Healthcare Inspectorate Wales

Arolygiaeth Gofal Iechyd Cymru

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health / Learning Disability Inspection (Unannounced)

Royal Glamorgan: Mental Health Unit: Cwm Taf UHB

13 -16 October 2015

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1. Introduction

Our mental health and learning disability inspections cover both independent hospitals and mental health services provided by the National Health Service (NHS). Inspection visits are a key aspect of our assessment of the quality and safety of mental health and learning disability services in Wales.

During our visits Healthcare Inspectorate Wales (HIW) ensures that the interests of the patients are monitored and settings fulfil their responsibilities by:

- Monitoring the compliance with the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards
- Complying, as applicable, with the Welsh Government's National Minimum Standards in line with the requirements of the Care Standards Act 2000 and the Independent Health Care (Wales) Regulations 2011.

The focus of HIW's mental health and learning disability inspections is to ensure that individuals accessing such services are:

- Safe
- Cared for in a therapeutic, homely environment
- In receipt of appropriate care and treatment from staff who are appropriately trained
- Encouraged to input into their care and treatment plan
- Supported to be as independent as possible
- Allowed and encouraged to make choice
- Given access to a range of activities that encourage them to reach their full potential
- Able to access independent advocates and are supported to raise concerns and complaints
- Supported to maintain relationships with family and friends where they wish to do so.

2. Methodology

The inspection model HIW uses to deliver the mental health and learning disability inspections includes:

- Comprehensive interviews and discussions with patients, relatives, advocates and a cross section of staff, including the responsible clinician, occupational therapists, psychologists, educationalists and nursing staff
- Interviews with senior staff including board members where possible
- Examination of care documentation including the multi–disciplinary team documentation
- Scrutiny of key policies and procedures
- Observation of the environment
- Scrutiny of the conditions of registration for the independent sector
- Examination of staff files including training records
- Scrutiny of recreational and social activities
- Scrutiny of the documentation for patients detained under the Mental Health Act 1983
- Consideration of the implementation of the Welsh Measure (2010)[1]
- Examination of restraint, complaints, concerns and Protection of Vulnerable Adults referral records
- An overview of the storage, administration, ordering and recording of drugs including controlled drugs
- Consideration of the quality of food
- Implementation of Deprivation of Liberty Safeguards (DOLS).

[1] The Measure is primary legislation made by the National Assembly for Wales; amongst other matters it makes provision in relation to assessment, care planning and coordination within secondary mental health services.

3. Context and description of service

There is one adult acute mental health in-patient unit for the whole of Cwm Taf based at the Royal Glamorgan Hospital. The unit comprises:

- A 14 bed admission/assessment unit
- 2 x 14 bed treatment wards (Wards 21 & 22)
- A 6 bed Psychiatric Intensive Care Unit (PICU)

Older persons' mental health beds were also at the Royal Glamorgan hospital, consisting of:

- Seren ward – 14 bedded organic mental assessment.
- Enhanced Care Area – 5 bedded ward for enhanced care.
- St David's Ward – 10 bedded functional mental assessment.

The Health Board also provides two dedicated in-patient rehabilitation services which are situated in Treorchy in the Rhondda Valley.

- Pinewood House is a 16 bed Community In-patient rehabilitation service situated on the High Street in Treorchy town centre
- The Supported Recovery Unit is a 15 bed High Dependency service based within Ysbyty George Thomas Hospital in Treorchy.

4. Summary

Our inspection at the Royal Glamorgan mental health unit took place across all seven of the mental heath wards. We found significant scope for improvement but were also pleased to reflect some positive findings. Throughout the visit we observed that staff were very dedicated and were caring towards the patient group.

Following our visit we issued an immediate assurance letter to the health board because of two issues that were a concern to us. The health board has provided a response to us stating the actions they will be undertaking to mitigate the areas HIW had concerns about.

One of the areas of concern was regarding nurse staffing levels. Low staffing numbers was an issue, particularly on the night of our arrival, and this had the potential to compromise patient and staff safety if an incident was to occur. We did observe a member of staff assisting on another ward which meant they had left the ward with one member of staff for 10 patients. The health board has taken immediate action and rostered a healthcare assistant to provide extra support for the two wards.

Significant environmental and maintenance issues were identified which were having an impact upon staff and patients. We found problems with the drainage which was causing particular problems in the toilets and showers, leaving unpleasant smells. We were reassured that the health board is dealing with this issue and we would encourage a quick resolution.

The environment was not conducive to patient wellbeing. The configuration of the environment raised safety concerns for staff and patients, particularly bedroom areas. In addition, we observed no nurse call alarm system in place, missing drawer fronts on some bedroom furniture, bedroom facilities including sinks, toilets and showers that were not working, broken electric sockets and door stops as well as no privacy curtains separating beds in the two-bedded bedrooms. Chips and holes in walls and ceilings were unsightly and windows were being kept open in some rooms by cups and other means.

The environment required attention to make it more conducive to patient well being. The outside spaces, particularly the smoking areas on the Admission Ward and Ward 21 were dirty and unwelcoming. A broken window had a temporary wooden replacement which had been there for a considerable period of time; this in turn had been defaced with writing. This window requires replacing.

The second immediate concern we raised with the health board was regarding ligature points and audits. A number of potential ligature points were identified throughout the wards during our visit. Although it was pleasing to note the investment in new bedroom furniture being installed on the psychiatric intensive care unit (PICU), some of the fixtures on the new furniture were not anti-ligature. The last ligature audit undertaken on the PICU was dated 2013, the other wards ligature audits undertaken within the last year. An immediate ligature audit was required for the PICU, which the health board has undertaken.

It was pleasing to note that the majority of patients we spoke to said they felt safe at the hospital. Therapies and activities were offered to patients both on and off the ward and Occupational Therapy had a regular presence on the wards to encourage patients to participate in activities.

Information for patients was available and visible on the wards, including advocacy, Citizen Advice Bureau and other information leaflets. Patients and staff said that representatives of advocacy services regularly attend the wards.

A review of staff mandatory training highlighted significant gaps in some areas. In addition, the staff mandatory training information available during our inspection was incomplete because the service was in the process of migrating to Electronic Staff Records, which is unsatisfactory. A review and update of staff skills and knowledge is required.

5. Findings

Core Standards

Ward environment

The mental health unit is a self contained unit adjoining the main building of Royal Glamorgan Hospital. The mental health unit has its own entrance and reception, with a number of offices and meeting rooms on the ground floor.

On entering the large foyer, doors lead to a number of areas and wards, including a Psychiatric Intensive Care Unit (PICU) and older person wards. The Admissions Ward and the two adult treatment wards, Ward 21 and Ward 22 are situated upstairs.

The wards upstairs were accessible by stairs or lift. Access to the wards was via an intercom system because the ward doors were locked. The main door to the wards was on Ward 21 and staff would escort visitors to the appropriate ward.

The Admissions Ward was a 14 bedded mixed gender ward. The ward had a mixture of bedrooms including five single en-suite bedrooms and four two-bedded dormitory style rooms. The single bedrooms all had en-suite facilities which included a shower, toilet and sink. The bedrooms had a single bed and storage for clothes and personal belongings. The two-bedded dormitory style bedrooms also had a bed and storage facilities and a shared sink. The sink in one of the rooms we visited had no running water, therefore unusable by the patients. In the same room, a chest of drawers had no drawer fronts and there were some chips in the walls and holes in the ceiling where railings had been recently removed.

There were gender specific toilets and showering/bathing facilities on the ward. One bathroom we viewed had no hoist for the bath; staff confirmed that if a hoist was required for a patient to bathe then the patient would be taken downstairs to use the facilities on the older person ward.

There were two meeting/visitor rooms on this ward. One room had a broken TV which needed to be removed. The other room had chairs, a computer and telephone, which could be used by patients. Throughout our visit we noted that a dirty cup had been left on the floor of this meeting room, which remained there for over two days.

The nurses' station had a patient information board which displayed personal details of each patient. The board was visible by other patients and visitors. A blind was available to cover the board when not in use, however during our visit we did not see the board covered. Patient information boards were also

visible on the other wards we visited at the hospital. In order to respect patients' confidentiality, patient information must be out of view on the wards when not in use.

The ward kitchen, which was locked, had a patient's fridge, toaster, microwave, staff fridge and water boiler. There were some cupboards that required fixing because they had broken doors and at the time of our visit there was an unpleasant smell which appeared to be related to the drainage system.

The patients' lounge had seating for ten patients despite the ward being able to accommodate 14 patients. There were a mix of single chairs and two-seater sofas. A TV was mounted on the wall, a table and the remains of a picture frame, which staff told us had been ripped by patients that day. A book case with a few books was available.

Situated next door was the patient dining-room. The room had a water cooler and four tables and 12 chairs. Patients were able to make their own hot drinks.

A small patio area provided patients with an outdoor space which was mainly used by patients as a smoking spot. The area had a bench, bin and lighter on the wall. The area was dirty and littered with cigarette ends and dirty cups had been left on a window sill. A broken window had a temporary wooden replacement which had been there for a considerable period of time, this in turn had been defaced with writing. This window needs replacing and the area generally requires tidying and upkeep.

Notice boards for patients displayed information, which included advocacy, Citizens Advice Bureau details, Hafal along with other information leaflets and posters. A payphone was situated in the corridor which was working.

Ward 21 and Ward 22 were both 14 bedded mixed gender treatment wards. Bedrooms on both wards offered single, en-suite accommodation as well as two-bedded dormitory style rooms. During the day, double doors which separated the two wards were open to allow patients access across both wards, at night these are locked.

Ward 21 had the main entrance door to all upstairs wards and all the rooms apart from bedrooms were situated along a corridor. The patients lounge provided seating for 13 people and the chairs and sofas were arranged around the edge of the room. A TV was fitted to the wall and a DVD player was connected to it, however cables connecting the devices were not securely concealed. A book case with missing shelves housed some books.

The dining-room had four tables and sufficient seating for the patient group. Tea and coffee facilities were also available for patients to access. A water cooler was situated outside the dining room.

Ward 21 had two outside spaces for patients to use. One was a patio area with seating and a wooden table. Flower pots with flowers in them made the space appear welcoming. The second area was used as a patient smoking space and was as dirty and unwelcoming as the patio area on the admissions ward. A sweeping brush had been left in the area and was moved by staff when we commented on the inappropriateness of the brush left in this area.

Ward 21 had notice boards for patients displaying information of patient support services such as advocacy.

As on the Admissions Ward, the nursing office on Ward 21 had a patient information board which contained personal details of each patient and this was visible to other patients and visitors. Patients' Personal information must be protected and not visible on display for other patients/visitors.

Sufficient storage space was an issue on Ward 21. The non-patient rooms we observed were being used as multi-functional storage spaces for items including Christmas decorations, patient belongings (past and present), condemned mattresses, a wheelchair, old signs and staff coats. The old sluice room might benefit from removing the sink to make extra space. A thorough clean and tidy of these rooms is required to ensure there are no potential fire risks or risks of cross infection/contamination.

We observed similar environmental issues on ward 22 that had been seen on other wards. Specific issues identified that need to be reviewed include:

- the payphone located in the corridor provided no privacy and was missing the handset.
- Notice boards had drawing pins in and these were easily accessible by the patients. An alternative method of attaching items to the notice board must be sought.
- Toilets situated opposite the patient lounge offered little dignity and the lock in the female bathroom was not fit for purpose.

One patient bedroom had significant issues. The toilet and shower in the en-suite were not working, there were no blinds or curtains on the window, an electric socket and door stop was broken, the window would not stay up and the patient had to use cups to keep it open.

The PICU is a six bedded, mixed gender ward. The layout and shape of the PICU bedrooms did not allow for the ease of support or restraint of patients if required. Four of the six en-suite showers and toilet were not working; with

only one additional bathroom on the PICU for up to six patients. This problem had been on-going for a considerable period of time and requires immediate attention.

It was pleasing to note that investment in new furniture had taken place and bedrooms were being up-graded with new cupboards. However, not all fittings on the new furniture were anti-ligature and therefore require replacing.

The mental health unit as a whole had issues with the drains and this problem was noticeable across the unit, with unpleasant smells noted on all the wards. Staff told us they were aware of this issue and it was being dealt with by the health board's estates department.

Recommendations

A review of the environment is required and repairs throughout the unit need to be undertaken to include:

- the payphone on ward 22 needs a replacement handset,
- bedroom furniture with missing drawer fronts need replacing,
- kitchen cupboards on the admission ward need fixing,
- sinks on the admission ward need to be have running water,
- toilet and showers on ward 22 and PICU needs urgent repairing because they were not working,
- blinds and/or curtains were not fitted to some bedroom windows
- an electric socket in a bedroom on ward 22 was broken and requires repair
- door stops in bedrooms were broken
- a review of the window opening mechanisms is required to ensure that windows can be sufficiently opened to allow access to fresh air
- chips and holes in walls and ceilings need to be repaired,
- the broken TV in the meeting room on the admission ward needs removing

- accessible drawing pins on some notice boards needs reviewed to ensure patient safety is not compromised

- the female bathroom lock on ward 22 requires attention to ensure it is fit for purpose

Outside spaces, particularly the smoking areas on the Admission Ward and Ward 21 require attention to ensure they are suitable for the patient group. They need a thorough clean and the safety glass window replaced.

The on-going issue regarding the drains throughout the unit needs to be progressed and solutions implemented to eliminate the unpleasant smells present on the wards.

A review of the storage facilities, specifically on ward 21 is required to ensure the rooms are being used appropriately and not dumping grounds for all equipment, belongings and ad-hoc items.

New furniture on the PICU requires review to ensure that fixtures and fittings are anti-ligature.

Safety

Insufficient nurse staffing numbers were evident on most of the wards during our evening visit. On the first night of our inspection Ward 21 and Ward 22 each had a registered nurse and one healthcare assistant on duty. During this time assistance was required on Ward 22, the healthcare assistant from Ward 21 provided this, leaving Ward 21 with one member of staff for 10 patients. This situation was unsafe for both patients and staff and requires a review to ensure sufficient staffing numbers are on duty.

Discussions with staff also highlighted issues regarding staffing numbers, with staff telling us they felt pressure when they had to cover patients on one-to-one observations, particularly if a patient was presenting in a challenging way. Concerns about the patient mix was raised by some staff, stating that patients with physical ailments required extra care and this was difficult to maintain on some shifts due to the numbers of staff on duty.

We identified a number of vacancies, specifically on the PICU that were in the process of being recruited to. During our visit we noted a number of staff undertaking bank shifts to deal with some of the staffing deficit. It was apparent that although the staff had knowledge of the unit generally, limited information about the patient group was observed, especially patient numbers and in particular any Mental Health Act (1983) sections patients were detained under.

The majority of patients we spoke to told us they felt safe at the hospital and staff had alarms should they need to raise an alert. However, there was no nurse call alarm system in patient bedrooms or patient areas.

A number of ligature points/hazards were visible throughout the wards. Some wards had beds in which ligatures could be attached too; new cupboards fitted on the PICU had handles which could be used as ligature points and piano hinges on the doors in the PICU were low enough to ligature on. The points of ligature audit provided to HIW during the inspection had been last completed and documented in 2013. A ligature point audit is immediately required for the PICU and the health board should ensure that such audits are undertaken regularly or following changes to the patient environment.

The configuration of the environment raised safety concerns for both staff and patients, particularly patient bedrooms. Some rooms were 'L' shaped and narrow and would prove difficult to undertake a restraint safely in these areas.

Recommendations

A review of nurse staffing numbers is required to ensure adequate staff are provided across all wards to ensure the safety and welfare of all patients and staff.

An audit of ligature points is required for the whole unit and the health board must ensure that audits are undertaken in line with the set timescales.

A review of the configuration of all ward environments is required to ensure that patient and staff safety is maintained in all areas, with a particular focus on patient bedrooms.

The multi-disciplinary team

The staff we spoke to commented positively on multi disciplinary team (MDT) working, citing a number of disciplines present at meetings, including, doctors, senior nursing staff, occupational therapy, pharmacy and the community treatment teams. Staff said the MDT work in a professional and collaborative way and professional views were sought and valued.

Ward rounds take place on a regular basis and daily on the Admissions Ward. Some staff said that historically these meetings went on for too long and changes to make them more time efficient had taken place.

Many of the wards, including PICU, did not have a lead consultant. At the time of our visit there were up to four consultants on some wards, each requiring their own ward round meetings. As a result of the number of meetings, some staff said staffing shortages sometimes had been a problem.

A review of consultant engagement would be beneficial to ensure that staff are working most efficiently whilst maintaining continuity of care for patients.

Staff said they regularly attended staff meetings which included daily handover meetings and team away days. Staff across a number of wards told us that daily handover was communicated verbally and staff would write down their own notes and shred them at the end of their shift. This handover system is unacceptable. Comprehensive and documented handover notes must be kept on the wards.

Recommendations

The health board must review consultant input to the wards at Royal Glamorgan Hospital.

An improved handover system must be implemented to ensure all handover information is recorded appropriately and not shredded.

Privacy and dignity

All patients had a bedroom, some had a single, en-suite room and other patients were in a two-bedded dormitory style room. Patients said that on the whole, staff would respect their privacy and dignity and knock on their bedroom door before entering. However, one patient did report that if you were not quick enough to answer staff when they knocked, they would open and enter the room, regardless if you were ready for them to enter your room.

Our review of the environment identified a number of privacy and dignity issues. There were no curtains between beds in a two-bedded room on the admission ward. Therefore, if a patient wanted to undress or change their clothing, there was no privacy for them to do so.

Some patients were able to lock their bedroom doors from inside the room, however, none of the patients we spoke to could lock their bedrooms when they left the room. A number of patients told us that as a result they had valuables go missing which had not been found and/or returned. Staff told us that on arrival all personal possessions are logged and patients are encouraged to give valuables to family for safe keeping. When staff are notified about a lost item, staff complete a search which is documented. If an item has not been found the information is passed to senior staff to decide if reimbursement is required.

It was pleasing to note that patients said they felt safe at the hospital, saying that feelings of being unsafe were often as a result of being unwell. The majority of patients we spoke to said they knew who their named nurse was. Although family and friends could visit their relatives, there was limited space

on the wards for them to have private time. Visitors were not allowed in the bedroom areas, so the dining room, lounge and any visitor rooms were utilised. Some patients said they could go off the ward with their family and friends.

The use of mobile phones by patients was allowed to maintain contact with family and friends. However, those patients with a mobile phone complained about the poor signal in the hospital, with some patients unable to pick up any signal. Patients and staff told us that ward telephones could be used to contact relatives and there were payphones on the wards. At the time of our visit the payphone on ward 22 had no handset and we were told it had been like this for some time. In addition, one patient told us that they had requested to make a phone call but staff had said no and gave no reason for their decision.

Some privacy and dignity issues were identified regarding the mixed gender wards, especially with the showering and toilet facilities on the wards. Ward 22 had toilet facilities situated opposite the patient lounge. Having the toilet so close to the lounge could potentially cause privacy and dignity issues especially if there are visitors in the lounge and if patients require assistance with toileting. The PICU had showering facilities in each bedroom, however four out of six of these were not working; as a result, this limited the facilities for patients (both male and female) with only additional one bathroom on the Ward. Staff told us that the shower issues on the PICU ward had been on-going for at least four years. Consideration needs to be given to reviewing the gender mix on the wards and ensuring that facilities are working.

White boards with patients personal information within the nurses office was visible from outside the nurses office on a number of wards. The information could potentially be seen by other patients and visitors to the wards, therefore the information needs to be protected from view to protect patient confidentiality.

Recommendations

Privacy curtains must be installed between beds in the two-bedded rooms.

A review of the mixed gender wards is required and consideration given to making some wards single gendered.

Patient information boards in the nurses office's need to be covered when not in use to protect the information contained.

Patient therapies and activities

The majority of patients we spoke to told us they had enough things to do and that they had been asked what they like to do. The mental health unit had an area in which patients could access a gym, pool table, arts and crafts and kitchen. On the wards, staff offered patients activities including bingo and told us access to jigsaws and board games were available. However, some patients we spoke to said the games and jigsaws were locked away. It is essential staff make it clear to patients how they can access these items. A pool car was available for the unit and staff told us that they had used it on occasions for community trips, as well as healthcare appointments at the dentist and opticians.

Patients with Section 17 Leave and those who were informal[2] could utilise their time and go outside to walk or go shopping in the local area. We spoke to one patient who attended an educational course at a local college.

During our visit we saw a relaxation session taking place on ward 21. Patients we spoke to who had attended this session told us how beneficial they found it. Some patients told us they had attended the cooking classes in the practice kitchen, which again was commented upon favourably by those patients.

The Occupational Therapy team based at the mental health unit undertook patient assessments, including upon admission, for patients on Admission Ward, Ward 21, Ward 22 and PICU. Occupational Therapy did not provide a service for the older persons' mental health wards, this was provided by a separate health board service. Therapies and activities were offered on the wards including mindfulness[3], cognitive behavioural therapy (CBT)[4] and crafts. Occupational Therapy staff told us that activity and therapy groups change on a regular basis to ensure they are suitable for the patient group.

There was an established full time clinical psychology post dedicated to the in-patient unit. However, at the time of the inspection this post was vacant and in the process of being recruited to. Subsequently at the time of our inspection patients would be referred to a psychologist if input from this service was required.

Access to other services, including dentist, optician and podiatrist were arranged for those patients requiring appointments.

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[2] An informal patient has agreed to come into or stay in hospital voluntarily. They are not being kept in hospital under the powers of the Mental Health Act 1983.

[3] Mindfulness 'is an integrative, mind-body based approach that helps people to manage their thoughts and feelings. It is becoming widely used in a range of contexts. It is recommended by NICE as a preventative practice for people with experience of recurrent depression'. For more information please visit http://www.mentalhealth.org.uk/help-information/mental-health-a-z/M/mindfulness/

[4] Cognitive Behavioural Therapy (CBT) is a talking therapy that can help you manage your problems by changing the way you think and behave.

Staff told us that all patients are referred to the advocacy service through the admission ward. Posters advertising advocacy and Citizen Advice Bureau services were visible on the wards and the majority of patients knew or had used them. Patients and staff said that advocacy were regular visitors to the wards, however staff told us that advocates no longer provide a service on the ward, instead they provide contact numbers to patients so they can telephone for specific information and advice.

General healthcare

A review of the PICU and Seren clinical rooms identified the following:

- The clinic on Seren ward was not fit for purpose because the room was also being used to store linen, patients' property and general equipment
- There was no hand washing facilities in the clinic room on Seren Ward
- Seren Ward's clinic room did not have a stable door. Medication was being administered from the room with the door being held open
- There was no Controlled Drug cupboard in the clinic on Seren ward
- A review of some medicine charts in Seren Wards's clinic highlighted several blank areas

The areas identified need to be reviewed and amended.

Recommendations

A review of Seren ward's clinical room is required to ensure clinical areas are used appropriately and not for storing linen, patients belongings. Hand washing facilities must be available and medication must be administered safely.

Food and nutrition

The majority of patients told us that they enjoyed the food served at the hospital. Patients were offered four meals a day, including breakfast, lunch, tea and supper.

Staff told us that breakfast consisted of cereals, toast and drinks. The cereals were sent up from the kitchen and staff on the ward would make toast for the patient group. Lunch and tea were served by catering staff and supper would consist of sandwiches or toast which staff on the ward would facilitate.

A menu was available for patients to choose what food they wanted. On the Admission Ward patients did not make their choices in advance. Staff told us that because the Admission Ward generally had a seven to ten day turnaround, patients would make their choices when the food trolley arrived on

the ward. Patients we spoke to told us they were not keen on this arrangement. One patient said the food was cold when it arrived and others told us that the variety was limited because they were the last ward served. The food trolley served food to Ward 21 and Ward 22 before serving on the Admission Ward.

Staff told us that patients with specific dietary needs were catered for. Diabetic options and soft food diets were provided for those that required it. Where necessary, staff could request a dietician to ensure a patient's diet was appropriate. The majority of patients and staff said there were hot and cold food options available at lunch and tea time, including cooked meals with a choice of meat or vegetarian option, salads, sandwiches, jacket potatoes and desserts.

One patient we spoke to told us that the vegetarian sandwich options were limited and they had to remove meat from their sandwich. Another patient had requested eggs for breakfast which had been refused. Staff should check that patients are provided with an option that is suitable for the patient.

The majority of patients said the portion sizes were satisfactory and if they requested more it was usually provided. During our visit we observed lunch being served on two wards, with the catering staff telling patients what the options were. Plates were served with the food requested and patients took them into the dining room to eat. We observed staff on Ward 21 set the dining room up with cutlery and condiments.

Patients could buy and store their own snacks and drinks. There were water coolers available for patients to access drinking water and set times were in place for patients to have hot drinks. Although HIW did not observe any patients being declined drinks or snacks, some patients told us of difficulties in obtaining a drink or snack outside of the set mealtimes. One patient in particular said when they asked staff for a hot drink they were told no.

Some fresh fruit was provided to the wards, although some patients said this was not always daily. Patients said they would like more fruit to be available and we were told by some patients that extra fruit had coincided with our presence on the wards.

Recommendations

A review of the current arrangements in place on the Admission Ward for how patients choose their food options is required to determine if pre-ordering food is better suited for the patients.

Any patient with a dietary requirement must have their needs met and should not be subjected to compromising their diets because food options are not available.

A review of the fruit provision to wards is required to ensure patients have access to fresh fruit.

Training

We reviewed ten staff files and identified only one out of the 10 files had comprehensive employment information on file. This included two references, an application form, contract of employment, fitness to work statement, job description and person specification. Evidence was found on this file that original documents including a passport and driving licence had been checked prior to the employee starting in their role.

The information on other files we reviewed was inconsistent. Some files had evidence of one reference, while another file had no references. A standard approach needs to be applied across all staff files to ensure evidence of the appointment is consistent.

Disclosure Barring Service (DBS) check is managed centrally within the health board's Workforce and OD, this information was not kept at Directorate level. Staff confirmed that DBS checks do take place for all new starters. In addition, staff told us that DBS checks were renewed for all staff on a regular basis. This practice ensures the hospital has an independent check that helps enhance the organisations ability to assess a person's integrity and character.

The files we reviewed in which staff had professional registrations showed that three out of the four had expired evidence. Although the files did not contain evidence of a current professional registration, there was a system in place which monitored this area. The e-rostering system flags up registrations/pins that are due to expire, resulting in an email to staff to action.

A system was in place for staff to receive an annual performance development review (PDR) and the majority of staff we spoke to confirmed they had an annual PDR. Statistics provided showed that ward 22 was 100% compliant with all 16 staff having a current PDR. The older person wards require attention because only 13 out of 43 staff had a PDR in place, with staff showing as expired in early 2015, 2014 and one in 2013.

A system of staff supervision was in place, with sessions held approximately every four to six weeks. The staff we spoke to said they were documented and discussions were meaningful. The supervision records we reviewed were dated in September and October 2015. The discussions covered a number of

areas including case load, fundamentals of care, training, leave and any other business.

A programme of mandatory training was in place for staff and a system was being used to capture, record and monitor progress for each employee. An analysis of the statistics provided by the health board did highlight significant gaps across the unit regarding mandatory training. The older person wards had a substantial deficit in training with areas including intermediate life support (ILS) and risk training recorded at 0% compliance.

Other training modules showed only seven staff out of 44 were compliant in fire training, some staff had not had an update since 2010. Infection control had two staff out of 44 compliant. Again, staff had not received training in this area since 2010 and one staff member in 2009. The severity of the gaps in training on this ward are extremely concerning and an immediate review is required to ensure all staff have up to date training to ensure the safety of staff and patients.

The violence and aggression module (C&D) had poor completion rates across the unit, with some staff not receiving this annual training since 2009. A review of the statistics for mandatory training is required and a plan put in place to immediately up-skill staff.

Recommendations

A review of staff files is required to ensure the information contained on file is consistent.

All staff must receive an annual PDR, with specific attention given to those who expired in 2013 and 2014.

A review of mandatory training is required to ensure all staff receive up to date skills and knowledge, specific attention must be given to those staff with expired and/or 0% compliance.

Monitoring the Mental Health Measure

We reviewed the care and treatment planning documentation for four patients at the Royal Glamorgan Mental Health unit. The main issue we identified regarding The Measure was who maintained responsibility for inputting the information and updating. There were areas of noteworthy practice in relation to Seren ward, where the information was regularly updated and was treated as a live document. Within the PICU it was seen as the community staffs responsibility and had very little application or use within the unit.

Access to care planning was a concern identified during our visit. Staff had four different systems to work from and none of them were able to access the other.

There was limited evidence of formal risk assessments on the PICU ward whilst on Seren there was evidence of good practice in relation to formalised assessments.

The following observations were also made:

- Two out of the four care and treatment plans reviewed had limited or no evidence of a full and comprehensive mental health assessment which incorporated the criteria set out in the Mental Health Measure
- One file had no evidence of a full physical health assessment and another file had no updates since June 2015
- One care and treatment plan reviewed was basic and community focussed, with no ward based objectives and outcomes to be achieved
- Two care plans had no evidence that unmet needs had been identified

Two of the care plans reviewed had no formal and/or current risk assessments.

Recommendation

All the areas identified must be addressed, including up to date assessments for physical health, risk and unmet needs. Full and comprehensive mental health assessments and care plans clearly stating the treatment plan, objectives and outcomes to be achieved.

6. Next Steps

The health board is required to complete an Improvement Plan (Appendix A) to address the key findings from the inspection and submit its Improvement Plan to HIW within two weeks of the publication of this report.

The health board's Improvement Plan should clearly state when and how the findings identified at the Royal Glamorgan Mental Health unit will be addressed, including timescales.

The health board's Improvement Plan, once agreed, will be published on the Healthcare Inspectorate Wales website and will be evaluated as part of the on-going mental health/learning disability inspection process.

Appendix A

Mental Health/ Learning Disability: **Improvement Plan**

Health Board: **Cwm Taf University Health Board**

Hospital: **Royal Glamorgan Mental Health Unit**

Date of Inspection: **13th – 16th October 2015**

Recommendation	Health Board Action	Responsible Officer	Timescale
A review of the environment is required and repairs throughout the unit need to be undertaken to include: • the payphone on ward 22 needs a handset, • bedroom furniture with missing drawer fronts need replacing,	Repair completed. Environmental audit completed and issues to be addressed via Estates Liaison Meeting	Directorate Support Manager Directorate Support Manager/Senior Nurses/Ward	Completed 28 February 2016

• kitchen cupboards on the admission ward need fixing, • sinks on the admission ward need to be have running water, • toilet and showers on ward 22 and PICU needs urgent repairing because they were not working, • blinds and/or curtains were not fitted to some bedrooms • an electric socket in a bedroom on ward 22 was broken and requires repair • door stops in bedrooms were broken • a review of the window opening mechanisms is required to ensure that windows can be sufficiently opened to allow access to fresh air	As above As above Repairs to toilets and showers in PICU completed in December 2015. Work ongoing in ward areas. Replacements ordered and awaiting supply and fitting Repair completed As above Funding allocated by Estates to complete this work across the unit.	Managers/Estates Estates Team Directorate Support Manager/Estates Estates Estates Estates	30 March 2016 30 March 2016 Completed 28 February 2016 30 April 2016

• chips and holes in walls and ceilings need to be repaired, • the broken TV in the meeting room on the admission ward needs removing • accessible drawing pins on some notice boards needs review to ensure patient safety is not compromised • the female bathroom lock on ward 22 requires attention to ensure it is fit for purpose	Environmental audit completed and issues to be addressed via Estates Liaison Meeting As above Review completed. Programme of replacement for enclosed notice boards to be progressed according to priority and availability of funding To be addressed via Estates Liaison Meeting	Directorate Support Manager/Senior Nurses/Ward Mgrs Directorate Support Manager/Senior Nurses/Ward Managers Directorate Support Manager	28 February 2016 30 September 2016 28 February 2016
Outside spaces, particularly the smoking areas on the admission ward and ward 21 require attention to ensure they are suitable for the patient group. They need a thorough clean and the safety glass window replaced.	Safety glass has been ordered Agree regular jet wash cycle for patio areas by Estates	Directorate Support Manager/Estates	30 March 2016

The on-going issue regarding the drains throughout the unit needs to be progressed and solutions implemented to eliminate the unpleasant smells present on the wards.	This has been an ongoing issue since the building was commissioned. The matter will be re-escalated through the Capital Programme and a bid developed for consideration by the UHB.	Directorate Support Manager/Capital Planning Board	30 June 2016
A review of the storage facilities, specifically on ward 21 is required to ensure the rooms are being used appropriately and not dumping grounds for all equipment, belongings and ad-hoc items.	Sluice area has been cleared Storage boxes ordered for patients to store personal belongings. Patients to be continually encouraged to limit the amount of personal belongings on the ward Review of off ward space to create additional storage space for wards. Seek funding for this scheme.	Ward Manager Ward Manager/Directorate Support Manager Ward Manager/Directorate Support Manager	Completed 30 March 2016 30 April 2016
New furniture on the PICU requires review to ensure that fixtures and fittings are anti-ligature.	The newly installed furniture has been checked and minor modifications agreed with the supplier to improve overall safety. This specification has been used for the next stage of replacement.	Head of Nursing/Directorate Support Manager	31 December 2015

A review of nurse staffing numbers is required to ensure adequate staff are provided across all wards to ensure the safety and welfare of all patients and staff.	Immediate action taken to strengthen nurse staffing levels by night. Staffing and skill mix review of nurse staffing across the acute mental health unit commenced. Benchmark information gathered. Mental Health Directorate involved in All Wales implementation of professional workload assessment/acuity tools. Paper to be prepared for consideration by Executive Director of Nursing and relevant Board members.	Head of Nursing/ Assistant Director of Operations	30 January 2016
An audit of ligature points is required for the whole unit and the health board must ensure that audits are undertaken in line with the set timescales.	All Ward Managers have completed or reviewed annual point of ligature audits and have been reminded of the need to update these following any changes to the patient environment. A system has been put in place to quality assure these and monitor compliance via the quarterly Directorate Health & Safety Meetings.	Head of Nursing/Health and Safety Co-ordinator	Completed

	<table><tr><th>Ward</th><th>Annual Ligature Audit date completed</th></tr><tr><td>PICU</td><td>29.10.2015</td></tr><tr><td>Seren Ward</td><td>01.11.2015</td></tr><tr><td>ECU</td><td>01.11.2015</td></tr><tr><td>SDU</td><td>01.11.2015</td></tr><tr><td>Ward 21</td><td>22.10.2015</td></tr><tr><td>Ward 22</td><td>26.11.2015</td></tr><tr><td>Admissions</td><td>11.11.2015</td></tr></table>		
A review of the configuration of all ward environments is required to ensure that patient and staff safety is maintained in all areas, with a particular focus on patient bedrooms.	The clinical areas were designed and commissioned by Welsh Health Estates in 2004 as an additional building unit to the Royal Glamorgan Hospital. It is highly unlikely that the configuration will be changed in the foreseeable future. However we will continue to ensure that risks associated with the environment are individually assessed for each patient in	Ward Manager	Ongoing

	their care and treatment plan.		
The health board must review consultant input to the wards at Royal Glamorgan Hospital.	A multi-disciplinary working group will be established to review current practices across all mental health wards at Royal Glamorgan	Clinical Director	30 July 2016
An improved handover system must be implemented to ensure all handover information is recorded appropriately and not shredded.	Development of standardised handover book to be progressed via Ward Manager Forum.	Senior Nurses	30 May 2016
Privacy curtains must be installed between beds in the two-bedded rooms.	Curtains ordered. Awaiting delivery and fitting	Estates	30 March 2016
A review of the mixed gender wards is required and consideration given to making some wards single gendered.	Patient feedback has not identified the current configuration as an issue. Given the available space, overall bed numbers and need for patient flow it is not possible to create single gender wards. Most bedrooms are single rooms with en suite facilities. Minimal two bed bays are single sex. Only communal areas are mixed sex. Safe and supportive observations support dignity issues.	Head of Nursing	Completed

Patient information boards in the nurses office's need to be covered when not in use to protect the information contained.	Blinds have been fitted to cover patient information boards when not in use	Directorate Support Manager	Completed
A review of Seren ward's clinical room is required to ensure clinical areas are used appropriately and not for storing linen, patients belongings. Hand washing facilities must be available and medication must be administered safely.	Review of space on Seren required to explore options ensure appropriate hand washing facilities	Directorate Support Manager/Estates	30 April 2016
A review of the current arrangements in place on the admission ward for how patients choose their food options is required to determine if pre-ordering food is better suited for the patients.	Options have been explored and due to patient turnover and brevity if patient stays the current system is felt to be most effective.	Ward Manager/Catering Dept	Completed
Any patient with a dietary requirement must have their needs met and should not be subjected to compromising their diets because food options are not available.	Current audits demonstrate that all dietary needs are catered for	Ward Managers/Catering Dept	Completed
A review of the fruit provision to wards is required to ensure patients have access to	Review of current provision completed.	Directorate Support Manager/Catering	Completed

fresh fruit.		Dept	
A review of staff files is required to ensure the information contained on file is consistent.	The Cwm Taf UHB personnel system is based centrally with Workforce and OD. The service is in the process of migration to Electronic Staff Records. Work will be undertaken to ensure the local system reflects the central record.	Assistant Director of Operations & Workforce and OD	30 September 2016
All staff must receive an annual PDR, with specific attention given to those who expired in 2013 and 2014.	Current PDR compliance is 77% and this is monitored at the monthly performance management meetings. Additional Ward Manager support has been allocated to the OPMH assessment unit to assist with workload.	Head of Nursing	Ongoing
A review of mandatory training is required to ensure all staff receive up to date skills and knowledge, specific attention must be given to those staff with expired and/or 0% compliance.	Training records have been reviewed. Due to current migration to Electronic Staff Records some inaccuracies were identified and corrected. Use of team time out days to be expanded to facilitate increased compliance	Ward Managers/Senior Nurses	30 March 2016
All the areas identified must be addressed, including up to date assessments for physical	A review of all assessment and documentation processes has been	Senior Nurses/Ward Managers	Completed

health, risk and unmet needs. Full and comprehensive mental health assessments and care plans clearly stating the treatment plan, objectives and outcomes to be achieved.	completed. Comprehensive CTP and risk information is available across all areas and is monitored via performance dashboard.		