms are not used as storage areas.	2.1 Managing risk and promoting health and safety	The disabled bathrooms are currently not in use where items are stored. Assess the alternative storage requirement needs on a site wide basis. Identify alternative storage and move all items that need to be stored on site.	Head of Operations	30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that risk assessments are undertaken for all individuals on a ward when a high/low profiling bed is being used.	2.1 Managing risk and promoting health and safety	Ensure the risk assessment and Bed Escalation Decision Making Guide is completed for every admission to identify the most appropriate bed. Further development of patient notes audit checklist to ensure inclusion of all required standards, risk assessments for high/low profiling beds. Routine checks to be added to the manager's weekly ward round and monthly Clinical Site Manager walkabout	Head of Nursing	15/11/21 30/10/21 30/10/21
The health board must ensure that there are regular environmental audits to identify any unreported damaged areas.	2.1 Managing risk and promoting health and safety	Environmental Audits to be completed monthly by the Clinical Site Manager, or designated manager in his/her absence. The Audit outcome will be an Agenda item in the monthly Quality, Safety and Experience (QSE) meeting to ensure actions have been taken, and monitoring and review arrangements are in place.	Head of Operations Head of Nursing Head of Nursing	30/12/21 30/12/21 30/12/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Continuation of the Credits for Cleaning bi monthly audits take place and feed into QSE meetings. To introduce quarterly senior management Hergest walk about together with Estates.	Head of Operations	30/12/21
The health board should ensure that there is representation from ward staff at meetings.	2.1 Managing risk and promoting health and safety	Review the Terms of Reference for core meeting to ensure there is appropriate representation from ward staff.	Head of Nursing	15/11/2021
The health board must ensure that all staff check visitor's compliance with COVID-19 procedures.	2.4 Infection Prevention and Control (IPC) and Decontamination	Email circulated to all areas on 14/09/21 reaffirming guidance for any visitors to the units. Reaffirm visitor process and procedures in MH&LD Staff Briefing. Delegate task of Notice Board responsibility to named member of staff, to ensure regular updates, refresh documents and items are clearly visible	Head of Operations	Completed 15/11/21 15/11/21
The health board must ensure that the isolation suite has suitable storage for PPE.	2.4 Infection Prevention and	Full review of this area has been completed with Infection Prevention	Head of Operations	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
	Control (IPC) and Decontamination	Lead, Acute Care Site manager, Head of Nursing and Head of Operations. Specific storage containers fixed to walls and in designated areas within this environment		
The health board must ensure that HIW are provided with details of improvements made to the isolation suite.	2.4 Infection Prevention and Control (IPC) and Decontamination	As noted in 2.4. Additionally, designated doffing and donning area is now available. Sink for effective hand hygiene is now in place. Clear signage visible to ensure staff compliance at all times.	Head of Operations	Completed
The health board must ensure that staff record fridge and clinical room temperatures.	2.6 Medicines Management	Communication to be circulated to all inpatient staff in relation to ensuring that staff record fridge and clinical room temperatures. Communication to be discussed during staff handovers. Nominated ward lead for the day to be allocated the responsibility that daily	Head of Nursing	22/11/21 22/11/21 Completed 31/10/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		fridge audits are completed and discussed at all handovers. Acute Care site Manager to routinely undertake spot checks to ensure implementation Continued support from pharmacy leads to ensure compliance during their weekly ward visits.		Completed Completed
The health board must ensure that any fridge or clinic room temperatures outside the required range are addressed.	2.6 Medicines Management	Any fridge or clinic temperatures outside the required range, following the routine checks highlighted above, to be addressed immediately or escalated as required if unable to be resolved. This issue identified during the HIW inspection was resolved at the time, via support from lead pharmacist.	Head of Operations	Completed
The health board must ensure they investigate the raised temperature in the clinical room.	2.6 Medicines Management	Undertake room temperature audit over a month, discuss results with Estates department for informed decision of next steps.	Head of Operations	30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Include clinical room temperature review on the Agenda of local area Estates meeting to ensure action progresses.		
The health board must ensure that dated of opening liquid medications are recorded.	2.6 Medicines Management	Communication circulated to reaffirm Medicines Management policy, including additional communication aligned to dating of opened liquid medications. Include spot checking of dates recorded on open medication on weekly ward manager walkabout.	Head of Nursing	05/11/21
The health board must ensure that any allergies are clearly specified on drug charts.	2.6 Medicines Management	Communication circulated to reaffirm Medicines Management policy, including additional communication aligned to allergies.	Head of Nursing	05/11/21
The health board must ensure that staff are aware of the location and content of the medication management policy.	2.6 Medicines Management	Communication circulated to reaffirm the location and content of Medication Management policy. Ensure location and content of Medication Management policy is included in staff Induction.	Head of Nursing Education and training lead	05/11/21 31/03/22

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Ensure the Medication Management policy is continually clearly displayed in all ward areas and clinical rooms.	Clinical Site Manager	05/11/21
The health board must ensure that the unmet needs are evidenced and documented within patient care plans.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of unmet needs. MH&LD Staff Briefing to include above correspondence. Further development of patient notes audit checklist to ensure inclusion of all required standards. Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation. Copies of correspondence are displayed on ward notice boards and discussed at handovers.	Head of Operations Head of Operations Head of Nursing Head of Nursing Clinical Site Manager	15/11/21 15/11/21 15/11/21 30/11/21 6/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that observation record sheets are accurately recorded.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of therapeutic, observation and engagement documentation requirements.	Head of Operations	15/11/21
		MH&LD Staff Briefing to also include above correspondence.	Head of Operations	15/11/21
		Further development of patient notes audit checklist to ensure inclusion of all required standards,	Head of Nursing	15/11/21
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/21
		Copies of correspondence to be displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/21
		Review of the current MH&LD Therapeutic, Observation and	Head of Operations	31/12/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Engagement policy and training plan to support implementation.		
The health board must ensure that food and fluid charts are completed in full and accurately recorded.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of food and fluid charts documentation is completed for relevant patients. MH&LD Staff Briefing to include above correspondence. Further development of patient notes audit checklist to ensure inclusion of all required standards. Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Head of Operations Head of Operations Head of Nursing Head of Nursing Clinical Site Manager	15/11/2021. 15/11/2021 15/11/2021 30/11/2021 16/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that review dates are recorded in care plans.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of care plans. MH&LD Staff Briefing to include above correspondence. Further development of patient notes audit checklist to ensure inclusion of all required standards Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Head of Nursing	15/11/2021. 15/11/2021 15/11/2021 30/10/2021 16/10/2021
The health board must ensure that patient records have evidence of physical assessments taking place.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of the risk booklet on admission	Head of Operations	15/11/2021.

Improvement needed	Standard	Service action	Responsible officer	Timescale
		MH&LD Staff Briefing to include above correspondence.	Head Of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/2021
The health board must ensure that capacity assessments are completed.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of capacity assessments.	Head of Operations	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/2021
The health board must ensure that COVID-19 care plans are fully completed.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of Covid 19 care plans.	Head of Operations	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Head of Nursing	16/11/2021
The health board must ensure that care co-ordinators are identified and named in patient records.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of details of all professionals involved in patients' care.	Head of Operations	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The health board must ensure that management and ward staff work together to build up confidence and trust.	Governance, Leadership and Accountability	Together with staff identify how confidence and trust can be strengthened. Communicate and engage with staff to listen to and understand how this can be achieved. To review the outcome of the MH&LD Reflect and Learn Survey, currently being undertaken across the Division. Increased visibility and accessibility of Senior Leadership Team across the unit. Implement 'You Said, we did' notice boards, and to enable staff to make suggestions install Suggestion boxes across the ward areas.	Head of Operations	31/12/21 16/11/2021 31/12/21 Completed 31/12/21
The health board must ensure that senior management improve communication with staff.	Governance, Leadership and Accountability	Increased presence on the wards by Senior Leadership Team.	Head of Operations	Develop cycle of visits by 30/11/21 30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Review and strengthen MH&LD Communication and Engagement plan. Continue with annual MH&LD Staff Briefing cycle of business. Review outcomes of the MH&LD Staff survey themes. Develop staff focus groups to ascertain preferred communication methods for staff.	Director of Nursing/Director of Operations. Director of Operations Head of Workforce Head of Operations	30/11/21 30/11/21 30/11/21
The health board must ensure that MDT work collaboratively with ward staff.	Governance, Leadership and Accountability	Review current function and Terms of Reference of Weekly MDT meetings, to ensure full engagement and collaboration with all disciplines.	Head of Nursing	16/11/2021
The health board must ensure that a consistent and stable senior management team is maintained.	Governance, Leadership and Accountability	The Division recognises the importance of stable leadership, and are actively progressing through workforce processes to enable the long term	Director of Operations/ Director of Nursing	31/03/2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		stability of the Senior Leadership team to be affirmed. In the meantime, consistency of interim arrangements will continue.		
The health board must ensure that staff do not work excessive hours.	7.1 Workforce	Memo circulated on 28/10/21 to all MH&LD staff. Memo to be displayed on notice boards and discussed in handovers. To continue with a daily review of any staff working excessive hours through the Acute Care Meetings and Safety Huddles to support resolution of any issues locally.	Head of Operations	Completed 05/11/21 Completed
The health board must ensure that staff have breaks and feel confident leaving the ward for breaks.	7.1 Workforce	Memo circulated on 28/10/21 to all MH&LD staff. Memo to be discussed at staff handovers. Memo to be displayed on ward notice boards.	Head of Operations Clinical Site Manager Clinical Site Manager	Completed 15/11/21 15/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		To continue with a daily review of any staff who are unable to take their breaks through the Acute Care Meetings and Safety Huddles to support resolution of any issues locally. Ensure escalation to SLT in hours, or bronze if out of hours, if staff unable to take their breaks.	Head of Operations Head of Operations	Completed Completed
The health board must ensure that there are appropriate areas where staff can take their breaks.	7.1 Workforce	Review of current staff rooms and facilities on site. Continue with the development of Wellness room on site.	Head of Operations	05/11/2021
The health board must ensure that staff rota records are robustly managed and that any changes or amendments to staffing are accurately recorded.	7.1 Workforce	Review of E roster KPI compliance on a weekly basis, to ensure actions taken where compliance it not met. Additional E roster training to be completed in order to ensure all managers are aware of KPI's and guidance.	Head of Nursing	Completed 30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that there are adequate staffing levels to maintain a safe environment at all times including additional staff to cover observation times.	7.1 Workforce	To continue with a daily review of staffing levels through the Acute Care Meetings and Safety Huddles to support resolution of any issues locally. Staffing establishment review commenced to enable creation of an agreed model, and understanding of staffing requirements to ensure safe delivery of care in all Divisional inpatient settings.	Head of Operations/Head of Nursing Director of Nursing	Completed daily. 30/1/2022
The health board must ensure that mandatory training figures are improved.	7.1 Workforce	Mandatory Training compliance monitored and reviewed weekly at Operational Leadership meeting. Local Area Performance report provides an in-depth summary of mandatory training for all staff disciplines, discussed and reviewed at the monthly Quality, Operational and Delivery meeting, recommended actions to be implemented as required.	Service Managers Head of Operations	Completed and continue to monitor weekly Completed monthly

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Divisional Mandatory training compliance reviewed at DSLT Finance and Performance meeting, recommended actions to be implemented as required.	Head of Operations	Continue monthly
The health board must ensure that regular team meetings take place for staff.	7.1 Workforce	SLT to work with ward managers to support full implementation of team meetings for all disciplines in their areas	Head of Operations.	15/11/2021

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.

Name (print): **Carole Evanson, MH&LD Director of Operations (Interim)**

Mike Smith, MH&LD Director of Nursing (Interim)

Date: 01/11/2021