Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Hydref and Gwanwyn Wards, Heddfan Psychiatric Unit, Wrexham Maelor Hospital

Inspection date: 07, 08 and 09 November 2022

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

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We found staff were committed to providing safe and effective patient care. Suitable protocols were generally in place to safely manage risk, health and safety and infection control.
Some improvements were required in relation to medications management, document completion and record keeping.
We found that some staff were deficient in Restrictive Physical Intervention training yet had participated in incidents of patient restraint without any training or after their training had expired. Therefore, we were not assured that staff and patients were being fully protected and safeguarded against injury. Our concerns regarding this were dealt with under our immediate assurance process.

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 of Heddfan Psychiatric Unit within Betsi Cadwaladr University Health Board on the evening of 07 November and the following days of 08 and 09 November 2022. The following hospital wards were reviewed during this inspection:

- Gwanwyn - a 13 bed mental health ward for older adults with an organic illness
- Hydref - 13 bed mental health ward for older adults with a functional illness.

Our team for the inspection comprised of three HIW Healthcare Inspectors, two clinical peer reviewers, a Mental Health Act reviewer and one patient experience reviewer. 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

All patients who completed a questionnaire rated the care and service provided by the hospital as either very good or good. We found a dedicated staff team that were committed to providing a high standard of care to patients. Staff interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke to were passionate about their roles and enthusiastic about how they supported and cared for the patients. Staff demonstrated that they had a desire to improve the quality of services and care delivered to patients.

What we found this service did well

- Staff demonstrated a good level of understanding of the patients they cared for
- Staff treated patients with kindness and respect.

Where the service could improve

- The broken dishwasher and faulty ceiling lights on Gwanwyn must be repaired or replaced to ensure staff and patient safety
- The ambient temperature of the wards must be reviewed to ensure the comfort of patients, staff and visitors
- The activities rooms on both wards should be tidied and maintained for the use of patients and staff
- Bedroom window and ensuite shower curtains must be provided for all patients to ensure that their privacy and dignity is protected.

Delivery of Safe and Effective Care

Overall Summary

We found that staff were committed to providing safe and effective patient care. We were generally assured that processes were in place to manage and review risks to help maintain the health and safety of the patients, staff and visitors at the hospital. Mental Health Act records were compliant with legislation and contained good evidence of visible advocacy involvement in patient care. Patient Care and Treatment Plans were well organised, easy to navigate and updated to reflect current needs and risks. However, we found that the quality of the Care and Treatment Plans was variable across the wards. Some improvements were required in respect of governance, record keeping and medications management. During the inspection it was concerning to note that the monthly ligature audit workbook had not been completed since February 2022, which could threaten patient safety.

What we found this service did well

- Legal documentation to detain patients under the Mental Health Act was compliant with the legislation
- Physical health care was monitored and recorded appropriately for patients
- Patients were involved in their Care and Treatment Plans where appropriate.

Where the service could improve

- A formal governance audit structure should be put in place to ensure the clinic rooms on the wards are maintained in a tidy and presentable state and that medicines are securely stored
- Regular audits must be undertaken to ensure that Medication Administration Records (MAR charts) are fully completed and consent to treatment is regularly reviewed
- Care and Treatment Plans should be fully completed and kept up to date in accordance with the Mental Health (Wales) Measure 2010
- A robust governance programme of audit must be implemented to ensure that access cards issued to hospital staff are monitored and accounted for in order to prevent security breaches and to ensure the safety of patients, staff and visitors
- The ligature audit workbook must be completed in line with health board policy.

Patients were asked how the hospital could improve the service it provides. They told us:

“More staff”

Patients provided us with the following comments:

“Medication distribution needs to be more appropriate to my requests"

“Mental health problems override my physical health problems in way I am treated”

“Never see somebody when needed”

“No GP available”

Quality of Management and Leadership

Overall Summary

The leadership team was approachable and supportive to staff and had a good understanding of patient needs. We saw evidence of good collaborative working across the health board to support improvements and disseminate quick learning from incidents and serious untoward events. We noted that there were a high number of vacancies on both wards at the time of our inspection. Most staff told us they felt there were not enough staff on the wards to enable them to do their job properly. Senior management confirmed that maintaining adequate staffing levels was a challenge on the wards and that a block booking of agency staff had been requested to temporarily reduce staffing pressures.

What we found this service did well

- We saw strong team working on both wards throughout our inspection
- Most staff told us they felt supported in their roles and described the leadership team as being approachable and supportive.

Where the service could improve

- The health board must ensure that all staff are compliant with mandatory training and provide robust governance oversight of this
- Out-dated policies must be reviewed to ensure they are kept up to date and support staff in their roles
- The health board should conduct further consultations with staff to discuss ways of improving the visibility and involvement of the senior management team on the wards
- The health board should actively focus on the recruitment of staff into permanent vacancies.

Staff told us:

Staff provided us with the following comments:

> “I think the only thing that lets us down as a whole is staffing levels are sometimes not sufficient therefore, we are unable to provide the quality of care we'd like to. We have recently had a few posts filled with permanent staff so hopefully this will improve.”

> “Our health care support workers are burnt out. They often express that they cannot get jobs done on time for the elderly as being asked to move wards and often leaves the wards short as other wards don’t count their nurses and we do, yet we’re often left struggling, and it impacts staff health and well-being in the work place mentally and physically.”

In our online staff survey, we asked a question about how the setting could improve service and received the following response:

> “More staff to help with the demand, senior managers should take care more of the staff and patients and less about paperwork and budget. Sometimes they don't want to know "what can they do to help" but why did it happen? Budget is important but it should be done accordingly to the situation and place. Not just one will pay for everything. Leaving us short and not available of doing our jobs to the best of our knowledge, isn't the answer, because staff will be fed up and leave the work.”

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.