Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Angelton Clinic, Glanrhyd Hospital, Cwm Taf Morgannwg University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. 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 Angelton Clinic, Glanrhyd Hospital, Cwm Taf Morgannwg University Health Board on the evening of 14 November 2022 and the following days of 15 and 16 November 2022. We reviewed Angelton Clinic, Wards 1 and 2 in this inspection.

Angelton Clinic provides a service for older people with serious and enduring mental health diagnoses and dementia.

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

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

This (full) report 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.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

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.

This is what we recommend the service can improve:

- Providing health information on the wards for patients and visitors.

This is what the service did well:

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Effective patient and family feedback processes.

Delivery of Safe and Effective Care

Overall summary:

Whilst the physical environment at Angelton Clinic was overall maintained to a good standard, we identified several areas that require action. We also raised a significant number of improvements required in most areas, including ligature risk assessments, medication management, care planning and audit activity. Due to the volume and nature of issues raised, HIW was not fully assured patients consistently receive safe and effective care.

Immediate assurances:

HIW highlighted the following serious issues which required immediate action by the health board to prevent significant harm to patients, members of the public and staff. Please note this list is not exhaustive and full details are contained in Appendix B:

- Ligature risks at the setting were not effectively managed
- Care plans were not being audited, records lacked evidence of patient involvement, and detailed and comprehensive decision making
- Medication fridges were not routinely locked.

This is what we recommend the service can improve:

- Individualised care planning and recording/access of patient notes
- Security of the internal ward entry doors
- Medications management including locking of medication fridges
- Environmental issues including flooring on both wards needing to be replaced and general maintenance issues on the wards.

This is what the service did well:

- Physical health assessments and monitoring were being completed.

Quality of Management and Leadership

Overall summary:

There was a clear organisational structure at the hospital. Staff engaged positively with our inspection and demonstrated a clear commitment to improvement. However, we noted a number of areas of improvement required in overall governance arrangements. The significance of these findings, along with the Safe and Effective Care, and Care Planning sections of this report, highlights the need for improvement in governance to support patient safety.

Immediate assurances:

HIW highlighted the following serious issues which required immediate action by the health board to prevent significant harm to patients, members of the public and staff. Please note this list is not exhaustive and full details are contained in Appendix B:

- Overall governance arrangements including poor access to patient records and no minute taking of any meetings.
- Patient care plans were not regularly being assessed and monitored by the health board
- Risk assessments not being completed regularly
- Mandatory training compliance is low.

This is what we recommend the service can improve

- Governance and audit processes at the hospital must improve to adequately monitor and maintain quality and safety at the hospital
- Completion of mandatory training
- Completion of supervision and appraisals.

This is what the service did well:

- Introduction of wellbeing champion for staff and patients
- Research and data analysis on falls.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Staying Healthy

Health Protection and Improvement
We handed out HIW questionnaires during the inspection to obtain views on the service provided at the hospital. We received no responses to the questionnaires. However, family members spoken to during the inspection spoke highly of staff and the care provided to their relatives. We also reviewed internal patient feedback logs to help us form a view on the overall patient experience.

We noted positive compliments through thank you letters and cards.

We looked at a sample of patient records and saw evidence that patients received appropriate physical assessments upon their admission in addition to their mental healthcare. Patients also received ongoing physical health checks during their stay such as weight management and monitoring. Measurements were recorded on National Early Warning Score charts and within physical health and wellbeing care plans.

Each ward had a patient lounge with a television and patients had access to an occupational therapy kitchen, and arts and crafts room. Family and staff members spoke highly of the activities co-ordinator who provided and arranged a variety of different activities for the patient group.

Dignified care

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 enthusiastic about their roles and how they supported and cared for the patients. We saw most staff taking time to speak with patients and address any needs or concerns the patients raised, this showed that staff had responsive and caring attitudes towards the patients.

Staff we spoke to demonstrated a good level of understanding of the patients they were caring for.

En-suite bedrooms for patients provided a good standard of privacy and dignity.

Each bedroom door had a vision panel which enabled staff to undertake observations from the corridor without opening the door to minimise any potential disruption to patients sleeping. During our tour of the hospital, we positively noted that the vision panels were closed by default to protect the privacy of patients as people passed the rooms.

Patients were able to personalise their rooms and store their own possessions. Personal items were risk assessed on an individual basis for the safety of each patient. This included the use of personal mobile phones. A telephone was available at the hospital for patients to use to contact friends and family if needed.

Patients could lock their rooms, but staff could override the locks if needed. We saw staff respecting the privacy of patients by knocking on bedroom doors before entering.

In addition to the communal lounges on each ward, there was a large reception area where patients could spend time away from the ward areas. Throughout the inspection we saw several patients use this area to meet with family members and visitors.

Communicating effectively

During the inspection we observed staff engaging and communicating in a positive way with patients.

We saw that staff engaged with patients in a sensitive way and took time to help them understand their care using appropriate language.

Patient information

We noted there was limited information displayed in the hospital to help patients and their families understand their care. There were no details about organisations that can provide help and support to patients and families affected by mental health conditions.

There was no information available on either ward on the role of HIW and how patients can contact the organisation. This is required by the Mental Health Act 1983 Code of Practice for Wales.

Staff told us that information on advocacy, HIW, and other support networks was available, however this was not displayed for patients or family members to see.

The health board must review the notice boards on both wards and ensure that information is up to date and relevant. The health board must make sure that particular attention is paid to what information is displayed. Information displayed must be relevant to patients and visitors.

Timely care

Timely Access

Overall, we found evidence that patients were provided with timely care during their time on the ward. Patient needs were promptly assessed upon admission, and we observed staff assisting patients in a timely manner when requested.

The ward held daily safety huddle meetings which established the bed occupancy levels, observations and staffing levels.

Individual care

Planning care to promote independence

We found that arrangements were in place to promote and protect patient rights.

There were facilities for patients to see their families in private. Rooms were also available for patients to spend time away from other patients according to their needs and wishes. Arrangements were in place for patients to make telephone calls in private.

We looked at the records for patients who were detained under the Mental Health Act (the Act) and saw that documentation required by legislation was in place within the sample of patient records we saw. This showed that patients' rights had been promoted and protected as required by the Act. The quality of these documents is discussed later in the report.

People's rights

Legal documentation we saw to detain patients under the Mental Health Act was compliant with the legislation. However, while reviewing three records, we noted that there were no capacity assessments being recorded in patient records. 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 salient points of having been admitted onto a locked ward with all its inherent restrictions.

There was also no information displayed on the wards to inform patients, who were not restricted by the Act, about their rights to leave the ward.

Listening and learning from feedback

Senior ward staff confirmed that wherever possible they would try and resolve complaints immediately. The health board also had a process in place where patients could escalate concerns via the health board Putting Things Right complaints procedure.

We found that patients and families were provided the opportunity to provide feedback on their care, treatment, and overall experience. There was evidence that Angelton clinic had arranged family engagement sessions and received positive feedback on the delivery of care provided to patients.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety

Access to the mental health unit and wards was secure to prevent unauthorised access. Staff could enter the wards with their health board identification cards, and visitors rang the buzzer at the ward entrances. During the inspection we frequently noted that the doors to the wards were often unlocked, meaning that patients could abscond, or unauthorised persons could enter the wards. This presents a risk to both patients and staff.

We noted that staff were not wearing alarms and there was no policy or risk assessment in place to indicate why staff were not given alarms., Given that there is no psychiatric emergency response available other than on the wards, this presents a risk to staff and patient safety.

There were nurse call points around the hospital and within patient bedrooms and bathrooms so that patients could summon aid if needed.

We saw evidence of various risk assessments that had been conducted including ligature point risk assessments and fire risk assessments.

The inspection team considered the ligature environmental risk assessment. We noted that some improvements had been made following a quality check that was undertaken in 2020 by HIW, however, not all remedial works had been completed. Throughout the inspection we identified that staff were not compliant with the ligature risk assessment. We reviewed the ligature audit completed in October 2022 and noted it highlighted red areas requiring urgent and immediate works action. In addition, both wards did not have access to ligature cutters.

We raised further concerns around management of risk following our review of patient records. This highlighted that documentation was not fully completed, specifically relating to suicide risk where sections remained blank or very brief information recorded that lacked specific detail.

Details of the concerns for patient safety regarding ligatures, and the immediate improvements and remedial action required are provided in Appendix B.

There were rooms that were deemed ‘ligature free rooms’ however there did not appear to be a robust plan for preventing patients deemed high risk entering other patients rooms and potentially obtaining items with which they could ligature. The health board should consider having an agreed list of restricted and prohibited items that are permitted on the ward which is clearly displayed within the ward area.

Strategies were described for managing challenging behaviour to promote the safety and wellbeing of patients. We were told that preventative techniques were

used and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the safe 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). Any use of restraint was documented.

The inspection team considered the hospital environment during a tour of the hospital on the first night of the inspection and the remaining days of the inspection. Overall, the wards appeared clean and tidy, however we identified several decorative and environmental issues that required attention:

- Hoist stored at end of corridor
- Skirting edges coming away from the walls on Ward 2
- Hole in ceiling in the female kitchen area on Ward 2
- Clinical room cupboards cluttered
- Macerator not working in sluice
- Lid broken on box of glucose monitoring kit
- Flooring on male corridor on Ward 2 needs to be replaced as it poses a trip hazard
- Flooring in clinic Ward 2 needs replacing
- Sink in clinic area on Ward 1 is broken
- Room 5, Ward 2 spotlight from the ensuite bathroom hanging from the ceiling
- No maintenance logs in clinic on Ward 1 for medical devices
- Ceiling tiles in staff office on Ward 2 need replacing.

Most of the above issues had been raised within the environmental spot checks undertaken by the ward managers but had not been resolved by the health board. It is important that the health board resolve these issues to ensure staff and patient safety on the wards.

Preventing pressure and tissue damage

We found that appropriate checklists were completed, and any ongoing risks would be monitored. Pressure relieving mattresses and cushions were available and being used.

Falls prevention

There were risk assessments in place for patients on both wards. We found that ward staff assessed patients for their risk of falling and made efforts to prevent falls.

Patient falls would be reported via the health board's electronic incident recording system. Staff explained that the incident reporting system would be followed to ensure lessons were learnt and acted on appropriately.

It was positive to see that research projects were being undertaken on the wards relating to falls. Staff described initiatives where collaborative work with Improvement Cymru was being undertaken to try and reduce and prevent falls.

Infection prevention and control

We found suitable IPC arrangements in place at the hospital. A range of up-to-date policies were available that detailed the various infection control procedures to keep staff and patients safe. We were told that regular audits had been completed to check the cleanliness of the environment and check compliance with hospital procedures. However, we were not provided with evidence to support that hand hygiene audits had been completed.

We saw that both wards were clean, tidy, and designed to facilitate effective cleaning. We also saw that staff had access to, and were using, personal protective equipment (PPE) where appropriate. Staff we spoke to confirmed that PPE was always readily available. Sufficient hand washing and drying facilities were available.

We were told by staff that when patients are barrier nursed, they place hand sanitising gel dispensers outside patient rooms. However, this may pose a risk to other patients. The health board should consider providing staff with personal hand sanitising gel dispensers, to ensure effective hand hygiene and reduce the risk to other patients.

Cleaning equipment was stored and organised appropriately. There were suitable arrangements in place for the disposal of clinical waste. However, waste urinals and bedpans were being disposed of via clinical waste bags. The health board need to review this process and ensure that all staff are using the sluice appropriately.

Nutrition and hydration

We reviewed five care records and confirmed that assessments of patients' eating and drinking needs had been completed, but these had not been reviewed on a weekly basis. Patient records documented specific individual dietary needs to maintain sufficient nutrition and fluid consumption.

The notice board on entry to the wards contained good information, outlining what different textured modified diets are benefitting patients and staff.
In one patient record we reviewed, we identified that not all staff were compliant with the directions given by the Speech and Language Therapist regarding a patient's nutritional requirements. In addition, the decision making around discontinuance of the patient's specific diet was not documented in notes, and

there was no evidence of decision making for the change to this patient's specific nutritional requirements.

Our concerns regarding this and the remedial actions required are detailed are provided in Appendix B.

Medicines management

On the first night of the inspection, we identified that the medication fridges on both Ward 1 and Ward 2 were unlocked. We noted they remained unlocked during the rest of our inspection. Our concerns regarding this were dealt with under our immediate assurance process, detailed in Appendix B.

On several occasions during the inspection, we noted that the medication trolley on both wards was often left unattended. This breached the health board policy, which stipulates that the medication trolley should not be left unattended unless locked and secured to the wall. The health board must ensure that staff comply with the health board policies and guidance on safe and secure storage of medication trolleys and how they are stored on the wards and in clinical rooms.

In addition, patient medication charts were left unattended on the trolley. The health board must ensure that patient records are not left unattended.

Relevant policies, such as medicines management, were out of date. The medication storage policy was due for review in 2021. In addition, the following medication policies provided to the inspection team were out of date:

- Rapid tranquiliser policy due for review 2015
- Administration medication procedure review date June 2021.

There was no evidence of a system of governance for staff to learn from drug errors and during discussions with staff, they were unclear as to how they would be made aware of any drug administration errors. We were told that team meetings did take place, however we were not provided with any minutes of meetings to evidence this.

There was no evidence of regular auditing of medication charts and from a sample of charts reviewed, we noted missing information, such as patient weights and legal status, and venous thromboembolism risk assessments were incomplete. There was evidence that pain medication was available and used, however, pain assessment tools were not being completed. In addition, patient names were not recorded on all sides of the medication charts.

Other than the issues noted above, we found that there were suitable arrangements for the safe and secure storage and administration of controlled drugs. There was evidence of regular temperature checks of the medication fridge to monitor that medication was stored at the manufacturer's advised temperature. We also noted some medication did not have stickers with the dates opened recorded on them.

In one set of notes we reviewed, it was recorded that a restraint had taken place and the correct paperwork had been completed, however there was no entries recorded in the patients notes to confirm the patient had been seen by a medic. This patient had also been subject of a further restraint on a separate day to receive medication, however there was no record of a restraint form on this occasion.

Furthermore, there did not appear to be consideration given to the cause of the patient's agitation. It was recorded that the patient had not had a bowel movement for over a week. This could have been a contributory factor to the agitation; however, there was no documentation visible in the case notes or within the drug chart that reflected attempts to remedy this by offering laxatives.

Safeguarding children and safeguarding adults at risk

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

Both wards provided care to adults only. Ward staff had access to the health board 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, some staff were unclear or lacked confidence in demonstrating the process of making a safeguarding referral. The health board must ensure that all staff are clear on their role and responsibilities in relation to safeguarding and the process of making a referral.

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

Medical devices, equipment and diagnostic systems

We saw evidence of weekly checks being undertaken on resuscitation and emergency equipment held on each ward. Staff had documented when these had occurred to ensure that the equipment was present and in date. Although the

emergency equipment was in a grab bag, sealed with a red tie, there was no daily checks undertaken. In addition, there was no system in place to check when it expires.

Effective care

Quality improvement, research and innovation

Senior staff described initiatives to develop and improve the service provided to patients. These included the collaborative work undertaken around falls, and the appointment of a wellbeing champion to the wards to support an alternative and holistic approach to care, provided to patients and staff.

A discharge planning nurse position had been funded, this individual had developed good links with care homes to support staff and patients with timely discharge which had alleviated pressure on staff. This is a seconded position, and it is important that the health board consider further funding of this post.

Information governance and communications technology

We found that patient records and identifiable patient data was not always kept securely to ensure that confidentiality was maintained. Patient Status at a Glance boards were in the nursing offices, and the board on Ward 2 was covered. However, the board on Ward 1 was visible to patients and visitors. The health board must make every effort to consistently protect patient confidentiality.

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. As highlighted in the medication section above, we noted that staff were not always storing records appropriately during our inspection.

During the inspection it was difficult to locate and access patient information.

Patient care plan records were not being regularly assessed and monitored by the health board to ensure quality of the service and to identify, assess and manage risk relating to safe patient care. Risk assessments were not up to date or comprehensive enough to enable a member of staff who does not know a patient to be confidently aware of the risks.

This would be of particular concern for an agency member of staff attending the ward for the first time where it would be very difficult for them to understand patient behaviours and the appropriate actions to take to manage them.

These issues were dealt with under our immediate assurance process, details of which can be found in Appendix B.

Mental Health Act Monitoring

We reviewed the statutory detention documents for three patients at Angelton Clinic.

Whilst it was evidenced that patients were being informed of their rights under the Act on detention, there was no record of ongoing provision of rights as directed by the Mental Health Act Code of Practice for Wales. This means that patients may not be fully aware of their rights under the Act.

Copies of detention papers were not available in records we reviewed. However, it was highlighted by staff that these may be in the process of being filed. We were told that there was a significant backlog of paperwork which needed to be filed. The health board must ensure that copies of detention papers are held with patients records and the backlog of paperwork to be filed is completed.

We also identified that consent to treatment certificates were not kept with patient medication drugs charts. To comply with the Mental Health Act, it is important that all consent to treatment certificates are kept with the medication charts.

A review of patient records also highlighted that there was limited involvement from advocacy services. The health board needs to consider how it fulfils individuals right to advocacy and how the hospital can support and ensure that independent patient representation is provided at the hospital.

It was seen as an area of good practice that the Mental Health Act office staff undertake twice yearly ward audits, and each ward are tasked with completed a weekly internal audit managed by the MHA administrator office who follows them up for completion.

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

We reviewed the care plans of five patients. We reviewed a sample of care files and found that improvements are required.

Care plan records were not comprehensive and were difficult to navigate.

Of the care plans reviewed; we identified several areas that required improvement:

- Care plans did not always demonstrate patient involvement or clearly record the patients view
- It was unclear if risks are being regularly reviewed or updated after incidents or changes in patients' presentation
- No evidence of pain assessments being completed
- No outcome measures documented

- Not documented that Care and Treatment Plans (CTP) had been signed, or that the patient had been given a copy
- There was no evidence to demonstrate that care plans are being regularly assessed or monitored.

In addition to the above, where challenging behaviour was mentioned in patient notes, there was no clear narrative or descriptive detail recorded as to why the patient's behaviour was challenging. Observation charts were not accurately completed, and in one set of patients notes the recording stated "in bedroom, settled" rather than explaining the patient's mental state.

In another set of patients notes the same staff member had signed for observations from 11:00 pm – 05:00 am, this contravenes national guidance. In addition, staff told us that they had not received any formal training on observations. The observation policy provided to us during the inspection was out of date and due for review in March 2022.

All the above issues further highlight that there is a deficiency in the audits taking place. To improve patient care and safety it is essential that accurate, consistent, and robust audits take place for the hospital to assess, evaluate and improve patient care and staff practices.

Quality of Management and Leadership

Governance, Leadership and Accountability

The significance of the areas of improvement identified in the Delivery of safe and effective care section of this report highlights the need for improvement in audit and governance regarding patient safety, care planning and monitoring.

We identified that no formal minutes were being routinely recorded for patient related meetings, weekly ward rounds, and for MDT meetings. This demonstrates a weakness in the governance processes in place to maintain patient safety.

During staff interviews and after requesting documentation to evidence staff supervision and training, inspectors were not provided with sufficient documentary evidence to confirm that regular appraisals, supervision and training is taking place.

As a result of these findings, we could not be assured that the health board's audit systems were effectively assessing and monitoring quality, nor that they were robust in their ability to identify, assess and manage risks relating to the health, welfare, and safety of patients. These matters were also dealt with under our immediate improvements process.

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

Discussions held with senior staff, highlighted that they were aware of some of the issues which required improvement and had a clear commitment to addressing those.

Throughout our inspection, senior staff made themselves available to speak to the HIW inspection team and engaged very positively with the process.

During our feedback meeting at the end of the inspection, senior ward staff and hospital managers were receptive to our comments. They demonstrated a commitment to learn from the inspection.

Workforce

The staffing levels appeared appropriate to support the safety of patients within the hospital at the time of our inspection. However, on the night of our arrival it was noted that there was only one qualified nurse on duty for the night shift, instead of the expected two due to sickness.

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

During our time on the wards, we observed good relationships between staff who we observed working well together as a team. It was clear to see that staff were striving to provide high levels of care to the patient groups.

The inspection team considered the staff training compliance on Wards 1 and 2 and provided with a list of staff mandatory training compliance on both wards. Training figures provided to us on the inspection indicated that compliance was extremely low. We could not be assured that staff are appropriately trained to maintain professional standards and compliance in the workplace which could impact on the safety of patients. There were also delays in providing the inspection team with the training data, this further demonstrated that there had not been any governance reporting, oversight, or analysis undertaken on training recently.

These issues were also dealt with under our immediate assurance process, further details can be found in Appendix B.

The inspection team felt that it would be beneficial for the health board to conduct a training needs analysis to provide staff with bespoke training relevant to their role, such as suicide awareness and response, refresher training on drugs administration, and staff should be given the opportunity to attend dementia care training.

We were provided with a range of policies, however, upon review most of the versions we received had passed their review date. The following policies were found to be out of date:

- Policy for locking doors in inpatient units next review 2020
- Safe and supportive engagement and observation policy due for review 19 March 2022
- Fire Policy next review March 2021

Furthermore, the health board's physical restraints policy was out of date; the copy provided during the inspection indicated that the violence and aggression management policy was due for review in September 2014. We were advised that a draft policy was due to be approved.

Some of these policies were still branded as Abertawe Bro Morgannwg University Health Board (ABMU) policies, and the operational policy was also branded as ABMU, evidencing that these had not been reviewed for a significant amount of time.

We were not assured that the staff were obtaining or being provided with the most up to date guidance to direct their professional practice. The health board must

make sure that all policies are updated and reviewed, and that the policies relate to the current health board.

Following this inspection, the health board must ensure that the governance and audit process improves at Angelton Clinic to ensure that there is robust oversight on quality and safety at the hospital.

4. 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 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 how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

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
Unlocked door which patients could potentially access, within the room was a bin full of batteries	Risk to patients	Brought to the attention of senior manager	Batteries disposed of and room locked

Appendix B - Immediate improvement plan

Service: **Angelton Clinic - Glanrhyd Hospital**

Date of inspection: **14 - 16 November 2022**

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
HIW were not assured that ligature risks are rectified. We identified concerns which could result in significant patient harm in a HIW quality check in 2020 and this has not been addressed. The health board must provide HIW with details on how they will ensure that the risk to patients from ligature within the wards will be managed, to prevent harm to patients at the setting.	2.1 Managing risk and promoting health and safety 3.1 Safe and Clinically	Email sent to Angelton Clinic's management team for dissemination to all ward staff on the importance of remaining compliant with the ligature risk assessment, in particular the bathroom doors on ward 2 which were left open at the time of the inspection. The Lead and Senior nurses will undertake spot checks weekly to ensure compliance of the ligature risk assessment.	Lead Nurse	18/11/22 Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Evidence The inspection team considered the ligature environmental risk assessment, and noted that some improvements had been made following a quality check that was undertaken in 2020 with the two anti-ligature rooms being made available on ward 2. However, a review of a ligature audit completed in October 2022 highlighted some specific areas as a red area that therefore require urgent and immediate works action. This audit stipulates the specified rooms must be locked when not in use. During the first night of the inspection, we observed and	Effective care	Progress against the action will be monitored as a standard agenda item for the next 6 months in the Quality, Safety, Risk and Experience meeting to monitor compliance.		
		Review ligature risk assessments for Ward 1 and Ward 2 as an immediate action and then audit the risk assessments on an ongoing monthly basis clearly identifying any changes. A review to be undertaken pan CTM on Older Adults Mental Health inpatient wards to agree key principles and a standard approach.	Ward Managers /Lead Nurse	31/01/23

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
confirmed that the specified rooms located on both wards remained open and unlocked. We raised this with senior member of ward staff, however these rooms remained unlocked for the duration of the inspection. In addition, the doors on Ward 1 were wedged open and easily accessible throughout the inspection. We also identified significant concerns regarding ligature cutters on both wards. There were no ligature cutters on Ward 2. Staff on Ward 1 did not know if a ligature cutter were available or not. Further concerns around management of risk were raised following a review of patient records. These highlighted that documentation was not fully completed, specifically suicide risk sections were incomplete or very brief information recorded that lacked specific detail. As a		Individual meetings held and actions confirmed in an email sent to Ward Managers to remind them of the requirement of monthly ligature risk assessment reviews.	Lead Nurse	25/11/22 Completed
		Ligature cutters immediately to be made available on each ward within Angelton Clinic. Ligature cutters have been purchased and are now available on both wards. Both cutters are kept in the clinic rooms on Ward 1 and Ward 2 on the emergency resuscitation trolley. Daily checks of the ligature cutters to be put in place, with a weekly audit by ward Manager and monthly by Senior Nurse.	Lead Nurse	31/01/23

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
result, we were not assured that the current controls or mitigating actions put in place were effective. HIW requires details of how the health board will ensure the risk to patients from ligature within the setting will be managed and avoided to prevent harm to patients at the setting.		All patient risk assessments to be reviewed and audited. Individual actions put in place where necessary and any further training needs escalated. This process will be reviewed in the minuted monthly Ward Managers meeting in Angelton Clinic. This will be monitored in the monthly Quality, Safety, Risk and Experience meeting.	Ward Managers/Senior Nurse	28/02/23

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		For 85% of qualified staff in Angelton Clinic to be trained in WAARN and CTM Risk formulation and these risk assessments to be put in place for all inpatients. This will be monitored in the monthly Quality, Safety, Risk and Experience meeting.	Senior/Lead Nurse	25/01/2023
		CTMUHB Mental Health Risk Assessment Steering Group to consider and review the need for all staff to receive training on suicide awareness.	Lead Nurse	28/02/2023
		Immediate assurance to be confirmed that all inpatient Mental Health wards in CTMUHB have ligature cutters.	Nurse Director	17/11/2022 Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
HIW is not assured that all aspects of care are being delivered in a safe and effective manner. **Evidence** In one patient's record we reviewed, the Speech and Language Therapist (SALT) directed staff to implement a puree level 4 diet. The patient's records documented that they were at risk from aspiration and choking if they ingested a normal diet. It is evidenced in the notes on the 3rd of October post the advice from the SALT that the patient had been given a level 7 diet, contrary to the SALT advice, therefore placing the patient at risk of significant harm. Discontinuance of care from the SALT took place on the 7th of November. The patient's records did not clearly state the decision why	Standard 3.1 Safe and Clinically Effective Care Standard 3.5 Record Keeping	Email to be sent to Ward Managers for dissemination to all ward staff reminding them of the importance of following Speech and Language Therapist recommendations and the escalation process if nursing staff have any concerns regarding these recommendations and the rationale. To ensure the compliance of staff adhering to Speech and Language Therapy recommendations set, clinical nursing note audits are to be carried out monthly, reviewing individual patient's therapy plans. This process will be reviewed in the minuted monthly Ward Managers meeting in Angelton Clinic.	Lead Nurse	19/11/22 Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
this ceased. It was also not clear if the patient required to continue on a level 4 diet. HIW requires details on how the health board will audit and quality assure patient records to ensure that all staff are complying with advice and guidance given by other professionals. HIW also require details on how the health board will ensure that staff record detailed and comprehensive decision making in care records.		Email to be sent to Speech and Language Therapist and Consultant Psychiatrist to request the rationale around the discharge of the patient mentioned in the HIW inspection. Rationale to be printed and clearly put into patient notes.	Lead Nurse	19/11/22 Completed
		Audit of clinical nursing notes to be undertaken on a monthly basis on both Ward 1 and Ward 2. This process will be reviewed in the minuted monthly Ward Managers meeting in Angelton Clinic. Nursing note audits will also form part of the monitoring in the monthly Quality, Safety, Risk and Experience meeting.	Ward Managers / Senior Nurse / Lead Nurse	28/02/23

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Speech and Language Therapists care plans to be displayed, on patient status boards (cover in place for confidentiality when not in use), ward kitchen's (only accessible for staff) and individual patient bedrooms. SALT recommendations to be communicated during handovers, this will be monitored through daily safety huddles between the Ward Managers and Senior Nurse.	Ward Managers / Senior Nurse	28/02/22
		Level 1 Dysphagia Training to be completed by all staff by 03/02/23.	Ward Managers / Senior/Lead Nurse	03/02/23

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
HIW were not assured that best practice guidance on storage of medication was being adhered to. In addition, there was no governance oversight or supervision to ensure staff were compliant. **Evidence** On the first night of the inspection, the inspection team noted that the lock on medication fridge on ward 2 was broken and therefore the fridge was unlocked. We were advised that the fridge had been like this for some time. We requested that the fridge was fixed or replaced. During the inspection, the fridge was replaced, however the medications from the old fridge had not been transferred across into the new fridge. On the last day of the inspection, the replacement fridge was checked, and it remained unlocked with the key in-situ.	2.6 Medicines Management	Clinic fridge lock checks to be completed daily by qualified staff, weekly audit by Ward Manager and monthly by Senior Nurse.	Senior/Lead Nurse	18/11/22 Completed
		Email to be sent to Ward Managers for dissemination to all ward staff on the daily check requirement and process if locks are found to be broken. The Lead and Senior Nurses will undertake spot checks weekly to ensure compliance. There will also be a formal weekly check of the locks by the Ward Manager and monthly by the Senior Nurse. This will also include a quality check on the estates log book.	Senior/Lead Nurse	28/02/23

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
In addition, on the first night of the inspection the fridge on Ward 1 was unlocked. We advised staff and senior management that the fridge should be locked. On the last day of the inspection, we checked the fridge on Ward 1, and it was again unlocked. Compliance around this must be monitored and the HB need to provide HIW with assurances on how they will monitor and ensure compliance.		Compliance and processes to be discussed in staff meetings to provide further support and guidance to staff and ensure the process and understanding is embedded into daily practice.		

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Quality of management and leadership				
HIW were not assured that the health board have a robust governance framework in place. **Evidence** During the inspection it was difficult to locate and access patient information. Attempting to follow the care and treatment of an individual was complex and time consuming across the individual sources. This would be of particular concern for an agency member of staff attending the ward for the first time where it would be very difficult for them to understand patient behaviours and the appropriate actions to take to manage them.	7.1 Workforce	All current risk assessments and Care and Treatment plans (CTP's) to be printed and made clearly accessible in every patient's clinical nursing notes.	Ward Manager / Ward Clerk	25/11/22 Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Patient care plan records were not regularly being assessed and monitored by the health board to ensure quality of the service and to identify, assess and manage risk relating to safe patient care. During the inspection there was limited or no evidence of regular audits of patient care records. In a sample of patient records reviewed there were not up to date risk assessments. Some documentation was not fully completed, such as leaving sections blank or inputting very brief information that lacked specific detail.		All CTPs to be audited as part of the monthly clinical nursing notes audits.	Ward Manager	25/11/22 Completed
		The results of monthly clinical nursing notes audits are to be reviewed in the monthly ward managers meetings in order to agree the actions and improvement plans which will be presented to Quality, Safety, Risk and Experience meetings.	Ward Manager/ Senior/ Lead Nurse	31/12/22

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
We also identified that no formal minutes were being routinely recorded for patient related meetings, weekly ward rounds, and for MDT meetings. This demonstrates a weakness in the governance processes in place, to maintaining patient safety. During staff interviews and after requesting documentation to evidence staff supervision and training, inspectors were not provided with sufficient documentary evidence to reflect that regular appraisals, supervision and training is taking place. The inspection team considered the staff training compliance on Wards 1 and 2. We were provided with a list of staff mandatory training compliance on both wards. Training figures provided to us on the		All qualified staff to be trained in Improvement Cymru Outcome Measure tools which can be used to describe the progress of care, support and treatment of our patients. 25 staff require training and all staff will be trained by 01/06/23. This will be monitored in the monthly Quality, Safety, Risk and Experience meeting.	Ward Manager /Senior Nurse	01/06/23
		For 85% of registered staff to be trained in WAARN and the risk formulation document so that there is consistency for all patients and the comprehensive recording of risk is improved. This will be monitored in the monthly Quality, Safety, Risk and Experience meeting.	Ward Manager	01/06/2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
inspection indicated that compliance was extremely low. We are not assured that staff are appropriately trained to maintain professional standards and compliance in the workplace which could impact on the safety of patients. Based on the extremely low percentages of violence and aggression training for staff - Violence and Aggression 3.57% on Ward 1 and 2.70% Ward 2. We are not assured that staff and patients are being fully protected and safeguarded against injury. Furthermore, the health board's Physical Restraint Policy was out of date; the copy we were handed indicated that the violence and aggression management policy was due for review in September 2014.		Governance processes to be reviewed particularly around minutes of patient and staff related meetings, weekly ward rounds and MDT meetings. Dates to be set for patient and staff meetings. Ward rounds and MDT documentation to be clearly identifiable in patient notes.	Senior Nurse/Ward Manager	31/12/22
		All staff to receive supervision at 3 monthly intervals and this is to be recorded within staff personal files. A review of the approach to staff supervision across the Mental Health Care Group to take place and the policy reviewed with and ratified by 28/03/23.	Senior Nurse/Ward Manager	28/03/2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
HIW must be provided with assurances and evidence as to how the health board will regularly assess and monitor the quality of service provisions within Angelton Clinic. The health board must ensure that all staff are appropriately trained and that monitoring of training figures and attendance is improved. The health board must ensure that all staff have access to violence and aggression training as soon as possible.		PADR's (appraisals) compliance to be over 85%. Compliance will be monitored at the minuted monthly ward managers meeting in Angelton Clinic.	Senior Nurse/Ward Manager	31/12/2022
		PADR's (appraisals) to be highlighted in ward managers offices and visual reminders set to maintain high compliance levels.	Senior Nurse/Ward Manager	23/11/2022 Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		PMVA Training needs analysis to be completed on Ward 1 and Ward 2 and ESR team to accurately reflect this on ESR system. Email to be sent to Compliance manager for this to be accurately amended.	Lead Nurse and Personal Safety Advisor for CTMUHB	22/11/2022 Completed
		PMVA policy to be ratified by the Health Board and in place. The Policy is complete and will be taken to the next HB Policy meeting for ratification	Head of Nursing/Lead Nurse	28/02/2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Following completion of a training needs analysis, ESR team to accurately reflect Angelton Clinic's PMVA requirements of: Personal Safety and De-escalation Module D Lower PMVA	Learning and Development Compliance Manager / Lead Nurse	31/12/2022
		Compliance for Prevention and Management of Violence and Aggression training (PMVA) to reach 85% Arrangements have been made for the PMVA trainers working in CAMHS to deliver 4 bespoke 2-day training sessions for all staff at Angleton clinic in February and March 2023	Lead Nurse and Personal Safety Advisor for CTMUHB	31/03/2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		ILS and BLS resuscitation training to reach 85% by 31/03/23.	Senior Nurse and Resuscitation Service Manager	31/03/2023
		Ward Managers to ensure that there is an appropriately ILS trained member of staff on duty in the case of emergency. This process will be reviewed in the minuted monthly Ward Managers meeting in Angelton Clinic.	Ward Manager	31/01/2023
		All staff to receive emergency evacuation training by 31/01/23. In the interim, in an emergency situation, all patients have ALBAC mats in their rooms and evacuation for patients nursed in bed would involve staff supporting the patient from bed to floor and the mats would assist the	Lead Nurse / HB Head of Health, Safety and Fire	31/03/23

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		patient's in getting out of the room safely. Currently there are 2 patients only who would require this level of support. Risk assessments will be put in place by 25/11/22.		

Service representative:

Name (print): Sophie Bassett

Job role: Lead Nurse

Date: 25/22/2022

Appendix C - Improvement plan

Service: **Angelton Clinic - Glanrhyd Hospital**

Date of inspection: **14 - 16 November 2022**

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/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that a range of information for patients is displayed within the wards that includes: • **The NHS Putting Things Right process** • **Guidance around mental health legislation** • **Healthcare Inspectorate Wales** • **Healthy eating and well-being.** • **Advocacy Service**	4.2 Patient Information	Patient information boards to be updated on Ward 1 and Ward 2 and in the atrium of Angelton Clinic for families/carers to reflect the improvement needed. An information booklet to be established in order to be provided on admission for patients/families. An information booklet will be developed in partnership with patients, relatives and carers in the patient and carers group meetings which are minuted.	Ward Managers Ward Managers / Senior Nurse	Completed 28/04/2023 28/04/2023

The health board must ensure that capacity assessments are recorded and included in patient records.	6.2 Patients' rights.	Monthly nursing note audits to include capacity assessment checks of individual patients. Currently the nursing note audit checks do not include the auditing of capacity assessments. This will be an addition to the existing audit process. This action will be closed after 6 months if there is evidence that this is embedded into practice. Monthly Ward Manager meetings to review progress against nursing note audits (with capacity assessments included) This action will require 2 months to embed into auditing process.	Ward Managers Senior Nurse	28/04/2023
The health board must ensure that ward doors are locked.	2.1 Managing risk and promoting	Previous 3 x Daily (magnetic lock) ward door checks in place.	Ward Managers	Completed

	health and safety	Daily checks to now reflect change in bathroom lock checks in line with updated ligature risk assessment completed New Monthly assurance checks to monitor compliance by Senior Nurse. Any issues identified are reported through estates maintenance log. No issues have been identified.	Ward Managers Senior Nurse Ward Managers	28/04/2023 28/04/2023 Completed
The health board must make sure that staff have access to personal safety alarms.	2.1 Managing risk and promoting health and safety	Personal safety alarms to be made available for all staff on both wards. Risk assessment/Standard Operating Procedure to be put into place to assess need for mandatory or optional use	Ward Managers/Senior Nurse Senior Nurse	Completed 28/02/2023

		dependent on outcome of risk assessments.		
The health board should consider having an agreed list of restricted and prohibited items that are permitted on the ward which is clearly displayed within the ward area.	2.1 Managing risk and promoting health and safety	Clear signage/ list of restricted items to be displayed on entrance to both wards. There requires a degree of flexibility and limitation on a blanket approach in this environment and this would be risk assessed appropriately.	Senior Nurse	Completed
The health board must ensure that the following environmental issues are resolved:- • **Hoist stored at end of corridor** • **Skirting edges coming away from the walls on Ward 2**	2.1 Managing risk and promoting health and safety	Status of environmental issues: Hoist stored at end of corridor – This has now been removed from the corridor and located in a store room. Skirting edges coming away from the walls on Ward 2 – All areas were replaced apart from two small areas outside of nursing	All actions: Ward Managers/Estates Team	Complete 28/04/2023

• **Hole in ceiling in the female kitchen area on Ward 2** • **Clinical room cupboards cluttered** • **Macerator not working in sluice** • **Lid broken on box of glucose monitoring kit** • **Flooring on male corridor on Ward 2 needs to be replaced as it is a trip hazard**		ward office (one on male side and one on female side). This has been logged with estates on 30/12/2022 job reference 60496 and 23/01/2023, job reference number is 62679. Hole in ceiling in the female kitchen area on Ward 2 Clinical room cupboards cluttered Macerator not working in sluice – Estates have reviewed this issue and this needs replacing. Email sent to estates requesting replacement. Re-booked with estates on 23/01/2023, job reference 62672. Lid broken on box of glucose monitoring kit – Complete, replaced.		Complete Complete28/04/2023 Complete 28/04/2023 28/04/2023

• **Flooring in clinic Ward 2 needs replacing** • **Sink in clinic area on Ward 1 is broken** • **Room 5, Ward 2 spot light from the ensuite bathroom hanging from the ceiling** • **No maintenance logs in clinic on Ward 1 for medical devices** • **Ceiling tiles in staff office on Ward 2 need replacing.**		Flooring on male corridor on Ward 2 needs to be replaced as it is a trip hazard – All has been replaced apart from one section of carpet. Re-booked with estates on 23/01/2023, job reference 62679. Flooring in clinic Ward 2 needs replacing – Booked on the 26/01/2023, job reference 63142 Sink in clinic area on Ward 1 is broken Room 5, Ward 2 spotlight from the ensuite bathroom hanging from the ceiling No maintenance logs in Clinic on Ward 1 for medical devices		Complete Complete Complete 28/04/2023 Complete Complete

		Ceiling tiles in staff office on Ward 2 need replacing Re-booked with estates on 26/01/2023, job reference 63119 Environmental audits to take place monthly. Environmental issues to form part of monthly Ward Managers meetings and if issues remain unresolved, escalation process to be followed which includes informing IPC leads in weekly meeting and informing Senior Management Team.		
The health board must ensure that regular hand hygiene audits take place.	2.4 Infection Prevention and Control (IPC) and Decontamination	Monthly hand hygiene audits to be maintained.	Ward Managers Senior Nurse	Complete

		Compliance against hand hygiene audits to be reviewed at monthly Ward Managers meetings. Train the trainer model to be re-introduced in Angelton Clinic to ensure standards are maintained.	Ward Manager	Complete 28/04/2023
The health board should consider providing staff with personal hand sanitising gel dispensers, to ensure effective hand hygiene and reduce the risk to other patients.	2.4 Infection Prevention and Control (IPC) and Decontamination	The health board to ensure staff have personal hand sanitising gel dispensers available.	Senior Nurse /Ward Manager	Complete
The health board must ensure that staff are disposing of clinical waste appropriately.	2.4 Infection Prevention and Control (IPC) and Decontamination	Appropriate disposal of clinical waste to be addressed within staff meetings and included in environmental audits moving forward	Ward Managers	28/02/2023 28/04/2023

		Training compliance for IPC level 2 to reach 85%.	Senior Nurse	
The health board must ensure that medication trolleys are not left unattended and that there are locked and secure when not in use.	2.9 Medical devices, equipment and diagnostic systems	Ensure medication trolleys are not left unattended/out of eyesight of staff. Medication trolleys returned to clinic rooms when not in use. Spot checks completed.	Ward Managers	Complete
The health board must ensure that that patient records are not left unattended.	2.1 Managing risk and promoting health and safety	Ensure patient identifiable information is stored in a secure place and ensure medication trolleys are not left unattended/out of eyesight of staff. Medication trolleys returned to clinic rooms when not in use. Spot checks to be completed. This action will be closed after 6 months of spot checks with no concerns.	Ward Managers Senior Nurse	Complete Complete

		Compliance to be reviewed in ward staff meetings.	Ward Managers	28/04/2023
The health board must ensure there is a routine audit of policies to ensure that ward staff have access to, and referring to the most recent version.	Governance, Leadership and Accountability	Review of updated policies to take place across the Mental Health Care Group in CTM and distributed through Quality, Safety, Risk and Experience Group meetings. Audit of policies to be undertaken on both Wards on a three monthly basis. The audit will report any changes or issues to the Quality, Safety, Risk & Experience Group. Up to date policies to be printed, displayed in a policy file. Additionally, process for accessing policies on the intranet to be shared in staff meetings and a 'how to guide' to be created.	Lead Nurse – Merthyr Cynon Senior Nurse Ward Managers	31/07/2023 31/07/2023 28/02/2023

The health board must ensure that there is a system in place for staff to learn from drug errors.	2.6 Medicines Management	The Health Board has developed a Bennion Error Scoring System (BESS) procedure to help managers identify the level of support required following a medication error. Once the BESS procedure has been ratified at HB level, Angelton staff to be prioritised in the training and roll out of this procedure and to use in practice Medication errors will form part of a standard agenda in the Quality, Safety, Risk & Experience Group meeting. Medication errors to be discussed in staff meetings and learning shared.	Senior Nurse Lead Nurse Ward Managers	28/04/2023 28/04/2023 28/04/2023
The health board must ensure that there is a system in place to audit medication charts.	2.1 Managing risk and promoting	Sample audit of medication charts to take place on a monthly basis, in addition to Controlled	Ward Managers/ Pharmacy	28/04/2023

	health and safety	Drug audit currently completed by Pharmacy. Registered nursing staff provide a quality assurance check at the end of each shift that all medications have been administered. This is documented on a checklist.	 All qualified staff	Completed
The health board must ensure that restraints are recorded in patient records and that patient's notes are updated.	3.5 Record keeping	Datix to be submitted and written account of restraint to be documented in patient notes. Restraint forms to be completed and uploaded to datix. Compliance to be monitored through monthly nursing note audits, ward manager meetings and Quality, Safety, Risk and Experience Group meeting.	Staff Nurses/Ward Managers Ward Managers/Senior Nurse	Completed

The health board must ensure that all staff are confident in how to deal with a safeguarding referral.	2.7 Safeguarding	80% compliance to be achieved for Level 2 and Level 3 Safeguarding Training. Safeguarding to be a standard agenda item in staff meetings to reiterate the process. Safeguarding referral process to be clearly visible in nursing office on both wards.	Ward Managers Ward Managers Ward Managers	31/07/2023 28/04/2023 Complete
The health board must ensure that patient status at a glance board is covered to protect patient details.	4.1 Dignified care	Appropriate blind covers to protect patient confidentiality to be maintained at all times when not in use. Compliance to be monitored on a by Ward Managers and escalated through Ward Managers meetings where needed.	Ward Managers Ward Managers	Complete 28/04/2023 Complete

		Spot checks to be undertaken by Senior Nurse on a weekly basis.	Senior Nurse	
The health board must ensure that patient records are regularly assessed and monitored, and that feedback is provided to staff.	3.5 Record keeping	Audit of clinical nursing notes to be undertaken on a monthly basis on both Ward 1 and Ward 2. (Please note evidence provided is previous nursing note audit which has now been amended). This process will be reviewed in the minuted monthly Ward Managers meeting in Angelton Clinic. Nursing note audits will also form part of the monitoring in the monthly Quality, Safety, Risk and Experience meeting. Feedback to be given to individual staff members through supervision.	Ward Managers Senior Nurse Lead Nurse Ward Manager	Completed (see Appendix 27) Completed 28/04/2023 28/04/2023

The health board must ensure that copies of detention papers are kept with patient records.	6.2 Peoples rights	Detention paper checks within the patient records to form part of monthly nursing note audits. Twice yearly audit of MHA documentation by the MHA office team. Nursing note audits will also form part of the monitoring in the monthly Clinical Service Group Quality, Safety, Risk and Experience meeting.	Ward Managers MHA team Lead Nurse	28/04/2023 Completed 28/04/2023
The health board must ensure that consent to treatment certificates is kept with patient's drug charts.	3.5 Record keeping	Monthly audit of nursing notes to incorporate consent to treatment certificates and appropriate storage of these in patient drug charts.	Ward Managers	28/04/2023

		Weekly section 58 audit of CO3 submitted to MHA office.	Ward Managers	Complete
The health board must ensure that advocacy support is available for all patients.	4.2 Patient Information	Patient information boards to be updated on Ward 1 and Ward 2 to reflect the improvement needed. Advocacy information to be provided in patient information admission booklet.	Ward Managers Ward Managers	Completed 28/04/2023
The health board must ensure that patient's views are recorded in care plans.	3.5 Record keeping	Individual care plans to incorporate patient views. Monthly nursing audits to capture compliance of this.	Ward Managers Ward Managers	28/04/2023 28/04/2023 28/04/2023

		Staff meetings to reiterate importance of patient centred care planning.	Ward Managers	
The health board must ensure that patients' risks are regularly updated and recorded in patient records.	3.5 Record keeping	All patient risk assessments to be reviewed and audited. Individual actions put in place where necessary and any further training needs escalated. This process will be reviewed in the monthly minuted Ward Managers meeting in Angelton Clinic. This will be monitored in the Quality, Safety, Risk and Experience Group meeting and closed after 6 months if compliance is maintained and standards upheld.	Ward Managers Senior Nurse Lead Nurse	Complete Complete 31/07/2023

The health board must ensure that there is evidence of pain assessments being completed in patient records.	3.5 Record keeping	All current patients have pain assessments if required. Monthly nursing audits to capture pain assessments to ensure compliance.	Ward Managers Ward Managers	Complete 28/04/2023
The health board must ensure that outcome measures are clearly recorded in patient records.	3.5 Record keeping	Older Peoples Inpatient Mental Health Service Outcome Measures implementation group to be progressed to identify appropriate outcome measure tool which can then be implemented and embedded into the service, in line with the national work led by Improvement Cymru.	Senior Nurse/Ward Managers	31/07/2023
The health board must ensure that care and treatment plans are signed and patients provided with a copy.	3.5 Record keeping	All care and treatment plans (CTP's) printed in patient's individual notes and signed. Where patients are unable to sign, this would be recorded and shared with families.	Ward Managers	Complete Complete

		Monthly CTP audits to take place, which will be reviewed in monthly ward manager meetings. Compliance against this to be reported through Quality, Safety, Risk & Experience Group meetings.	Senior Nurse Lead Nurse	28/04/2023
The health board must ensure that care plans are regularly assessed and monitored.	3.5 Record keeping	Audit of clinical nursing notes to be undertaken on a monthly basis on both Ward 1 and Ward 2. This process will be reviewed in the minutes recorded in monthly Ward Managers meeting in Angelton Clinic. Nursing note audits will also form part of the monitoring in the monthly Quality, Safety, Risk and Experience meeting	Ward Managers Senior Nurse Lead Nurse	Complete Complete 28/04/2023

The health board must ensure that detailed entries on patients' behaviours are documented.	3.5 Record keeping	Daily records to evidence detailed entries on patients' behaviours and Ward Managers to share good practice examples. Incident logs to be recorded in patient notes and discussed appropriately in ward rounds.	Ward Managers	Complete
The health board must ensure that observation charts are accurately completed and that observations comply with national guidelines.	3.5 Record keeping	National guidelines to be discussed/disseminated in staff meetings. Staff allocation list in place to ensure adherence to national guidelines around enhanced levels of observation and the management of this. Appropriate training to be reviewed and provided if required.	Ward Managers Ward Managers Advanced Nurse Practitioner / Ward Managers / Senior Nurse	Complete Complete 28/04/2023

The health board must ensure that meetings are recorded, and minutes can be produced when requested.	Governance, Leadership and Accountability	Minutes taken for monthly meetings which are to take place for patients and staff. Carers meeting to take place three monthly.	Ward Managers Senior Nurse	Complete 28/04/2023
The health board must ensure that regular supervision takes place.	7.1 Workforce	3 monthly supervisions to be put into place. (Evidence attached anonymised to maintain confidentiality). Compliance against this to be measured in monthly ward manager meetings.	Ward Manager Senior Nurse	Complete Complete
The health board must ensure that appraisals are regularly completed.	7.1 Workforce	PADR compliance to be above 85% (excluding Long Term Sick Leave)	Ward Managers	28/04/2023

		Compliance measured through monthly workforce meetings	Senior Nurse/Lead Nurse	28/04/2023
The health board should undertake a training needs analysis to ensure that staff are having the correct and appropriate training for their roles.	7.1 Workforce	CTM Mandatory training needs analysis / review to be undertaken and reflected on ESR	Lead Nurse	28/04/2023

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Sophie Bassett, Lead Nurse, Mental Health Services, Bridgend