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15 November 2014

Dear Professor Purt,

Re: Visit undertaken to Ty Llywelyn unit, Bryn y Neuadd hospital, Llanfairfechen on the 4th, 5th and 6th November 2014

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to the Ty Llywelyn unit at Bryn y Neuadd hospital, Llanfairfechen on the 4th, 5th and 6th November 2014.

Bryn y Neuadd hospital is within Betsi Cadwaladr University Health Board (BCUHB) and is located in Llanfairfechan. The hospital houses a learning disability unit, a mental health unit (Carreg Fawr) and a medium-secure unit (Ty Llywelyn).

Ty Llywelyn is a 25 bedded purpose-built unit. The unit has 3 wards: Gwion (Psychiatric Intensive Care, 5 beds), Branwen (Admission and Assessment, 10 beds) and Pwyll (Rehabilitation, 10 beds).

Our visit highlighted areas that are noteworthy and include:

- The positive way staff engaged with the inspection process
- The good rapport we observed between patients and staff
- A very good example of a comprehensive care and treatment plan for patient A on Pwyll ward was seen and reviewed. However, see point 3 for areas for improvement

- The Dialectical Behaviour Therapy[1] (DBT) initiative is to be commended
- The good level of patient involvement in the care planning process
- Positive feedback was received from patients regarding the physical training initiative and trainer
- Some local initiatives had commenced in relation to audit processes.

Our visit also highlighted a number of issues. We provided a verbal overview of our concerns to your senior management team at the end of our visit on 6th November 2014. A summary of these is set out below:

Issue of concern
1. Staff must be available in adequate numbers to facilitate effective patient care. On the night of our visit, there was one registered nurse on duty for each ward, with one of the nurses having responsibility for the whole unit. As a result no registered nurse breaks were taken and there was inadequate registered nurses should an incident have occurred. However, during the previous day shift there were four registered nurses on duty on one ward and this indicated a lack of a structured approach to effectively staff the unit. In addition, a staff nurse was assaulted on 05/10/2014 and needed medical treatment and this left two registered nurses for three wards. Sufficient staffing must be available across the hospital for all shifts to ensure safe care for patients and the safety of staff. 2. There were no printers available on the individual wards for staff to immediately print off essential patient documents/paperwork. This system impacted upon staff's time, whereby printed documents had to be collected from the administration block. As a result, a member of staff had to leave the ward, book out of the unit and collect the print outs, a task reportedly taking approximately 12 minutes at a time. A review of this procedure and availability of equipment is required to find a more efficient system. 3. Five sets of patient care documentation were examined and the following observations were made: a. There was confusion and no clear process in place to locate patient B's next of kin (NoK) details. There was no contact number available, however, the name of the NoK was eventually found b. The monitoring of physical observations for patient B was very confusing and not consistently documented c. Discharge planning needs to be further developed as it lacked

[1] Dialectical behaviour therapy (DBT) is a psychological therapy designed to help people change patterns of behaviour that are not effective, such as self-harm, suicidal thinking and substance abuse. This approach works towards helping people increase their emotional and cognitive regulation by learning about the triggers that lead to reactive states and helping to assess which coping skills to apply in the sequence of events, thoughts, feelings and behaviours that lead to the undesired behaviour.

detail, specifically for patients C, D and B
   d. All areas of the care plan need to be completed for patient C
   e. Care plans for patient C must reflect current levels of observation
   f. The care and treatment plan for patient E lacked detail and must be further developed
   g. There were no details of NoK available on the paper file/electronic system, eventually this was located within the missing persons information
   h. Physical observations for patient E were not routinely recorded when it had been identified as a requirement of the care plan
   i. There were gaps in the medication administration records.

   The above areas identified must be addressed as a matter of urgency.

4. Mandatory training statistics from the SharePoint system highlighted alarming data. Statistics identified that no staff had completed training in manual handling, food hygiene, breakaway techniques, Mental Capacity Act and Mental Health Act 1983 awareness. Compliance rates for other areas were not much better with fire safety 10%, life support 41%, Protection of Vulnerable Adults (PoVA) level 3 at 53% and Restrictive Physical Intervention (RPI) 26%. All staff must complete the necessary mandatory training to ensure patient and staff safety.
   During the feedback session we were told that these statistics were not accurate and staff had completed more training than the statistics showed. However no data was produced to evidence the accurate position of mandatory training for the Ty Llywelyn unit.

5. There was no record of any staff supervision taking place and staff told us that they do not all receive regular supervision. All staff must have supervision.

6. A review of the provision of food is required. The quality, portion size, variety and temperature of the food was negatively commented upon. Patients and staff told us that food can wait on the food trolley for up to 40 minutes before it gets served, resulting in food that has gone dry and that looks very unappetizing.

7. A sample of 5 staff files were examined and the following observations were made:
   a. Files were not always updated. One employee had started in November 2013 but the paper file contained no information
   b. The front sheets on files need to be amended to reflect the information that is computerized and would not be found on file
   c. Some information was filled under wrong headings, for example qualifications were filed under discipline and grievance
   d. The files generally required updating and reviewing.

   The issues highlighted above need to be addressed.

8. Staff morale was generally low and staff told us of feeling undervalued, not

supported, unfairness of decisions and inaction with issues raised. Staff morale must be improved.

9. Staff felt that equal value was not given to all disciplines at multi disciplinary team (MDT) meetings. A review of the MDT process is required to ensure every discipline represented is treated fairly and equally within MDT meetings.

10. Some issues were reported in terms of patients accessing General Practitioner time to receive adequate physical care. An urgent review of GP cover is required to ensure that patients receive effective physical care and treatment.

Wider BCUHB Issues;

11. There were a significant number of Consultant (Responsible Clinician) and Senior House Officer vacancies within the mental health/learning disability clinical programme group. A strategy for addressing this area must be implemented.

12. A robust process for the reviewing of essential documents including protocols, policies and procedures must be introduced immediately. The protocol in use at the time of our visit for rapid tranquilisation provided poor guidance. It was out of date, having been due for review in June 2010. A revised document had been drafted in 2013, but no further work had been undertaken and the revised document had not been agreed or issued.

13. A strategic review of the mental health services must be undertaken including the range of services provided and the environment and lack of adequate intensive care suite facilities for dealing with particularly challenging patients. A report on this area is required by the end December 2014.

14. A review of the robustness of audit and governance processes to ensure issues are addressed.

15. A review of the recruitment and retention of staff is required. A number of nursing staff have left during the year and there have been difficulties in filling medical posts.

Mental Health Act Monitoring – The Administration of the Act

We reviewed the statutory detention documents of 5 of the detained patients being cared for on 3 of the wards at the time of our visit. The following noteworthy areas were identified:

- The audits reviewed with regard to the Mental Health Act 1983 (MHA) were followed up with action plans

The following points were identified and need to be included in your action plan:

16. Staff identified some pressures and hassles in getting statutory reports for Tribunals and the Ministry of Justice (MoJ).

17. The integrated files required the divisions for legal materials to be broken down, making it easier to read and locate essential legal information.

You are required to submit a detailed action plan to HIW by **15th December 2014** setting out the action you have already taken as well as that which you intend to take to address each of the above issues. The action plan should set out timescales and details of who will be responsible for taking the action forward. When the plan has been agreed by HIW as being appropriate you will be required to provide monthly progress updates.

On receipt of this letter the Health Board is required to comment on the factual accuracy of the issues detailed and on receipt of your action plan, a copy of this management letter, accompanied by your action plan will be published on our website.

We may undertake a further visit to ensure that the above issues have been properly addressed and we will undertake more frequent visits if we have concerns that necessary action is not being taken forward in a timely manner.

Please do not hesitate to contact me should you wish to discuss the content of this letter.

Yours sincerely

Mr John Powell
Head of Regulation

cc – Dr Peter Higson, Chair, Betsi Cadwaladr Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

Professor Matthew Makin, Medical Director, Betsi Cadwaladr Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

Mr Geoff Lang, Director of Primary, Community & Mental Health, Betsi Cadwaladr Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

Dr Giles Harborne, Chief of Staff, Betsi Cadwaladr Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

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