Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Ward F, Neath Port Talbot Hospital, Swansea Bay University Health Board

Inspection date: 22, 23 and 24 May 2023

Publication date: 24 August 2023

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

Digital ISBN

We observed staff treating patients with respect and supporting patients in a dignified and sensitive way. Patients provided positive feedback to us throughout the inspection about their experiences on the ward.

We felt the health board could do more to ensure patients are able to participate in a range of individualised therapeutic and social activities to aid in their recoveries.

A range of up-to-date health and safety policies were available and appropriate risk assessments were being undertaken. However, improvements were required to the seclusion arrangements in place on the ward to ensure they adhere to the health board policy and best practice standards.

Appropriate governance processes were in place to review issues related to patient care and identify improvements. The majority of staff members recommended the ward as a place to work and said that they would be happy with the standard of care provided for their friends or family.

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

What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Ward F, Neath Port Talbot Hospital, Swansea Bay University Health Board on 22, 23 and 24 May 2023. Ward F is a 21 bedded inpatient assessment and treatment ward for adults experiencing acute mental health problems. We were told that an agreement was in place for the ward to also use spare beds at the adjacent five bedded Detox Ward if required. At the time of our arrival there were 20 patients on the ward, and two Ward F patients being cared for on the Detox Ward.

Our team for the inspection comprised a HIW Senior Healthcare Inspector (who led the inspection), three clinical peer reviewers and one patient experience reviewer.

This summary version of the report is designed for members of the public.

A full report, which is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients can be found on our website.

Quality of Patient Experience

Overall Summary

All patients had their own bedroom and bathroom which maintained their privacy and dignity. Patients could engage and provide feedback about their care in a number of ways. Staff had undertaken equality, diversity and inclusion training to help recognise the importance of treating all patients fairly. Patients had weekly access to a mental health advocate who provided information and support with any issues they may have regarding their care.

Where the service could improve

- Physical healthcare care plans must be developed for patients when required
- Health promotion information must be made available to patients
- The health board must ensure that patients adhere to the Welsh Government smoking legislation on hospital grounds
- Bilingual patient information must be made available to ensure Welsh speakers are offered language services that meet their needs.

Delivery of Safe and Effective Care

Overall Summary

Effective infection, prevention and control (IPC) arrangements were evident. There were established safeguarding processes in place and referrals were being directed to external agencies as and when required. Robust procedures were evidenced in relation to the safe management of medicines on the ward. Medication Administration Records (MAR charts) were being maintained to a good standard. The statutory documentation we saw verified that the patients were appropriately legally detained.

The health board must ensure positive behaviour plans are developed to understand what things are important to patients. The health board must also significantly improve the care and treatment planning process and arrangements in place to ensure they meet the requirements of the Mental Health Measure Wales 2010.

Where the service could improve

- A policy must be developed that details the expectations on staff security in relation to personal alarms and staff radios and ensure staff are aware and adhere to it
- All incidents must be recorded on the electronic system in a timely manner and all relevant information in relation to the incident must be captured accurately
- We recommend the health board completes the anti-ligature refurbishment work on the remaining bedrooms and undertakes the anti-ligature refurbishments identified in the ligature risk assessment.

What we found this service did well

- The pharmacist who regularly visited the ward was supportive to staff, visible and engaged with patients to educate and provide information to them about their medication.

Quality of Management and Leadership

Overall Summary

Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. It was clear from our discussions with senior staff that the health board was reviewing the provision of the service on the ward to enhance the environment and efficiency of the service.

Overall mandatory training compliance rates were high among staff on the ward. However, the health board must ensure that staff receive their annual appraisals and have access to regular formal clinical supervision to help their learning and development.

Where the service could improve

- The health board must engage with staff to ensure their health and wellbeing is being protected
- Information on the Putting Things Right process must be made available to patients
- The health board should disseminate the whistleblowing policy and remind staff where they can access it should they have any concerns they wish to raise.

Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health boards to provide documented evidence of action taken and/or progress made.