Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Pine and Ash Wards, Hafan y Coed Mental Health Unit, University Hospital Llandough, Cardiff and Vale 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 Hafan y Coed Mental Health Unit, University Hospital Llandough, Cardiff and Vale University Health Board on 09, 10 and 11 January 2023. The following hospital wards were reviewed during this inspection:

- Pine Ward - 12 beds providing in-patient detoxification services for adult patients
- Ash Ward – 11 beds providing neuropsychiatry services for adult patients.

Our team for the inspection comprised of three HIW Healthcare Inspectors, two clinical peer reviewers and Mental Health Act peer 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:
All patients who completed a HIW questionnaire rated the care and service provided by the hospital as either very good or good. 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 patient group.

This is what we recommend the service can improve:

- The health board must ensure that patients adhere to the Welsh Government smoking legislation in the hospital
- The cigarette butts in the raised planters in the garden area of Pine must be removed and the garden maintained for patient use
- A process should be put in place to engage patients and carers in order to gain feedback of their experience on the wards
- All patient bathrooms must have appropriate privacy doors fitted to protect patient privacy and dignity
- Patient specific language and communication needs should be reviewed to ensure effective, accessible, appropriate and timely communication is tailored to the needs of each individual patient.

This is what the service did well:

- We found sufficient and appropriate recreational and social activities provided on the wards for patients
- Both wards provided a calm, therapeutic environment for patients in keeping with their needs.

Delivery of Safe and Effective Care

Overall summary:
We found that staff were committed to providing safe and effective patient care. Various 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. However, we found that some improvements were required in respect of infection prevention and control, training compliance and medications management, to ensure staff and patient safety. Mental Health Act records contained good evidence of visible advocacy involvement in patient care. Patient Care and Treatment Plans and

Addictions Care Plans were well organised and easy to navigate, but we observed that the quality of the care plans was variable across the wards. Improvements were required in respect of governance and record completion.

Immediate assurances:

We examined staff training records, staffing rotas and incident forms. We noted that overall staff compliance with Strategies and Interventions for Managing Aggression (SIMA) training was 51 per cent on Ash ward and 70 per cent on Pine ward. Following a review of Datix incidents we identified that some staff had been involved in incidents of restraint on Ash ward who were not compliant with their SIMA training. This meant that we were not assured that staff and patients are being fully protected and safeguarded against injury during incidents of restraint.

Further details of the immediate improvements and remedial actions required are provided in Appendix B.

This is what we recommend the service can improve:

- The health board must ensure that working personal alarms are provided for all staff
- The patient practice of placing clothing and bedding on their bedroom doors must be prevented to ensure the safety of patients, staff and visitors
- The security measures for Ash ward must be reviewed and addressed to prevent any potential unauthorised access or egress via the Day Unit, to ensure the safety of patients, staff and visitors
- The clinic rooms on the wards must be maintained appropriately, and medication securely stored
- Medication Administration Records must be consistently signed and dated when medication is prescribed and administered
- Measures should be undertaken to ensure that patient care plans are completed correctly, contain sufficiently detailed information and are individualised to patients.

This is what the service did well:

- Legal documentation to detain patients under the Mental Health Act was compliant with the legislation
- Patients were involved in their Care and Treatment Plans where appropriate.

Quality of Management and Leadership

Overall summary:
We witnessed strong team working on both wards throughout our inspection. All staff members who responded to the HIW questionnaire recommended the hospital as a place to work and agreed that they would be happy with the standard of care provided for their friends or family. The leadership team was approachable and appeared supportive to staff and had a good understanding of patient needs, but some staff told us that working practices could be improved with better visibility and involvement form the senior management team. We saw evidence of good collaborative working across the health board to support improvements and disseminate quick learning from incidents and serious untoward events.

This is what we recommend the service can improve:

This is what the service did well:

- Most staff who completed a HIW online questionnaire agreed they were able to meet the conflicting demands on their time at work
- Staff demonstrated that they had a desire to improve the quality of services and care delivered to patients.

3. What we found

Quality of Patient Experience

We gave HIW questionnaires to patients during the inspection to obtain their views on the service provided at the hospital. In total, we received seven completed questionnaires. All patients who completed a questionnaire rated the care and service provided by the hospital as either good or very good.

Staying Healthy

Health Protection and Improvement
We observed that all patients received a physical health assessment upon admission to the hospital. Following admission, physical healthcare plans documented any required ongoing health promotion and preventative interventions, such as dietician support and access to GPs.

During our evening tour of the wards we found that the environment of care was clean and clutter free. Both wards provided a calm, therapeutic environment for patients in keeping with their needs. Patients had access to their bedrooms, communal lounges and outside garden areas. All patients who completed our questionnaire agreed that they were able to go outside for exercise or wellbeing. We found that within the garden areas of the wards there was evidence of patients smoking on hospital grounds, which contravenes current Welsh Government legislation. The health board must ensure that patients adhere to the Welsh Government smoking legislation on hospital grounds. Furthermore, on Pine ward we observed that there were numerous cigarette butts in the raised planters in the garden area which presented as unsightly and unhygienic. We highlighted this issue to staff during the inspection and we recommend that the area must be cleaned and maintained for patient use.

Most patients who completed a questionnaire agreed that there were sufficient and appropriate recreational and social activities on the wards. It was pleasing to observe that both wards were supported by occupational therapists (OTs) who undertook therapeutic activities with patients. Ash ward had an activities room for patients offering a range of activities including board games, puzzles and art therapy, as well as a pool table for supervised patient use. We saw information notice boards advertising meaningful activities for patients which encouraged them to gather, socialise and utilise physical and cognitive skills.

On Pine ward, the Therapeutic Day Unit (TDU) provided a Therapeutic Day Programme (TDP) which offered specialist addictions support and meaningful recreational activities for patients. The TDP was an asset to the ward, providing opportunities for patients to develop valuable life skills and to connect with community services which assist in their ongoing recovery from addiction. During our inspection, patients on Pine ward told us they would like additional activities on the main ward after their therapy sessions at the TDU. We discussed this matter with staff, and it was pleasing to hear that a table football and a pool table had been purchased for the ward.

During the inspection, we observed that both wards offered limited opportunities for patients to undertake physical exercise. Patients and staff confirmed that there were hospital gym facilities located outside of the wards available for patient use, but there was no information displayed on the wards about how and when each patient could use the gym facilities. We recommend that this information should be displayed on both wards to raise patient awareness and promote a healthy lifestyle.

We observed that Ash ward had an exercise bike available for patient use, but there was no additional gym equipment on the ward. On Pine ward, we saw a small room which offered limited gym facilities for patients. Staff advised us that this gym was not often used by patients because the off-ward hospital gym was better equipped. Patients were given a morning timeslot to make use of the hospital gym facilities but could only visit the gym if a member of staff was available to escort them. If staffing levels were low, patients were not able to visit the gym. We recommend that the current arrangements regarding patient gym access be reviewed, with a view to offering patients more regular access to the gym facilities over a wider time period of the day.

During our inspection, we generally found there was a lack of health promotion information on display on the wards. For example, no information relating to healthy eating and exercise was displayed on the wards. We recommend that health promotion information should be displayed on both wards for patient awareness.

Dignified care

Dignified care

Throughout the inspection, we observed committed and respectful interactions between staff and patients on both wards. Staff demonstrated a caring and understanding attitude to patients and communicated using appropriate and effective language. Staff and patients we spoke with during the inspection, and all patients who completed our questionnaire confirmed that staff listen to patients

and treat them with dignity and respect. Patients we spoke with told us that staff knocked on their door before entering their rooms, which evidences the respect of staff for patient privacy.

During our inspection we generally found that sufficient measures were in place to protect patient privacy. Both wards provided mixed gender accommodation and there were no gender segregation areas on the wards, but each patient had their own room with ensuite shower facilities. We saw an appropriate mix of staff working on the wards who were supportive in meeting the needs of the patient group. It was positive to observe patient needs being met immediately, particularly in relation to patient personal care. However, in one bedroom on Pine ward, we saw that the ensuite bathroom privacy doors were missing and we highlighted this issue to staff. The health board must ensure that all patient bathrooms have appropriate privacy doors to ensure patient privacy and dignity is protected on the wards.

During the inspection we saw that patient bedroom doors 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. It was positive to see that patients could close the vision panels from inside their rooms if they wished. We also saw staff closing the vision panels following observations, which evidences the respect of staff for patient privacy.

Communicating effectively

Daily handover meetings were held for nursing staff to share patient information and to update the multidisciplinary team (MDT) on any concerns, issues or incidents that had taken place the day before. Staff demonstrated a good level of understanding of the individuals they were caring for, and that discussions focused on what was best for the patient. The wards used digital technology as a tool to support effective communication by way of online meetings, telephone discussions and email exchanges to ensure timely patient care.

During the inspection we generally observed effective and sensitive communication between staff and patients, but some improvements were required in respect of how the hospital addresses patient language and communication needs. We saw limited examples of patient information provided in Welsh and English on the wards. Staff advised us that there were no patients who required services in Welsh on the wards at the time of our inspection. However, one Welsh-speaking patient who completed our questionnaire told us that their preferred language was Welsh but that they were not actively offered the opportunity to speak Welsh throughout their patient journey. We further observed that a non-English speaking patient was being cared for at the hospital and this situation caused communication difficulties between the patient and ward staff. Staff told us that the patient had access to an

interpreter and an Independent Mental Health advocate who supported them in relevant formal meetings concerning their care and treatment. We were assured that the patient was receiving good care at the hospital, but it was apparent that there was lack of continuous engagement and support for the patient in their own language consistently throughout the day. We were informed that that the ongoing communication barrier was being addressed informally, by utilising two members of ward staff who spoke the same language to ensure effective communication. However, unless these members of staff were on duty and available, the patient was unable to communicate with staff on an unplanned day-to-day basis, or in any emergency situation. We further learned that relevant information, including the patient's care plan and other documentation, had not been provided to the patient in their own language. We highlighted our concerns to staff during the inspection and we recommend the following:

- The hospital should offer language services that meet patient needs throughout their care
- Relevant patient information should be provided to the patient in their preferred language
- Patient specific language and communication needs should be reviewed to ensure effective, accessible, appropriate and timely communication is tailored to the needs of each individual patient.

Patient information

We generally found a lack of information displayed for patients, families and carers on the wards. It was pleasing to see an organisational staff chart which displayed individual staff names and photographs on Ash ward. However, we were advised that family and carers only enter the visitors room of the ward and not the ward itself, so they would not have access to this information. There was no organisational staff chart displayed on Pine ward for patient, staff and visitor awareness. We recommend that both wards should display up-to-date organisational staff charts in a location where they can be viewed by patients, staff and visitors.

On Pine ward we saw some limited information which included posters for advocacy and drug and alcohol services. However, there was no similar patient information on Ash ward. On both wards we saw that no information was displayed regarding the role of Healthcare Inspectorate Wales, the Mental Health Act, complaints processes nor translation services. Staff advised us that this information was available to patients, but it was not clearly displayed on the wards where it would benefit patients, in a format that would be accessible to patients with communication difficulties or cognitive impairment. The health board should ensure that relevant and up to date patient information is displayed in the communal areas of the wards. Patient information should be provided in an

accessible format for patients with communication difficulties or cognitive impairment.

Timely care

Timely Access

The wards held daily handover meetings to establish bed occupancy levels and to discuss patients care needs. Nursing staff also attended regular multidisciplinary (MDT) meetings in which information was shared to ensure the timely care of patients. We observed that there were many additional meetings and processes that supported the effective care of patients. These included weekly ward rounds, weekly discharge planning meetings and monthly Quality, Safety and Experience meetings. Staff also attended multi-professional Sentinels and Lessons Learned meetings to discuss adverse incidents and near misses in order to identify trends and opportunities for wider organisational learning. We observed that patients were regularly monitored and received timely care in accordance with clinical need.

Individual care

Planning care to promote independence

During the inspection we reviewed the care and treatment plans (CTPs) and Addictions Care Plans (ACPs) of four patients across both wards. Within the care plans there was evidence of comprehensive risk assessments with supportive MDT involvement. The quality of care plan completion was variable across the wards, but it was positive to see that the plans were focused on the individual recovery and rehabilitation of patients. It was evident that patients had been involved in the development of their care plans wherever possible. On Pine ward, patients spoke highly of their involvement in their Addictions Care Plan, stating they had as much involvement in the process as they wanted. We saw evidence of patients, their representatives and community services involvement in the care planning process. All the patients who completed our questionnaire told us they felt very involved or quite involved in the development of their care plan. More findings on the patient care plans can be found in the Monitoring the Mental Health (Wales) Measure 2010: care planning and provision section of this report.

We found that patients on both wards were supported to make their own decisions wherever possible. It was positive to learn that patients on Pine ward attended regular therapy sessions involving external organisations who would support them after discharge. On both wards we observed patients making their own food and clothing choices and maintaining regular contact with family and friends with the support of ward staff. Both wards had visiting rooms for patients to see their families in private. Patients had access to their own mobile phones where

appropriate, and hospital electronic devices were available for virtual patient meetings with friends and family. Patients also had access to a landline telephone room and there were suitable areas where patients could speak privately with staff if required. All patients who completed our questionnaire told us they had had contact with friends or family within the past month. Rooms were also available for patients to spend time away from other patients according to their needs and wishes.

During our inspection we noted that all patients on Pine ward and some on Ash ward were provided with key to their bedrooms based on individual patient risk assessment, which supported their independence.

People's rights

During the inspection, we reviewed four records of patients who had been detained at the hospital under the Mental Health Act. The legal documentation we reviewed was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code). Patients had access to a mental health advocate who can provide information and support to patients with any issues they may have regarding their care. Further information on our findings on the legal documentation is detailed in the Mental Health Act Monitoring section of this report.

We found that satisfactory arrangements were in place to promote and protect patient rights. Regular ward meetings were held to review and discuss practices to minimise the restrictions on patients based on individual patient risks. Patient care was generally consistent in accordance with the patient age group and requirements. The hospital had established policies to help ensure that patient equality and diversity were respected, and their human rights maintained. Reasonable adjustments were in place so that everyone could access and use services on an equal basis. The doors to the main unit and the internal corridors were wide enough to accommodate wheelchair access. A lift was available for use to access the first floor. Mechanical hoists and specialist equipment such as motorised wheelchairs were available to be used by patients where required. Both wards had communal bathrooms with specialist bathing equipment for patients. During our evening tour of Pine ward, we noted that the light in the communal bathroom was faulty, which prevented patients from using these facilities. We were informed that the matter had been previously reported but the light had not yet been repaired. We recommend that the Pine communal bathroom ceiling light be repaired to allow patients to use the bathroom facilities safely.

Listening and learning from feedback

The health board had a process in place where patients could escalate concerns via the health board's Putting Things Right complaints procedure. Senior staff on both

wards confirmed that wherever possible they would try to resolve complaints immediately and share learning from incidents appropriately. However, we found there was no Putting Things Right information regarding the process of making a complaint displayed on the wards. This means patients were not clearly signposted to the complaints process. Patients we spoke to during the inspection told us they would speak directly to staff if they had any concerns or complaints to discuss. Staff told us that they regularly speak to patients to gain their views and to ensure therapies and activities were appropriate. Any complaints from a patient or visitors would be referred to a qualified member of staff for further action. We recommend that Putting Things Right information should be displayed on the ward for the information of patients and visitors.

During our discussions with staff, we learned that there was no official process in place whereby patients could discuss issues and provide feedback. Half of the staff members who completed our online questionnaire disagreed that patient experience feedback was collected and that their organisation acts on concerns raised by patients. Only one member of staff agreed that that they received regular updates on patient experience feedback. All the staff who completed our online questionnaire stated that they did not know whether feedback from patients was used to make informed decisions within the hospital.

During our inspection, we saw no evidence of patient meeting arrangements, feedback forms nor suggestion boxes which would demonstrate that feedback is routinely captured and acted upon as necessary. In the visitor's room of Ash ward, we saw an encased notice board containing outdated patient comments which had fallen from the board into the bottom of the case, leaving the board itself empty. In the visitor's room of Pine ward, the patient information boards displaying health board information, nurse staffing arrangements and a 'how are we doing?' board inviting patient feedback were all entirely empty at the time of our inspection. We discussed this issue with staff and it was positive to note that the Pine board was fully completed prior to the end of our inspection. We recommend that a process be put in place to engage patients and carers to gain feedback of their experience on the ward, and that the patient feedback boards should be kept up to date.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety
We observed that the hospital had processes in place to manage and review risks to help maintain the health and safety of the patients, staff and visitors at the hospital. Patients had call buttons or alarm strips in their bedrooms to alert staff if needed. The environment was generally well maintained, fit for purpose and appropriate for the patient group. All patients that completed a questionnaire told us that they felt safe while at the hospital. All staff who completed an online questionnaire agreed that they were satisfied with the quality of care they give to patients. However, we noted some potential risks to staff and patient safety which required improvement.

During our evening tour of the ward, we found that the electronic door dividing Pine ward and its Day Unit was insecure. Staff initially advised that it was faulty but later confirmed that this was not the case, and that the door had accidentally been left been insecure by staff. We recommend that measures are undertaken to ensure the ongoing security of this door to protect staff and patient safety.

We were assured that there was a sufficient number of personal alarms and access cards for all staff, including bank and agency staff working on the wards. However, we were told that while regular staff were provided with working lanyard personal alarms, bank and agency staff were given a different type of personal alarm. Staff told us that not all of the alarms work and there is no way of testing them. It was concerning to learn that ward staff could not be assured that they were using working personal alarms and the potential risk this posed to staff and patient safety. We were further advised there was no health board policy in place in respect of personal alarms which would provide guidance for staff. The health board must ensure that working personal alarms are provided for all staff. We further recommend that a personal alarm policy is drafted to ensure the safety of staff, patients and visitors.

On Ash ward, we saw good evidence of daily environmental and health and safety checks carried out by an allocated member of staff. However, we noted that these were simply visual checks, and no supplementary documentation was completed as record of the checks being done. Additionally, we did not find evidence of any maintenance requests for remedial work following any issues identified. We recommend that a record of the daily environmental and health and safety checks is made, to ensure any issues identified are raised and addressed appropriately. We further noted that the ligature audit on Ash ward was thoroughly completed

regarding risks and ligature point scoring but provided very little evidence of the action taken to mitigate the risks. The health board must ensure that the ligature audits are fully completed to reflect the risks and any mitigating actions taken.

On Ash ward, we identified an ongoing risk to patient safety in that patients were placing clothing and bedding over their bedroom doors to prevent them from slamming shut. Staff told us the noise caused by the door slamming disturbed and upset the patients. It was concerning to note that this practice presented as a potential fire safety risk in the hospital, and we highlighted this issue to staff during the inspection. We recommend that the health board should seek to find a long-term solution to reduce the sound of the doors closing on Ash ward, and the patient practice of placing clothing and bedding on their bedroom doors must be reviewed and prevented to ensure the safety of patients, staff and visitors on the ward.

During the inspection, we saw that the main ward entrances were secured from unauthorised access, but Ash ward patients had access to an outside garden area which was shared with Ash Day Unit. We noted that the door to Ash ward from the communal garden via its Day Unit was kept unlocked during the day. We were advised that the day unit is staffed throughout the day and that patients from Ash ward who presented as an absconsion risk were supervised whilst using the garden area. Staff stated that they monitor the situation and exercise additional caution, but it was possible that patients could abscond or that unauthorised persons could enter the ward from the garden. It was concerning to note that there was no formal governance process in place in respect of this risk. We recommend that the security measures for Ash ward be reviewed and addressed to prevent any unauthorised access or egress via the Day Unit, to ensure the safety of patients, staff and visitors.

Preventing pressure and tissue damage

We looked at a sample of patient records on both wards and generally found evidence that patients received appropriate physical assessments upon their admission, and ongoing physical health checks including monitoring of pressure areas during their stay. The physical healthcare monitoring included Waterlow risk assessments to help staff assess the risk and prevent patients from developing pressure ulcers.

Falls prevention

We saw that the physical healthcare monitoring of patients included monitoring their risk of falls. We found that the assessments were generally evidenced based and reflected best practice.

Infection prevention and control

All of the patients who completed a questionnaire agreed that the environment was very clean or fairly clean and this was evidenced throughout our inspection. We generally found suitable infection prevention and control (IPC) arrangements in place at the hospital. A range of up-to-date policies were available that detailed the various infection control procedures to help keep staff and patients safe. Regular audits had been completed to check the cleanliness of the environment and compliance with hospital procedures. We saw the wards being cleaned regularly throughout our inspection, and cleaning equipment was stored and organised appropriately. Daily environmental checks were conducted by ward staff, and monthly cleaning audits were completed by IPC team. There was evidence of easily available cleaning products, gloves and PPE. It was pleasing to see that the wards had an appointed IPC lead and staff we spoke to during the inspection demonstrated a good knowledge of IPC.

During the inspection it was positive to see that hand hygiene facilities were available for staff, patients and visitors. We witnessed staff washing hands regularly, including following interventions with patients. However, some staff we spoke to were unaware of the IPC policy and where to find it. We further did not see appropriate signage regarding hand washing and other infection control issues on display during the inspection. We recommend that the health board ensure ongoing staff awareness of the IPC policy and provide adequate signage on the wards in respect of IPC and hand washing.

We found that some IPC improvements were required on both wards during our inspection. During our evening tour of the wards, we noted that the updated guidance regarding the wearing of PPE was not being adhered to. Some staff were observed not wearing masks consistently in clinical areas despite the signage and recent guidance issued by the corporate IPC team advising them to do so. We discussed this matter with nursing staff and it was positive to note that staff correctly adhered to the IPC guidance for the remainder of our inspection. We recommend that the hospital IPC guidance in relation to the wearing of masks on the wards should be reinforced with staff to ensure safety of patients, staff and visitors.

On Ash ward we found that there was a general lack of documentary evidence of cleaning equipment being cleaned after patient use. We saw hoists and bathing equipment which did not display labels or stickers which indicated the date and time the equipment was sanitised, and we highlighted this issue to staff. We recommend that the health board must ensure that communal patient facilities are promptly cleaned and adequately labelled after use, to ensure the safety of patients and staff.

On Ash Ward, we found that the patient fridge in the Activities of Daily Living (ADL) kitchen was dirty and odorous. We raised this issue to staff and we recommend that the communal patient fridges must be regularly cleaned and maintained for patient use. During our tour of Ash ward, we saw drainage panels on the floor of the clinic room and dining room which were sealed with industrial tape stuck to the floors. Staff told us that there was a sewage pipe under the floor and the panels had been taped to prevent drainage odour from escaping into the rooms. We identified this as an IPC issue which prevented the area from being cleaned effectively. We recommend that this issue be rectified to allow for effective cleaning and ensure the safety of patients and staff.

We were advised that the communal patient facilities were in working order on both wards. However, we saw that there was an apparent leak from the washing machine in the ADL kitchen on Ash ward which we highlighted to staff during the inspection. We recommend that the washing machine be repaired on Ash ward for patient use. We further found that the linen room on Pine ward was in an untidy and disorganised state, with patient clothes unlabelled or bagged and strewn about. Similarly, the patient laundry area on Pine was in an untidy state, with unlabelled or unbagged patient clothing scattered on shelves and surfaces.
We recommend that the laundry areas of Pine ward be tidied and maintained for patient use. We also saw that the spout of the hot water dispenser in the Pine lounge was heavily corroded, and we recommend that it must be repaired or replaced to ensure patient safety.

Nutrition and hydration
Our examination of case notes and clinical entries found that patients were supported to meet their individual dietary needs and provided with diets in accordance with their medical needs. We observed that patient nutritional and hydration needs were assessed, recorded and addressed. Diabetes Specialist Nurses were available on site for patients. We saw examples of dietician involvement and of staff appropriately recording patient fluids and food intake. We saw evidence of Malnutrition Universal Screen Tool (MUST) assessments and observed a Speech and Language Therapist (SALT) interacting with patients during the inspection. Comprehensive physical health assessments were undertaken by the ward doctor on admission to the wards. Weight management and monitoring was evident in the patient care and treatment plans we viewed. Patient care plans detailed any swallowing concerns for staff awareness.

Both wards had patient facilities where they could access food and drinks throughout the day. It was positive to note that there were communal areas where patients could store their own food items on the wards. However, on both wards we observed that most of the communal cereals in the dining rooms were kept in unlabelled, undated containers which prevented the expiry date from being

viewed. On Pine ward, we saw one boxed cereal which had an expiry date of September 2022. We also saw some patient food items in the lounge fridge of Pine ward which were opened and unpackaged, so it was impossible to see the expiry dates. We recommend that the communal food on the wards must be regularly checked and labelled appropriately, to ensure patient safety.

During the inspection we observed that staff were supportive of individual patient food choices and were seen to assist and support patients at mealtimes. However, staff told they told us they were concerned about the poor quality of the food served to patients on the wards. Some of the patients who completed a HIW questionnaire and patients we spoke with during the inspection told us that the quality of the food was not good in the hospital. We were advised that the quality and quantity of the food has been the subject of several patient complaints. Staff and patients confirmed that the food choices on both wards were limited, repetitive and of insufficient quantity. We were advised that the hot food served to patients was pre-cooked in the main hospital and then sent to the wards for serving. Menus were not provided in advance for patient awareness, they could only make their food choice when the food arrived on the wards. Only two meal choices were provided in an equal number of each option for the total number of ward patients, on a first-come-first-served basis. There was no alternative option for patients if the more popular choice had had been taken. We were further advised of one recent occasion when no food was brought to patients on the wards from the main hospital, resulting in the patients being provided with snacks in place of a meal. We recommend that the health board must undertake a review of the choice, quality and preparation of patient food provided at the hospital, to ensure that it meets patient satisfaction and dietary requirements.

Medicines management

We observed that relevant policies, such as Medicines Management and Rapid Tranquillisation, were available to staff electronically on computers but were out of date. We noted that the health board's Medicines Management Policy expired in March 2021. Rapid Tranquilisation guidelines were incorporated into the health board's Prevention and Management of Violent and aggressive Situations Procedure which had expired in 2016. The health board must review any out-dated policies and ensure that policies and procedures are kept up to date and reviewed to support staff in their roles.

During our evening tour of the hospital, we inspected the clinic rooms on both wards. We found that the clinic room was well organised on Pine ward. Medications were stored appropriately, and controlled drugs were sufficiently secured within the clinic and treatment rooms. We noted that the fridge alarm in the clinic room was sounding at the time of our inspection, but the matter was

addressed over the course of inspection and the fridge alarm was confirmed to be working correctly on the final day of our inspection.

On Ash ward, we found that the clinic room was cluttered and disorganised. The medication trolley was not fixed to the wall and was insecure in that one of its drawers was unlocked. The drugs fridge was found to be unlocked with medication inside and we saw prescribed medication left out of work surfaces. There were numerous gaps in the fridge temperature check chart and there was no clinical waste bin in the clinic room. We discussed our concerns with staff and over the course of our inspection and it was positive to see that these issues were rectified, and the clinic room was reorganised prior to the end of our inspection. However, no clinical waste bin was provided in the medication room throughout the inspection. The health board must ensure that the clinic rooms on the wards are maintained appropriately, and that medication is securely stored.

During the inspection we saw evidence of regular medication reviews completed during weekly ward rounds. Staff told us that there was good pharmacy involvement with weekly pharmacy medication audits. However, we were advised there were no ward-based audits in place to ensure nursing compliance with medicines management and we recommend that an audit process be put in place in respect of this.

On both wards, medical and nursing staff conducted a regular review of patients on the wards we observed sensitive and appropriate prescribing of medication. We saw examples of good practice on Ash ward in that patients received medication privately in accordance with their needs. On Pine ward it was positive to see specific guidelines being developed to support the prescribing practices. Patients had individualised medication regimes and there were specific patient information leaflets available to support their understanding of these medications. We saw good collaboration between addiction services and the Diabetes Nurse Specialist in reviewing more complex medication regimes.

Overall, we generally found that Medication Administration Records (MAR) were completed adequately, and controlled drugs were administered correctly, according to legislation and guidance. However, some improvements were required in respect of MAR completion. On Pine ward, we reviewed a sample of five patient Medication Administration Records (MAR) and found that in two of the records the Mental Health Act (MHA) status of the patients was not indicated, although one of the patients was detained under the MHA. We also found that the same two MAR charts had an overall total of five missing signatures during December 2022.

On Ash Ward we found several missing signatures within the MAR charts, and some missing counter signatures in the Controlled Drugs (CD) records we viewed. On

discussing the matter with staff they could not confirm whether the medication in question had been administered to the patients concerned. We further found that Consent to Treatment forms were not attached to MAR charts and we highlighted this issue to staff during the inspection. The health board must ensure that MAR charts and Controlled Drugs (CD) records are consistently signed and dated when medication is prescribed and administered. Consent to Treatments forms should be attached to MAR charts and regularly reviewed.

Safeguarding children and safeguarding adults at risk
Both wards provided care to adults only. There were established health board policies and processes in place to ensure that staff safeguarded vulnerable adults, with referrals to external agencies as and when required. Staff had access to the health board safeguarding procedures on the intranet. During the inspection, we viewed samples of safeguarding referrals and spoke to senior staff, who confirmed that staff were aware of the correct procedure to follow should they have a safeguarding concern. During our discussions with ward staff, they were able to show understanding of the All Wales safeguarding requirements and the process of making a safeguarding referral to the Safeguarding Team. Senior staff showed good understanding of their duties and responsibilities in respect of safeguarding the particular vulnerabilities of the patient group.

Patients we spoke with during the inspection told us they felt supported on the ward and able to report any concerns to the ward staff. Advocacy arrangements were in place for patients to raise concerns, and patients were supported by third sector services which could also address any issues they might have.

During the inspection we confirmed that all ward staff would require Adult Safeguarding Training at levels two and three, however, we were not provided with the ward training record compliance which related to the appropriate level of safeguarding training expected for ward staff. Therefore, we could not determine if staff were fully compliant with mandatory safeguarding training.

Medical devices, equipment and diagnostic systems
We found appropriate resuscitation equipment in place on both wards. 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.

Effective care

Safe and clinically effective care
Over the course of our inspection, we looked at the systems and governance arrangements in place to help ensure that staff provided safe and clinically

effective care for patients. There was an established filing system in place for recording, reviewing, and monitoring patient safety incidents. Discussions with staff and evidence obtained during the inspection confirmed that incidents were investigated and managed appropriately. There was a process of incident management and escalation in place to ensure that incident reports were reviewed in a timely manner. Staff confirmed that debriefs take place following incidents and relevant learning was shared with staff verbally and electronically.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents within the unit and the wider organisation. In our discussions with staff, it was reassuring to see that staff felt confident in reporting and raising these issues, which demonstrated professional integrity. All the staff who completed our online survey agreed that they would know to report concerns about unsafe practices and that the hospital encourages them to report errors, near misses or incidents. This culture of reporting should be encouraged and supported by the health board so that staff feel valued in contributing to change and are confident in reporting issues that affect staff and patient safety.

We witnessed therapeutic observations of patients being conducted and recorded correctly throughout our inspection, with good staff coordination and team support. However, we noted that the health board's Observation and Enhanced Engagement Procedure was out of date and the review date was November 2021. Some staff we spoke to during the inspection did not know where to access this policy. The health board must review the Observation and Enhanced Engagement Procedure to ensure staff awareness and patient safety.

It was positive to note that the wards used 'Safewards' as a preventative measure and appropriate strategies were in place to reduce the need for restrictive practices. During our conversations with staff, they showed good understanding of the restrictive practices available to them as well as appropriate preventative measures which can reduce the need for restrictive responses to challenging behaviour. We witnessed positive engagement between staff and patients and saw evidence of restrictive practices being used as a last resort, with thorough monitoring around therapeutic effect and risk, and diversionary tactics in place as a method of de-escalation. It was evident from observations and discussions with staff that challenging behaviours were being managed effectively. However, we found that immediate improvements were required in respect of restrictive practices.

During our inspection, it was identified that some staff had been involved in incidents of restraint who were not compliant with their Strategies and Interventions for Managing Aggression (SIMA) training. We note that there had been ten incidents of restraint on Ash Ward within the last six months, and four of these

had involved staff who were not compliant with their SIMA training. We further noted that some of the ten Datix reports did not correctly and fully record the details of involved staff, so it was not possible to identify if any further incidents of restraint had occurred which involved untrained or non-compliant staff during our inspection. On Pine ward, most of the patients were elective patients who were consenting to the ward restrictions and had signed a contract which outlined the expectations on the ward. We were told that there had been no incidents of restraint on Pine Ward within the last six months prior to our inspection. Because staff had engaged in incidents of restraint who were not compliant with SIMA training, we were not assured that staff and patients were being fully protected and safeguarded against injury. Furthermore, the health board's Prevention and Management of Violent and Aggressive Situations and Psychiatric Emergencies Procedure was out of date; we noted the review date for the policy was 21 February 2016.

Through additional examination of mandatory training compliance, we identified that 51% of staff on Ash ward and 70% of staff on Pine ward were compliant with training courses in Basic Life Support, Advanced Life Support and Automated External Defibrillator. Because of the low level of staff compliance with these training courses, we were not assured that staff and patients were being fully protected and safeguarded on the wards.

Our concerns regarding this issue 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. Further information on the improvements we identified, and the actions taken by the health board, are provided in Appendix B.

Quality improvement, research and innovation

During our inspection we were provided with many examples where the Senior management were reviewing the provision of service on the wards and the wider health board with a view to improving patient care. There were various meetings held to identify issues, points of learning, themes and trends in order to share information with staff. It was positive to hear the future plans for both wards during the inspection. The identity of Pine ward was being re-established solely as an Addictions Unit following a period during which the ward had also cared for different patient groups. Ward staff spoke warmly about the ongoing decorative and environmental improvements on the ward which aimed to improve the patient experience. On Ash ward, senior staff spoke passionately of the wider ongoing business plan to transform and expand the Welsh Neuropsychiatry Service into a national liaison service which will work closely with partners to develop pathways that provide an equitable Neuropsychiatric rehabilitation service to patients across Wales.

We were pleased to learn of recent staffing appointments in Education and Quality which provide additional oversight of nursing governance, training and staff development. We noted the future Adult Directorate plans to create an inpatient senior management post within the hospital which will have complete oversight of the services provided on all wards at Hafan Y Coed.

During our inspection we learned that the MHA Team has put forward an initiative to appoint MHA champions on each ward at Hafan Y Coed and we recommend that that active consideration is being given to this.

Record keeping

We generally found well-organised paper and electronic records completed on both wards, which were easy to navigate through clearly marked sections. Records were easy to find and accessible to all staff. However, we noted that information was recorded on two separate patient health record systems which could cause confusion for unfamiliar staff. We recommend that measures are taken to ensure that patient information is recorded on one patient health system to avoid confusion or duplication.

During our evening tour of the wards, it was positive to observe that Patient Status at a Glance Boards were mounted in the secure nursing offices of the wards in a position where they could not be seen from outside, which protected patient confidentiality. Paper records were adequately secured in nursing offices, while electronic notes were password protected within the Patient Record Information System (PaRIS). In this way, we were assured that patient privacy and confidentiality was protected.

However, we noted that the health board's Patient Records Management Procedure (including retention and destruction schedule) expired in August 2021. The health board must review this policy to ensure compliance with legislation and provide clear guidance to staff.

Mental Health Act Monitoring

It was pleasing to learn that there is an effective Mental Health Act Team at Hafan Y Coed which comprises a Mental Health Act Administrator, a deputy Mental Health Act Administrator and additional administrative support assistants. We found that all these staff members were highly motivated and appropriately trained in all areas of the Mental Health Act (MHA). The team provided valuable training to ward staff and to Mental Health Review Panel members.

We examined four records of patients who were detained under the Mental Health Act and found that legal documentation to detain patients under the Act was

compliant with the MHA and Code of Practice. Robust monitoring and audit processes were in place in relation to MHA documentation. Overall, the records we viewed were well organised, easy to navigate and contained detailed and relevant information. Patients were legally detained, and the documentation supported this. There was good evidence of Independent Mental Capacity Advocate and Independent Mental Health Advocacy involvement in patient case work. It was positive to learn that when MHA document completion issues had previously been identified at Hafan Y Coed, the Mental Health Team had good governance oversight of the situation and had put training processes place to share learning and prevent reoccurrence.

During the inspection we noted that section 17 leave forms were completed appropriately, conditions of the leave were clearly outlined and patient risks were broadly assessed within the patient Care and Treatment Plans (CTPs).

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

Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010. We reviewed a sample of Care and Treatment Plans (CTPs) and found that they were completed in accordance with the Mental Health (Wales) Measure 2010. We also reviewed a sample of patient Addictions Care Plans (ACPs). The records were well organised and easy to navigate via the PaRIS electronic health record system. It was pleasing to see that the care plans were person-centred, with evidence of patient and family involvement where appropriate. To support patient care plans, there was an extensive range of assessments to identify and monitor the provision of patient care, along with risk assessments which set out the identified risks and how to mitigate and manage them. Multidisciplinary team (MDT) participation was evident across both wards and included the involvement of external agencies where required. Discharge planning and preparation was evident on both wards, and this included community professionals and resources appropriate to the patient. Advocacy services were available to patients on both wards. However, we found that the quality of the care plans was variable across the wards and some improvements were required in respect of care plan completion.

On Ash ward, the CTPs contained insufficient information which did not clearly outline the patient interventions and rationale behind them. Some areas of the CTPs were comprised of only a few sentences, which could result in confusion and misunderstanding by unfamiliar staff. Due to the lack of information within the CTPs we were not assured that any unfamiliar or irregular ward staff members would be able to provide the most appropriate patient care. We further did not see evidence that patients were provided with copies of their CTPs. We recommend that more detailed information be recorded within the CTPS to reflect

patient needs and reasons for interventions in order to ensure safe patient care. We further recommend that patients are provided with copies of their CTPs.

It was positive to see that the Wales Applied Risk Research Network (WARRN) risk assessment process had been introduced to the hospital and within the patient records there was evidence of comprehensive assessments and risk assessment. On Ash ward we saw that WARRN risk assessments were being completed, however it was difficult to determine when they were being reviewed and it was not always clear that the WARRN was being updated in conjunction with the CTP. We saw one CTP in which we could not find evidence of specific physical health assessments being completed within the CTP nor within other domains of the clinical notes. We recommend that WARRN risk assessments are completed and updated in conjunction with the CTPs.

On Pine ward, we found that the completion of the patient Addictions Care Plans was relevant and proportionate to the nature of the admissions and length of patient stays. We found a range of evidence-based assessment tools in the patient records, and it was positive to note a robust approach to the physical health monitoring of patients. However, we found the ACPs lacked individuality in their completion. We saw one ACP on Pine which had clearly been cut and pasted from another patient care plan, as it contained the incorrect patient name and health board references. We recommend that measures are taken to ensure that care plans are correctly completed and individualised to patients.

Within some of the care plans we viewed during the inspection, we found there were inconsistencies between what was recorded in the plans and in risk assessments regarding the observation levels of patients. We recommend that measures must be undertaken to ensure that the information recorded in care plans corresponds to the information recorded in risk assessments, to ensure they do not provide conflicting information which could compromise staff and patient safety.

Quality of Management and Leadership

We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital. In total, we received four responses from staff at the setting.

Staff responses were mostly positive, with all respondents recommending the hospital as a place to work and most agreed that they would be happy with the standard of care provided for their friends or family. Some of the questionnaire results and comments from staff members appear throughout the report.

Governance, Leadership and Accountability
It was positive to observe strong team working on both wards throughout our inspection. Staff were respectful of each other and there was a positive approach to team working with clear lines of responsibility for certain tasks. We witnessed positive interactions between staff within the ward and with external professionals visiting.

The staff members we interviewed during the inspection spoke passionately about their roles. Staff told us that they felt supported in their roles and described the leadership team as being approachable. All staff members who completed our online survey agreed their organisation encourages teamwork and that their organisation was supportive and helpful to them.

However, half of the staff members who completed our online questionnaire disagreed that the senior management team was visible to staff and that communication between senior management and staff was effective. Half of the respondents told us that they did not feel that senior managers try to involve staff in important decisions. Some staff we spoke to during our inspection advised us that they felt that working practices would be improved with better visibility and involvement form the senior management team. In our online staff questionnaire, we asked how the setting could improve the service it provides and received the following response:

> *"Senior management (not ward manager) should be more visible and share decision making with the staff to ensure cohesive and effective work. Offer more staff and patient feedback to help improve the service. Listen and act appropriately when staff raise concerns about other staff members"*

Senior staff we spoke to during the inspection confirmed that there are regular health board wide staff surveys to obtain staff feedback on their experience in the

workplace, and that processes were in place to identify and address any staff wellbeing and welfare issues. We recommend that the health board conduct further discussions with staff to gain their feedback on ways in which the involvement and visibility of the senior management team can be improved on the wards.

During our inspection, it was pleasing to find an effective governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care which supported improvements and shared learning from incidents and serious untoward events. However, we found that some improvements were required in respect of mandatory training compliance governance during our inspection.

Most staff who participated in our online survey agreed that training helped them do their job more effectively and deliver a better patient experience. They further agreed that training helped them stay up to date with professional requirements. However, during our inspection we found that staff had difficulty in retrieving training compliance data and we were not provided with an accurate overall picture of staff mandatory compliance throughout the inspection. We noted that majority of staff training compliance records were monitored on the Electronic Staff Record (ESR) system. However, their SIMA, Basic Life Support and AED training was recorded by other means and did not form part of their overall ESR training compliance score. We were provided with ESR overall training compliance figures which indicated that training compliance was 68% on Pine ward an 77% on Ash Ward. However, the overall compliance figures recorded the ESR system did not display the staff compliance with some mandatory training courses including Safeguarding level 2 and 3, Resuscitation level 2 and Infection and Prevention Control level 2 which would be required. We further noted that some mandatory training courses were marked as 'not required' for some staff on the ESR system which would certainly be required, and in our discussions with staff they could not explain the reasoning for this.

Because we were not provided with accurate mandatory training compliance figures during the inspection, we could not be assured that ward staff were compliant with their mandatory training, nor that there was robust governance oversight in respect of this. We discussed this matter with senior staff who agreed that the ESR system was difficult to operate and that there were often delays in the system which prevented accurate data retrieval. Senior staff advised us that had been challenges with the provision of mandatory training for staff during the Covid-19 pandemic, but that they were now offering regular training sessions for staff. We recommend the following improvements in respect of mandatory training:

- The health board must implement a robust program of governance oversight in respect of mandatory training compliance to ensure that mandatory training is completed, regularly monitored and that staff are supported to attend the training
- Supervisory staff should be trained to utilise the training matrix system so that they can access staff training information and provide oversight of particular training areas
- The training matrix system should be reviewed to ensure that current and accurate training compliance figures can be retrieved, for the effective management of staff training levels and the safety of patients and staff
- The training matrix system should be reviewed with a view to recording all staff training compliance on one system for ease of governance and monitoring.

We discussed these issues with staff during the inspection and were advised that arrangements were ongoing to resolve the training deficiencies of staff. We were further advised that the annual staff appraisal percentage on both wards was approximately 50% and we recommend that efforts must be made to complete these as soon as possible.

During our inspection, we reviewed several health board policies in addition to those not previously mentioned in this report. We noted that the Adult in Patient Sleeping out Guidance policy was still in draft format since our previous inspections of the setting, but we were advised that the policy is in full use and due to be ratified in January 2023. We further noted that the Procedure for NHS staff to Raise Concerns Policy had not been reviewed since 2017. We recommend that any outdated policies and procedures are reviewed and kept up to date in order to provide clear guidance to staff. We were told that ward staff refer to the intranet to access the relevant health board policies, but some staff we spoke to during the inspection did not know how to access the relevant clinical policies, procedures and professional guidelines relevant to their roles. We recommend that all staff should receive additional guidance on where and how they access the most up to date health board policies to support them in their roles.

Workforce

Most staff who completed a HIW online survey agreed they were able to meet the conflicting demands on their time at work. However, staff we spoke to during our inspection, and all staff who completed our online survey, told us there were not enough staff on the wards to enable them to do their job properly. Staff told us:

> *"Staff are taken to cover other areas of the hospital daily. This puts extra strain on those on shift. We are therefore unable to spend as much time with patients"*

"The health board are more concerned with saving money than about safe staffing levels, staff wellbeing, the care patients receive. I suppose what can be expected though when the NHS is run by this current government"

Senior staff we spoke to during the inspection cited low staffing levels as being the biggest challenge of working on the wards, particularly since the COVID-19 pandemic and the ongoing staff absence and sickness which followed. They told us that the ongoing use of bank and agency staff to alleviate the staffing pressures was higher than desired, but robust recruitment processes were ongoing within the hospital and wider health board to recruit into vacant posts.

At the time of our inspection, there were no nursing staff vacancies on Pine Ward. Staff told us that the staffing situation was planned around weekly patient admissions to the unit, with additional bank or agency staff members arranged as necessary. We noted that the health board operates a 'sleeping out' practice where in the event of bed shortages, patients are required to spend a night on another ward. We reviewed current sleeping out arrangements for patients sleeping out on Pine Ward and noted that that the restrictions placed upon patients were individualised and care planned appropriately, with consideration for the impact on the rights of individual patients in accordance with the Sleeping Out Policy. However, staff we spoke to during the inspection expressed their concern at the risks posed and the additional workload presented by them having to care for detained Sleeping Out patients from acute mental health wards who were routinely placed on Pine ward, which is a less restrictive detoxification ward for informal patients. Staff advised us that this situation placed additional pressure on staff and other patients on the ward in terms of staff numbers, skills and training. We recommend that the health board undertake measures to ensure that a sufficient number and skill mix of staff are provided to manage the additional demands of caring for sleeping out patients as appropriate.

We were advised that there were 0.6 registered nurse vacancies and 2.96 Healthcare Support worker vacancies on Ash Ward. Recent staff sickness had created additional pressure for staff, but the ward was sufficiently staffed at the time of our inspection. We recommend that the health board should actively continue to recruit permanent staff into vacant posts in on the wards.

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
During our inspection we found the clinic room on Ash ward was cluttered and disorganised. The medication trolley was not fixed to the wall and was insecure, with one of its drawers unlocked. The drugs fridge was unlocked with medication inside and prescribed medication was left out of work surfaces. There were numerous gaps in the fridge temperature check chart and there was no clinical waste bin in the clinic room.	Because medication was not securely and safely stored, we were not assured that patients were not at risk of harm	We discussed our concerns with staff	Over the course of our inspection it was positive to see that these issues were rectified, and the clinic room was reorganised prior to the end of our inspection. However, no clinical waste bin was provided in the medication room throughout the inspection.

Appendix B - Immediate improvement plan

Service: Hafan y Coed - Ash and Pine Wards

Date of inspection: 9, 10 and 11 January 2023

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
During the inspection we examined staff training records, staffing rotas and incident forms. We noted that overall staff compliance with Strategies and Interventions for Managing Aggression (SIMA) training was 51% on Ash ward and 70% on Pine ward. Through a review of Datix incidents it was identified that some staff had been involved in incidents of restraint on Ash ward who were not compliant with their SIMA training. We found four Datix incidents of restraint involving non-compliant				

staff on Ash Ward within the past six months but noted that some Datix reports did not fully record the details of involved staff. Because staff had engaged in incidents of restraint who were not compliant with SIMA training, we were not assured that staff and patients are being fully protected and safeguarded against injury.

Furthermore, the health board's Prevention and Management of Violent and Aggressive Situations and Psychiatric Emergencies Procedure was out of date; we noted the review date for the policy was 21 February 2016.

Through additional examination of mandatory training compliance, we identified that 51% of staff on Ash ward and 70% of staff on Pine ward were compliant with mandatory training courses in Basic Life Support, Advanced Life Support and Automated External Defibrillator. Because of the low

level of staff compliance with these mandatory training courses, we were not assured that staff and patients are being fully protected and safeguarded on the wards. The Health Board must:				
Ensure that all staff are compliant with Strategies and Interventions for Managing Aggression training		A review has been undertaken to identify the staff that are out of compliance with the SIMA training on Ash and Pine wards to prioritise attendance on training. Additional training dates have been made available to fast track these members of staff dependant on rotas. Staff will also be offered overtime or time owing to attend in their own time when it is not possible to be released from the rota! A review of compliance with SIMA training will also take place across all areas of Mental Health Clinical Board to prioritise staff attendance on SIMA training where needed The frequency of training sessions is increasing from March 2023 which will	Lead Nurse for Adult MH/Lead Nurse for MHOP	April 2023

		allow greater accessibility to training SIMA training compliance has been included on ESR to support improved monitoring		
Provide assurance that staff and patients will be fully protected to ensure only staff that are compliant with their Strategies and Interventions for Managing Aggression training are involved in incidents of restraint		In the interim whilst addressing training compliance consideration will be given to ensure that SIMA trained staff are available on each shift to ensure where possible trained staff only participate in this procedure. Staff will also be reminded through email and safety briefing at handover.	Senior Nurse for Adult Mental Health/MHOP	Complete/ongoing
Ensure that the details of all staff involved in restraints are fully documented in Datix reports		All incidents of restraint are recorded in detail on Datix and are reviewed on a regular basis by the senior nurse. An audit will be undertaken to evaluate the quality of details provided on Datix	Senior Nurse for Adult Mental Health/MHOP	March 2023
Ensure that all staff are compliant with mandatory training courses in Basic Life Support, Advanced Life Support and Automated External Defibrillator		Basic life support which includes training for Automated External Defibrillator is provided during the SIMA training. Advanced life support is not a mandatory requirement for these areas, however senior clinical staff attend Intermediate life support training. In addition to fast	SIMA Lead Nurse	March 2023

		tracking staff through SIMA training, we will also provide additional Basic Life Support training on Ash and Pine Ward to maintain patient safety		
Ensure that the Prevention and Management of Violent and Aggressive Situations and Psychiatric Emergencies Procedure is reviewed to provide clear guidance to staff.		There is a wider piece of work in progress evaluating all policies, guidance and strategies in Mental Health Clinical Board. This includes 'Prevention and Management of Violent and Aggressive Situations and Psychiatric Emergencies Procedure'. To ensure that we maintain patient Safety this procedure will be discussed in next Controlled Documents and Polices Group to evaluate if the procedure remains in line with best practice and consider any interim measures that may be needed to mitigate any risks to staff and patients.	Director of Nursing for Mental Health Clinical Board	February 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): Mark Doherty

Job role: **Director of Nursing for Mental Health Clinical Board**

Date: **19 January 2023**

Appendix C - Improvement plan

Service: Hafan y Coed - Ash and Pine Wards

Date of inspection: 9, 10 and 11 January 2023

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 patients adhere to the Welsh Government smoking legislation in the hospital	Staying Healthy	Due to the complexity related to this recommendation within Mental Health Services, a phased approach is being taken in line with best practice to minimise the risk of any unintended consequences and ensure progress towards a smoke free environment. This includes actions including: Director of Operations Clinical 1. Engagement with patients regarding smoking cessation and co - produced meetings will be arranged with	Director of Operations	May 2023

		patients to provide environmentally safe and recovery focused alternatives. 2. A Patient Group Directive for nicotine replacement therapies has now been approved by the Health Board which will improve availability of Nicotine replacement therapies for patients. 3. Smoking champions have been identified to lead on this work in ward areas to provide direct support to patients who wish to stop smoking. 4. Identity availability of safe vaping products to support patients transitioning from smoking. 5. Smoking cessation training is being tested by two key members of staff who will lead on this. Staff will be enrolled on to the training once the leads have clarified the numbers and commitment required. Environmental		Complete Complete May 2023 May 2023

		6. Ferrous sensors are being procured. These support the staff to detect hidden ignition sources to prevent covert smoking and consequently, unwanted fire notices and the risk of deliberate or accidental fires. 7. A speaker broadcasting an automated message is due to be installed at the front entrance of hospital to discourage smoking May 2023 Procurement tender by April 2023 Procurement tender by April 202 3 8. Removal of all smoking shelters by Estates on completion of actions.		Procurement tender by April 2023 Procurement tender by April 2023 By September 2023
The cigarette butts in the raised planters in the garden area of Pine must be removed, and the garden maintained for patient use	Staying Healthy	The area has been cleaned, a cleaning schedule created and receptacles for cigarette butts has been provided during the transition period to a smoke free unit continues.	Estates and Ward Manager	April 2023
The current arrangements regarding patient gym access should be reviewed, with a view to offering patients more regular	Staying Healthy	Availability and access arrangements to the gym will be explored and a detailed information leaflet will be developed to inform all relevant	Directorate Manager, Adult Mental Health	April 2023

access to the gym facilities over a wider time period of the day		patient groups of what is available to them and can use to its fullest extent. Staffing for the area is provided by CD&T Clinical Board. This work was discussed at the Q&S meeting in April.		
Health promotion information should be displayed on both wards for patient awareness.	Staying Healthy	Review of all relevant health promotion material to be conducted, sourced and displayed prominently in all wards.	Lead Nurses, Adult Mental Health and MHSOP	April 2023
		Information for relatives and patients in ward lobbies has been updated.	Ward Manager	Completed
		A roll-out of Releasing Time to Care across Hafan Y Coed is planned, this is an evaluation over a 6-week period of all patient information available, ward ergonomics and exploration of which activities give quality and which can be scaled back.	Nurse Development Office	Completion of first round - May 2023
		Viewpoint patient feedback and experience device has been reinstalled	Lead Nurse Adult Directorate	Completed

		and rotated round wards. Order for anchor points to facilitate this.		
The health board must ensure that all patient bathrooms have appropriate privacy doors to ensure patient privacy and dignity is protected on the wards.	Dignified Care	A maintenance request has been raised, and the Estates Department will replace the missing door.	Ward manager	March 2023
The hospital should offer language services that meet patient needs throughout their care	Communicating effectively	The UHB have several different methods for accessing interpreters for patients. Ash ward use a face-to-face interpreter service frequently on the ward which can be used within the day. For more urgent requirements Language Line can be accessed when required at key points of care. Language Line information for patients will be displayed on wards to ensure	Ward Manager	March 2023

		that they are aware of the services that are available to them. The care and treatment plan is also being translated.		
Relevant patient information should be provided to the patient in their preferred language	Communicating effectively	One Care and Treatment Plan awaiting return of Polish translation.	Ward Manager	March 2023
Patient specific language and communication needs should be reviewed to ensure effective, accessible, appropriate and timely communication is tailored to the needs of each individual patient	Communicating effectively	This review of patient information has been undertaken. Translators are booked for clinicians to communicate with patients on ward rounds and other key occasions. Language Line is available for more urgent situations or out of hours. Speech and Language Therapists are also available to Ash Ward. Diverse Cymru have been commissioned to provide training for diversity awareness for the implementation of Black and Ethnic Minority Mental Health Good Practice Certification Scheme and will be rolled-out for staff within Mental Health Clinical Board.	Ward manager	Initial review complete September 2023

Both wards should display up-to-date organisational staff charts in a location where they can be viewed by patients, staff and visitors	Patient information	Information boards have been updated in ward lobbies. Organisational charts will be developed and displayed in visitor areas as well as patient only areas.	Ward Managers Lead Nurses, Adult Mental Health and MHSOP	Complete April 2023
The health board should ensure that relevant and up to date patient information is displayed in the communal areas of the wards including health promotion, the role of the HIW, Mental Health Act information, how to raise a complaint and translation services. Patient information should be provided in an accessible format for patients with communication difficulties or cognitive impairment	Patient information	Information boards have been updated in ward lobbies. A review will take place of all relevant patient information, the required information will be sourced and displayed prominently in all ward areas.	Ward Managers Lead Nurses, Adult Mental Health and MHSOP	Complete April 2023
The Pine communal bathroom ceiling light must be repaired to allow patients to use the bathroom facilities safely.	People's rights	A maintenance request has been submitted to the Estates Department to repair/replace the ceiling light.	Inpatient Operational Manager	March 2023

A process should be put in place to engage patients and carers to gain feedback of their experience on the ward, and that the patient feedback board should be kept up to date	Listening and learning from feedback	The “Good feedback” Viewpoint push button system has been installed. Feedback from patients is discussed in the monthly Q&S meetings.	Directorate Team	Complete
		A directorate workstream will be developed to focus on patient experience, feedback, monitor completion of any actions and evaluate and address any emerging themes.	Director of Mental Health Nursing	May 2023
		The Clinical Board will work with the Lead for Co-production and Caniad (commissioned service user and carer representatives) to develop a process for gathering and processing patient and carer experience feedback.	Director of Mental Health Nursing	May 2023
Putting Things Right information should be displayed on the ward for the information of patients and visitors	Listening and learning from feedback	Information boards have been updated in ward lobbies with PTR information.	Ward Managers	Complete

Measures must be undertaken to ensure the security of the door dividing Pine ward and its Day Unit	Safe Care	Daily checks of the security door have been added to the ward daily checking schedule to ensuring all staff are aware of the override key on keychains.	Ward Manager	Complete
The health board must ensure that working personal alarms are provided for all staff. We further recommend that a personal alarm policy is drafted to ensure the safety of staff, patients and visitors	Safe Care	An audit to be undertaken of all current alarm devices in all in-patient areas. Any faulty devices will be replaced immediately where necessary. Checking of personal alarm systems also been added to the daily schedule of the 'safe to start' checklist. A personal alarm policy/protocol will be developed which will provide clear information to staff regarding the appropriate use, maintenance and safety checks required regarding personal alarm systems. This will go through the Controlled Document Process meeting for ratification.	Directorate Managers, Adult Mental Health and MHSOP Lead Nurses, Adult Mental Health and MHSOP Lead Nurses, Adult Mental Health and MHSOP	April 2023 Complete June 2023

The health board must ensure that the ligature audits are fully completed to reflect the risks and any mitigating actions taken	Safe Care	Risk mitigation has been included in the audit documentation and risk assessment for ligature audits and a report has been sent to H&S.	Ward Managers	Complete
		The audit results are reviewed by the directorates, any risks identified are escalated to the directorate management team and added to the risk register, depending on the level of risk this may also be escalated to the Clinical Board and added to the Corporate Risk Register. Decisions are supported by the Observation Policy, Daily Environmental Checks and Ligature Risk Policy for Hafan Y Coed.	Ward Managers	April 2023
		Completed ligature audits will be transferred to the AMaT system which will enhance oversight of the audit and monitoring of progress and completions actions.	Ward Managers	April 2023
		Initial discussions have taken place between the Mental Health Clinical Board and the Estates Department to	Mental Health Clinical Board	Complete

		evaluate available options around minimising environmental risks. This work is ongoing.		
The health board should seek to find a long-term solution to reduce the sound of the doors closing on Ash ward, and the patient practice of placing clothing and bedding on their doors must be reviewed and prevented in order to ensure the safety of patients, staff and visitors	Safe Care	A meeting has taken place with the Estates Department to explore solutions available, A meeting has also taken place with an external company to look at alternative doors and closers. The directorate manager is to meet with the Estates Department for an update. To ensure the safety staff and visitors the use of bedding or other artefacts to prevent doors from closing has been stopped and shared with staff via the safe to start meetings.	Directorate manager Directorate manager Ward Managers	Complete March 2023
The security measures for Ash ward must be reviewed and addressed to prevent any unauthorised access or egress via the Day Unit, to ensure the safety of patients, staff and visitors.	Safe Care	Review of the security measures has taken place, and conversations with the Day Unit Manager. Security doors are now locked at all times. New	Service Manager	Complete

		notices are in place regarding this requirement.		
The health board should ensure ongoing staff awareness of the IPC policy and provide adequate signage on the wards in respect of IPC and hand washing.	Infection prevention and control	Latest IP&C guidance related to (COVID-19) is accessible to all staff via the IP&C page on the UHB intranet site which is regularly updated by the IP&C Department. All staff will be reminded to ensure that they are familiar and up-to-date with the guidance. Infection Prevention and Control Policy to be disseminated throughout nursing governance structures and to all wards. Discussions to take place between the Lead Nurses and IP&C team regarding undertaking IP&C audits and agree an appropriate schedule of audit to be added to Tenable or AMaT depending on requirements.	Ward Managers Director of Nursing Mental Health Lead Nurses, Adult Mental Health and MHSOP	Complete March 2023 March 2023 April 2023

		IP&C and hand washing signage/posters to be updated and distributed in the appropriate areas.	Directorate Managers, Adult Mental Health and MHSOP/IP&C team	March 2023
The hospital IPC guidance in relation to the wearing of masks on the wards should be reinforced with staff to ensure safety of patients, staff and visitors.	Infection prevention and control	Staff have been reminded regarding the importance of adhering the latest guidance on wearing PPE by email and on daily handover. This Is also accessible via the UHB IP&C intranet page. Memorandum to be distributed reminding staff of current PPE requirements, and spot checks to be undertaken.	Ward Managers Director of Nursing / Lead Nurses	Completed March 2023
Communal patient facilities must be promptly cleaned and adequately labelled after use, to ensure the safety of patients and staff.	Infection prevention and control	Discussion has taken place with Infection Prevention and Control. Labels/Stickers have been ordered. Spot checks will take place as part of the daily checks to ensure compliance.	Ward Managers	Complete
The Pine hot water dispenser must be repaired or replaced to ensure patient safety.	Infection prevention and control	Maintenance request has been submitted to the Estates Department.	Ward Manager	March 2023

The communal patient fridges must be regularly cleaned and maintained for patient use	Infection prevention and control	New cleanliness monitoring sheets have been developed are now in use to ensure the cleanliness of the communal areas, this has also been added to the daily check list.	Ward Managers	Complete
The industrial tape stuck to the drainage panels in the clinic room and dining room of Ash ward must be removed and the drainage issue addressed to ensure effective cleaning and to protect the safety of patients and staff	Infection prevention and control	A maintenance request was raised and the Estates Department replaced tape. Second maintenance request was raised 23/2/23 to make fix more permanent.	Ward Manager Ash	March 2023
The washing machine must be repaired on Ash ward to ensure patient safety.	Infection prevention and control	Washing machine has been repaired and is in full working order.	Ward Manager	Completed
The laundry areas of Pine ward be tidied and maintained for patient use.	Infection prevention and control	The laundry room has been tidied and is on a daily schedule of checks to ensure this is maintained.	Ward Manager	Completed
The communal food on the wards must be regularly checked and labelled appropriately, to ensure patient safety.	Nutrition and hydration	Food storage containers are now labelled with regular checks completed by kitchen staff.	Ward managers	Completed

The health board should undertake a review of the choice, quality and preparation of patient food provided at the hospital, to ensure that it meets patient satisfaction and dietary requirements.	Nutrition and hydration	Meeting held with Catering managers. UHL kitchens will be operational in April 23, when a full menu choice will return. In the meantime, a more varied choice has been agreed.	Director of Operations Mental Health Clinical Board	Complete
The health board must review any out-dated policies and ensure that policies and procedures are kept up to date and reviewed to support staff in their roles.	Medicines management	The process for oversight, scrutiny and ratification of all controlled documents, to be reinstituted. The Medicines Management Code Policy is currently under review and will be subject to the UHB policy and ratification process.	Director of Nursing, Mental Health Senior Nurse for Medicines Management	Completed June 2023
The clinic rooms on the wards must be maintained appropriately, and that medication must be securely stored.	Medicines management	Locks have been installed where required. An audit of medicines management and storage has been undertaken and added to the ward audit schedule on Tendable.	Lead Nurse MHSOP Directorate	Complete
Ward-based audits should be put in place to ensure nursing compliance with medicines management	Medicines management	A programme of audits of practice to be rolled out across all in-patient areas, conducted by the Practice Development Nurses.	Deputy Director of Nursing, Mental Health	Completed

		Medicine chart audits are completed by pharmacy – this will be discussed with Pharmacy Lead and added to Tendable ward audit system.		
The health board must ensure that MAR charts and Controlled Drugs records are consistently signed and dated when medication is prescribed and administered. We further recommend that that Consent to Treatments forms should be attached to MAR charts and regularly reviewed.	Medicines management	A MAR charts audit has been completed. MAR chart and CD record compliance are to be incorporated into Tendable audits.	Ward Manager Lead Nurses, Adult Mental Health and MHSO	Completed May 2023
The health board must review the Observation and Enhanced Engagement Procedure to ensure staff awareness and patient safety.	Safe and clinically effective care	The Observation and Engagement Policy is to be reviewed and taken through Mental Health Clinical Board ratification process and disseminated to staff.	Deputy Director of Nursing, Mental	Completed
Measures should be taken to ensure that patient information is recorded on one patient health record system to avoid confusion or duplication.	Record keeping	Staff have been reminded by the lead nurses regarding the risks associated with cut and pasting information into care plans and that this is not in line with best practice. An audit of care	Lead Nurses in Directorates	Complete

		plans has been added to AMaT and the results will be presented at Q&S.		
The Patient Records Management Procedure (including retention and destruction schedule) expired in August 2021. The health board must review this policy to ensure compliance with legislation and provide clear guidance to staff	Record keeping	The UHB The Patient Records Management Procedure is currently in the ratification process which is expected to be completed by the end of April 2023	Directorate Manager for Patient Records/Information Governance Manager	May 2023
More detailed information must be recorded within the CTPs to reflect patient needs and reasons for interventions in order to ensure safe patient care.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	Audit to be completed by the ward manager and lead nurse practitioner on the 10/03/2023.	Ward Manager	March 2023
We recommend that patients are provided with copies of their CTPs.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	The Mental Health Clinical Board will implement an audit of all care and nursing intervention plans, with clear criteria around evidence of co-production, family and carer involvement, incorporation of risk information and individualisation. Where necessary, training and supervision will be provided by the	Director of Nursing, Mental Health	September 2023

		senior nurses for education and quality, and the practice development nurses.		
WARRN risk assessments should be completed and updated in conjunction with the CTPs	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	The Mental Health Clinical Board will implement an audit of all care and nursing intervention plans, with clear criteria around evidence of co-production, family and carer involvement, incorporation of risk information and individualisation. Where necessary, training and supervision will be provided by the senior nurses for education and quality, and the practice development nurses.	Director of Nursing, Mental Health	September 2023
Measures must be taken to ensure that care plans are correctly completed and individualised to patients	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	The Mental Health Clinical Board will implement an audit of all care and nursing intervention plans, with clear criteria around evidence of co-production, family and carer involvement, incorporation of risk information and individualisation. Where necessary, training and supervision will be provided by the senior nurses for education and quality, and the practice development nurses.	Director of Nursing, Mental Health	September 2023

Measures must be undertaken to ensure that the information recorded in care plans corresponds to the information recorded in risk assessments, to ensure they do not provide conflicting information which could compromise staff and patient safety.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	The Mental Health Clinical Board will implement an audit of all care and nursing intervention plans, with clear criteria around evidence of co-production, family and carer involvement, incorporation of risk information and individualisation. Where necessary, training and supervision will be provided by the senior nurses for education and quality, and the practice development nurses.	Director of Nursing, Mental Health	September 2023
The health board should conduct further discussions with staff to gain their feedback on ways in which the involvement and visibility of senior management can be improved	Governance, Leadership and Accountability	Preliminary discussions have taken place for the Mental Health Clinical Board, People Services and Staff Side Representation to work collaboratively to implement a number of "Engagement Workshops" across all grades and disciplinary categories. MHCB will also develop a programme of "Clinical Board Walkabouts" to take place through the year 2023. MHCB will also be guided by the outcome of staff experience surveys conducted by the University Health Board.	Director of Operations, Mental Health and Director of Nursing, Mental Health	December 2023

The health board must implement a robust program of governance oversight in respect of mandatory training compliance to ensure that mandatory training is completed, regularly monitored and that staff are supported to attend the training	Governance, Leadership and Accountability	Mental Health Clinical Board are Working Collaboratively with Education Culture and Organisational Development (ECOD) to undertake a review of the specific requirements for MHCB mandatory training and undertake the necessary modifications to the ESR to ensure that there is oversight of all staff mandatory training and support staff to achieve compliance.	Director of Nursing for Mental Health Clinical Board / ECOD department	June 2023
Supervisory staff should be trained to utilise the training matrix system so that they can obtain the relevant information and provide oversight of staff training	Governance, Leadership and Accountability	A list of SIMA trained staff (including compliance with Basic Life Support and Defibrillator training) is available which will be added to ESR. In addition, SIMA trained staff compliance will be raised with the Health Roster as a safety net (Electronic rostering) to ensure SIMA strained staff are always on shift.	Directorate Lead Nurses Director of Nursing	Complete September 2023
The training matrix system should be reviewed to ensure that true and accurate training compliance figures can be retrieved for the	Governance, Leadership and Accountability	"Mapping" of core training needs and current information on training matrix has been commenced to ensure accuracy and updated where	Lead Nurses for Adult Mental Health and MHSOP, supported by Senior	July 2023

effective management of staff training levels and the safety of patients and staff		necessary. Working collaboratively with ECOD so that ESR can be modified accordingly.	Nurses for Education and Quality	
The training matrix system should be reviewed with a view to recording all staff training compliance on one system for ease of governance and monitoring	Governance, Leadership and Accountability	MHCB are working collaboratively with ECOD to develop a 'how to' guide to view training compliance which can be disseminated to managers.	Director of Nursing	Complete
Annual staff appraisals must be completed for all ward staff	Governance, Leadership and Accountability	MHCB is committed to a 10% per month improvement in appraisal compliance, following a decline over the period of COVID. We will achieve 80% compliance by August 2023.	Directorate Managers, Adult Mental Health and MHSOP	August 2023
Any outdated policies and procedures must be reviewed and kept up to date in order to provide clear guidance to staff	Governance, Leadership and Accountability	The process for oversight, scrutiny and ratification of all controlled documents, has been reinstated. The process of full review and updating of all relevant policies is in progress will take approximately 12 months to complete. High priority policies will be identified and processed first (such as risk assessment, Observations and Engagement Policy)	Director of Nursing, Mental Health	Complete Ongoing December 2023

All staff should receive additional guidance on where and how they access the most up to date health board policies to support them in their roles	Governance, Leadership and Accountability	The Mental Health Clinical Board will work with Corporate Governance and the Communications Department within the UHB to develop an interactive and accessible map of all relevant policies.	Director of Operations, Mental Health/Senior Corporate Governance Office	March 2024
The health board should undertake measures to ensure that a sufficient numbers and skill mix of staff are provided to manage the additional demands of caring for sleeping out patients as appropriate	Workforce	Work is taking place at a national level in support of safe staffing levels. Recommendations that emerge from this work will need to be considered when developing an in-patient staffing establishment that is safe, skilled and therapeutic. The revised in-patient establishment will be submitted to the Executive Board in line with the UHB's Establishment Sign-Off Process. The Outliers Policy has been reviewed and will to be taken to next Controlled Document Group for ratification which will address the issues raised.	Director of Nursing Director of Nursing	July 2023 April 2023
The health board should actively continue to recruit permanent staff into vacant posts in on the wards	Workforce	There is active recruitment process in place throughout the year which includes:	Mental Health Clinical Board	Complete Ongoing

		Generic posts being advertised on a frequent basis. • Mental health specific open days twice a year. • Engagement at national recruitment events and with universities for newly registered band 5's. • Wards with vacancies including Ash and Pine attend the open days to engage with potential students who will be recruited through streamlining. Rolling adverts. • Exit questionnaires are reviewed and management engage with staff prior to leaving wherever possible to evaluate if any measures can be taken for individuals to remain in their roles.		

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: Director of Nursing Mental Health Clinical Board

Name (print): Mark Doherty Job role: Director of Nursing for Mental Health Clinical Board Date: 20/3/23