Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Bryngofal Ward, Prince Philip Hospital, Hywel Dda University Health Board

Inspection date: 11, 12, and 13 July 2022

Publication date: 12 October 2022

This summary document provides an overview of the outcome of the inspection

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

There was evidence of strong and supportive leadership on the ward.

Some patient areas require improvements to make the ward more welcoming for patients.

Note the inspection findings relate to the point in time that the inspection was undertaken.

What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Prince Philip Hospital, Hywel Dda University Health Board on 11, 12 and 13 July 2022.

Our team, for the inspection comprised of three HIW Inspectors and three clinical peer reviewers. The inspection was led by a HIW Senior Healthcare Inspector.

This summary version of the report is designed for members of the public.

A full report, which is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients can be found on our website.

Quality of Patient Experience

Overall Summary

- We found a dedicated staff team that were committed to providing a high standard of care to patients.
- We saw staff interacting with patients respectfully throughout the inspection.
- Patients we spoke to told us they were happy, and that they were receiving good care at the hospital.
- Patients had access to a mental health advocate who provided information and support with any issues they may have about their care.

What we found this service did well

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Patients we spoke to told us they were happy and receiving good care.

Where the service could improve

- Work must be undertaken to improve the appearance of the garden for patients and broken bench replaced
- Patient areas require redecorating and new flooring
- The ward could be made more homely and welcoming, as it appears stark and clinical in places.

Patients told us:

Patients provided us with the following comments:

“Staff should have name tags as there are so many”

Delivery of Safe and Effective Care

Overall Summary

- Staff appeared committed to providing safe and effective care.
- Patient care and treatment plans were being kept to a good standard.
- Safe and therapeutic responses were in place to manage challenging behaviour and promote the safety and wellbeing of patients.
- Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation.
- However, some further improvements are needed regarding the administration of the Act.

What we found this service did well

- Care plans were detailed and there was clear evidence of patient involvement
- Medication records were comprehensive and complete, and we saw evidence of audits taking place.

Where the service could improve

- Implementation of the Mental Health Act

- Policy on bank staff being trained in restrictive physical intervention as the unit is a stand-alone ward without the benefit of access to staff from other wards to provide support.

Patients told us:

Patients provided us with the following comments:

Patients told us that staff spent time with them.

Quality of Management and Leadership

Overall Summary

- We observed a committed staff team who had a good understanding of the needs of the patients at the hospital.
- There was dedicated and passionate leadership displayed by the ward manager.

What we found this service did well

- Staff were positive about the support and leadership they received

- We found an effective governance structure in place in terms of regular audit activities and meetings to discuss incidents, findings and issues related to patient care.

Where the service could improve

- Mandatory training compliance.

Staff told us:

Staff provided us with the following comments:

Staff told us that they felt supported by the ward manager and leadership team

Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the

actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health boards to provide documented evidence of action taken and/or progress made.