Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Hospital Inspection Report (Unannounced)

## Ward F, Neath Port Talbot Hospital, Swansea Bay 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 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.

During the inspection we invited staff to complete a questionnaire to tell us their views on working for the service. A total of ten questionnaires were completed by staff. Feedback we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

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

This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

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

# 2. Summary of inspection

## Quality of Patient Experience

Overall summary:

We observed staff treating patients with respect and supporting patients in a dignified and sensitive way. 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.

The health board must do more to ensure that patients are able to participate in a range of individualised therapeutic and social activities to aid in their recoveries.

This is what we recommend the service can 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.

This is what the service did well:

- Patients provided positive feedback about their experiences.

## Delivery of Safe and Effective Care

Overall summary:

A range of up-to-date health and safety policies were available and appropriate risk assessments were being undertaken. However, we felt further improvements were needed to provide a safer environment for patients and staff. For example, the seclusion arrangements in place on the ward must be improved to ensure they adhere to the health board policy and best practice standards.

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.

This is what we recommend the service can 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.

This is what the 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:

Appropriate governance processes were in place to review issues related to patient care and identify improvements. 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.

This is what we recommend the service can 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.

# 3. What we found

# Quality of Patient Experience

## Patient Feedback

During the inspection we distributed HIW questionnaires to patients to obtain their views on the care and treatment they have received. A total of eight questionnaires were completed. We also spoke with patients on the ward when appropriate to do so.

Patients generally provided positive feedback about their experiences. The majority of patients that completed a questionnaire rated the care and service they had received as very good. All patients we spoke with were complimentary about the care provided and about their interactions with staff.

## Person centred

### Health Promotion

We discussed the arrangements in place to meet the physical health care needs of patients on the ward. Patients receive a physical health care assessment on admission. We looked at a sample of patient records and saw that one patient had a diagnosed medical condition. However, we did not see evidence that a care plan had been developed to set out how this condition would be managed during their stay on the ward.

**The health board must ensure that physical healthcare care plans are developed for patients when required.**

During our tour of the ward we did not find any health promotion information on display to encourage patients to take responsibility for their own health and wellbeing.

**The health board must ensure health promotion information is available to support patients to make decisions that impact positively on their health and wellbeing.**

Patients could access a large, enclosed garden throughout the day times. All patients that completed a questionnaire agreed that they were able to go outside for exercise.

Throughout the inspection we observed patients smoking in the garden. This practice contravened both the health board policy regarding smoking as well as current Welsh Government legislation on smoke-free hospital grounds. We also noted numerous discarded cigarette butts on the floor in the garden which presented as unsightly and unhygienic.

**The health board must ensure that patients adhere to the Welsh Government smoking legislation on hospital grounds. The health board must also ensure that the garden is kept clean at all times.**

**Dignified and Respectful Care**

Throughout the inspection we observed all staff treating patients with dignity and respect. Staff took time to speak with patients and address any needs or concerns they raised, which demonstrated a responsive and caring attitude towards the patients. The majority of patients who we spoke to during the inspection and that completed our questionnaire confirmed that staff were polite, supportive, and helpful.

All patients had their own bedroom and bathroom which maintained their privacy and dignity. All staff members that completed a questionnaire agreed that the privacy and dignity of patients is maintained during their time at the hospital.

**Patient information**

We found limited information was available to help patients and their families understand their care. Apart from information on advocacy services, there was no information available on the Mental Health Act, HIW, how patients could make a complaint, or details about the staff members working on the ward. We were told by staff that patients are provided with an information leaflet on admission to the ward. However, some patients we spoke to during the inspection told us that they had not received a copy of the leaflet. We also noted that the leaflet was out-of-date and included incorrect details about the ward manager.

**The health board must ensure patients are provided with relevant and up-to-date information about their care and the services and support available on the ward.**

We were told that there was an insufficient number of rooms available for Consultant Psychiatrists to hold confidential conversations with patients. This meant that meetings with patients were sometimes delayed or held in areas where confidentiality could not be guaranteed.

**The health board must ensure adequate provision of rooms or spaces where staff can hold conversations with patients in private to protect patient confidentiality.**

### Individualised care

During our review of patient records, it was not clear what therapeutic interventions had been put in place for each patient to aid their recovery. We were informed that some activities were being organised and undertaken with patients, for example, cookery lessons and walks. We saw that some books and games were available in the dining room but there appeared to be a lack of other therapy facilities available on the ward. One room located off the ward had a pool table and sports equipment stored in it, but staff confirmed that patients were not using the room due to the need for the room to be used by staff. We observed staff taking some patients to Swansea, but we did not observe any patients participating in activities on the ward throughout the inspection.

**The health board must do more to ensure that patients are able to participate in a range of individualised therapeutic and social activities to aid in their recoveries. These interventions must be documented in a care and treatment plan as set out by the Mental Health Measure Wales 2010 to provide clarity on what outcomes are set to be achieved.**

Patients were able to store possessions and personalise their rooms where appropriate. We saw patients were being supported to carry out their own washing in the laundry room to promote independence. Separate rooms were available for patients to see their family and friends in private. All staff members that completed a questionnaire felt that patients are informed and involved in decisions about their care.

## Timely

### Timely Care

Processes were in place that supported the timely and effective care of patients in accordance with individual and clinical need. A meeting was being held every morning for staff to update the multidisciplinary team (MDT) and senior management on any concerns, issues or incidents that had taken place the day before. We attended one of these meetings and noted good discussions being had around patient care needs. We also observed discussions being had between staff to establish bed occupancy levels and how best to manage admissions, discharges and the use of the additional beds in the Detox Ward.

## Equitable

### Communication and language

Patients appeared confident in approaching staff to engage in discussions. In return, we saw that staff took the time to speak with patients to understand their needs or any concerns the patients raised.

Patients had access to their own mobile phone where appropriate, but a telephone was available on each ward for patients to use if required.

We saw Welsh speaking staff members present on the ward who were identifiable by a 'Iaith Gwaith' badge embroidered on their uniform. Staff were undertaking Welsh language training to understand the importance of meeting the language needs of patients. However, we did not see any bilingual patient information on display throughout the ward.

**The health board must ensure that bilingual patient information is available to ensure Welsh speakers are offered language services that meet their needs as a natural part of their care.**

We were informed that translation services would be sought should patients wish to communicate in another language.

**Rights and Equality**

We reviewed four patient records of individuals that had been detained on the ward under the Mental Health Act. The documentation we saw was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code). Further information on our findings is detailed in the Mental Health Act Monitoring section of this report.

We found satisfactory arrangements in place to promote and protect patient rights. Overall staff compliance with mandatory Equality, Diversity and Human Rights training was 86 per cent. Policies were in place to help ensure that everyone had access to the same opportunities and to the same fair treatment. We were told that discussions would be had with transgender patients to ensure they are appropriately placed and uphold their equality rights. We were also provided with an example where a sign language interpreter was brought on to the ward to ensure a deaf patient could participate and engage in their MDT reviews, which we noted as good practice.

All patients had weekly access to a mental health advocate who provided information and support to patients with any issues they may have regarding their care.

# Delivery of Safe and Effective Care

## Safe

**Risk management**
A range of up-to-date health and safety policies were available and appropriate risk assessments were being undertaken. However, we felt further improvements were needed to provide a safer environment for patients and staff.

The environment of the ward was tired, well-worn and in need of redecoration. For example, areas of the dining room wall had pen scribbles, cracked plaster and peeling paint. A glass panel on a corridor door was also smashed and was only covered with tape which presented a safety risk to patients. We escalated our concerns to the senior management team who confirmed that these issues had been raised with the contractors responsible for the upkeep of the building. However, we were told that there have been problems with the timeliness of such issues being repaired.

**The health board must liaise with the contractors to ensure the environment of the ward is refurbished and repaired to a suitable standard to provide a safe environment of care for the patients.**

An up-to-date ligature point risk assessment had been undertaken that detailed the actions taken to mitigate and reduce the risk of ligature on the ward. A ligature knife was appropriately stored for use in the event of a self-harm emergency.

**However, we recommend the health board also purchases a specialised wire cutter for ligatures as an extra precaution.**

We were told that a programme of anti-ligature refurbishments had recently been completed on the majority of bedrooms on the ward. While this is a positive development, we noted that other ligature risks had been recommended for anti-ligature work in 2020 which still hadn't been completed.

**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 as a priority due to the increased acuity of patients presenting to the ward since the ward became the single point of assessment for the region.**

At the time of the inspection the ward contained a mixture of informal patients and patients detained under the Mental Health Act. This meant that for safety reasons the main door to the ward was locked. We were informed by staff that the main door was not secure enough to prevent patients from absconding from the ward. We were told that plans were in place to replace the door and make further improvements to the adjacent area to make it more secure.

**We recommend the health board undertakes this work as a matter of priority to help ensure patients are kept safe.**

We saw that personal alarms and radios were available for staff to use in an emergency. However, during the inspection we noted that staff were not using them. We asked to see the policy on the use of personal alarms and were told that no such policy was in place. Furthermore, we noted that following the anti-ligature refurbishment work undertaken in the patient bedrooms, the beds were now situated far away from the nurse call alarms so we were not assured that patients could summon assistance if required in an emergency.

**The health board must develop a policy that details the expectations on staff security in relation to personal alarms and staff radios and ensure staff are aware and adhere to it. Furthermore, the health board must review the location of the nurse call alarms in the refurbished patient bedrooms.**

A Section 136 suite was located adjacent to the ward. The suite is not managed by staff from Ward F. However, we visited the suite during the inspection. We noted that the suite was in need of some improvements to ensure it would meet best practice guidelines:

- The furniture in the suite was not fixed to the floor
- Fire extinguishers were located at the back of the assessment room.

**The health board must review the environment of the Section 136 suite and ensure it meets best practice guidelines to provide a place of safety for staff, patients and police officers.**

**Infection prevention and control and decontamination**
We found suitable infection prevention and control (IPC) arrangements in place. Up-to-date policies were available that detailed the various procedures to keep the environment clean and staff and patients safe. Regular audits had been completed to monitor compliance with hospital procedures. The training statistics provided evidenced a high level of staff compliance with IPC training at 88 per cent.

All patients that completed a questionnaire agreed that the environment was very clean. All staff members that completed a questionnaire provided positive feedback about the IPC arrangements in place on the ward.
At the time of the inspection staff were not expected to wear face masks, but we saw that face masks and other PPE were available if required. We saw staff encouraging patients to wash their hands before eating which we noted as good IPC practice.

We saw that a checklist was in place that clearly set out the cleaning tasks that needed to be completed. While this was a positive initiative, we noted gaps in the checklist for previous months which highlighted that the tasks weren't always being completed.

**The health board must ensure the checklist is maintained appropriately to document the cleaning tasks undertaken across the ward.**

The majority of furniture and fittings appeared to be in a good state of repair to enable suitable decontamination. However, we noted areas across the ward needed to be tidied:

- The laundry room had limited storage areas and was cluttered during the inspection
- The ward had two communal bathrooms; during the inspection we noted one bathroom was used for storage of mobility equipment and the other bathroom had dirty towels left on the side.

**The health board must ensure all clutter is removed from the ward and the communal bathrooms must be kept clear at all times for patients to use.**

**Safeguarding children and adults**
We found suitable measures in place to safeguard vulnerable adults. A lead nurse on the ward had been appointed as the safeguarding representative. There were established processes in place and referrals were being directed to external agencies as and when required. The staff we spoke with during the inspection demonstrated excellent knowledge of the safeguarding procedures and reporting arrangements.

We were told that safeguarding incidents and concerns were discussed regularly as between senior staff and the MDT to help identify any themes and lessons learned. Compliance among staff on the ward with safeguarding training courses was high at 90 per cent.

The majority of patients that completed a questionnaire told us that they felt safe at the hospital.

**Medicines management**
We reviewed the hospital's clinic arrangements and found that robust procedures were in place for the safe management of medicines on the ward. Relevant policies, such as medicines management and rapid tranquillisation, were in date and were available to staff. There were two medication rooms on the ward. During our tour of the ward the rooms were a little untidy, but it was positive to note that the rooms were tidied and cleaned by the end of the inspection.

Medication was being stored securely in cupboards at all times and medication fridges were locked when not in use. We noted that the medication trolley had a crack on the front of it which raised a doubt over how secure it was.

**The health board must ensure that the medication trolley is either repaired or replaced to make it more secure.**

We saw that daily temperature checks of the medication fridge and room were being completed to ensure that medication was stored at the manufacturer's advised temperature. Appropriate arrangements were in place for the storage and safe use of controlled drugs and drugs liable to misuse.

We received positive feedback from nursing staff regarding engagement with the hospital pharmacist who regularly visited the ward to undertake stock checks and participate in ward rounds. We were told the pharmacist was supportive, visible and engaged with patients to educate and provide information to them about their medication.

We viewed a sample of Medication Administration Records (MAR charts) and found they were being maintained to a good standard. The MAR charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. We saw a checklist was in place for staff to review and check signatures on every handover, and this appeared to be having a good effect. However, we did note that the current MHA legal status for patients was not always recorded on the MAR chart. We also found instances where consent to treatment certificates were not being stored alongside the MAR chart. This meant there was a risk that some medication could be administered to patients in error.

**The health board must ensure that the MHA legal status is recorded for each patient and that consent to treatment certificates are stored alongside the MAR chart for each patient.**

The health board may also wish to consider attaching a photograph of each patient on to the MAR chart to help non-permanent staff avoid administering medication to the wrong patient.

### Challenging behaviour

The hospital had policies in place to help protect the safety and wellbeing of patients and staff. The management of violence and aggression policy described approaches for staff to follow to safely manage challenging behaviour. It was positive to note that during the inspection we observed staff engaging with patients and providing reassurance, support and verbal de-escalation.
While staff were aware of how to identify potential triggers and manage patients effectively, we did not see this documented within the patient records we reviewed. For example, positive behaviour support (PBS) plans for patients were not in place.

**The health board must ensure PBS plans are developed with patients that contain proactive and reactive strategies to understand what things are important to patients and help staff identify when they may need to intervene to de-escalate challenging behaviour.**

We were told that staff would observe patients more frequently in line with the safe and supportive observations policy if their behaviour required closer monitoring. Observation levels for individual patients were discussed among the MDT in the daily handover meetings. We noted that staff did not receive training on how to undertake effective and safe observations and the health board may wish to consider arranging this for their staff.

It appeared that restrictive practices were only being used as a last resort. The majority of incidents were lower level safeholds. We were told that any incidents of restrictive practice are discussed in a quality and safety forum to help identify lessons learned.

## Effective

### Effective care

There was an established electronic system in place for recording, reviewing and monitoring incidents. There was a hierarchy of incident sign-off with regular incident reports produced and reviewed so that occurrence of incidents could be monitored and analysed. However, we noted that the details of a physical intervention that took place on the second day of the inspection had still not been recorded on to the electronic system by the end of the third day of the inspection. In addition, we reviewed a historical incident form and found that it did not contain all the necessary information in relation to the physical intervention. For

example, we could not determine from the form where an intramuscular (IM) injection had been administered on the patient. While investigating this, we also discovered that the MAR chart for that patient did not clearly indicate to staff where IM injections should be administered for that patient.

**The health board must ensure all incidents are recorded on the electronic system in a timely manner and ensure all relevant information in relation to the incident is captured accurately. The health board must also ensure that MAR charts indicate to staff where IM injections should be administered for each patient.**

During the inspection we noted a patient was being secluded in a separate area of the ward. We looked at the arrangements in place to manage this patient and identified a number of concerns:

- The area being used to seclude the patient did not conform to best practice standards or to the health board policy and procedures for the use of seclusion. Notably, a clock was not visible and there was no temperature control outside the area
- The separate toilet facility being used by the patient had not been adapted for high risk patients
- We were concerned that the patient was not having access to regular periods of fresh air
- There was no seclusion care plan in place for the patient which contravened the health board policy
- We were informed that there were not enough resources available for patients in seclusion to participate in activities.

**The health board must review the seclusion arrangements in place on Ward F and make improvements to address these concerns and ensure they adhere to the health board policy and best practice standards.**

We saw evidence of weekly checks being undertaken on resuscitation and emergency equipment held on the ward. Staff had documented when these had occurred to ensure that the equipment was present, in date and safe to use in the event of an emergency such as patient collapse.

**Patient records**

Patient records were being maintained via paper files and electronically. Paper files were securely stored on site and the electronic system was password protected to prevent unauthorised access and breaches in confidentiality.

We found the patient records to be hard to navigate with some information limited to certain members of staff. This meant it was hard for all staff to understand the full care needs of each individual patient.

**The health board should review the way patient records are being maintained to make sure all staff have access to key information about each patient and that the information is easy to find.**

Improvements were also required in terms of record keeping and in particular the care and treatment planning documentation. Further information on our findings is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

**Nutrition and hydration**

We were told that patients could choose from the general hospital menu which rotated on a three weekly basis. The food appeared to be of a good standard and looked appetising. The patients we spoke with during the inspection praised the quality and taste of the food. Patients told us they were supported to make healthy food choices. However, we did not find evidence within patient records that patients were being supported to meet their individual dietary needs.

**The health board must ensure that the nutritional and hydration needs of patients are assessed on admission and care plans developed to detail how these needs will be managed if required.**

We noted that the décor of the dining room could be improved; some paint had peeled and there were various scuff marks on the doors and floors.

**The health board must provide a suitable and pleasant environment for patients to eat their meals.**

**Mental Health Act Monitoring**

We reviewed the statutory detention documents of four patients currently residing on the ward. We were assured that the health board's responsibilities under the Mental Health Act (the Act) were being upheld. All records were found to be compliant with the Act and Code of Practice. Clear reasons were being documented to evidence why detention under the Act was the most appropriate way of providing care for patients. There was good support available for patients from the local Independent Mental Health Advocacy service.

Mental Health Act files were very well organised, easy to navigate and contained detailed and relevant information. Good arrangements were in place to document Section 17 leave appropriately. We saw that leave was being suitably risk assessed

and that the forms determined the conditions and outcomes of the leave for each patient. The health board may wish to consider adding a photograph to the Section 17 leave form to help identify patients in the event of them not returning from leave.

**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 found that appropriate risk assessments were being undertaken and documented. However, in the four patient records we reviewed, we were not assured that the risk assessments were being used to compile Care and Treatment Plans (CTP) that reflected the individual needs of patients. Only two of the four patients had a CTP in place. Of the two CTPs, one was out-of-date, and the other had not been updated since the patient had been admitted to the ward. Furthermore, some of the domains of the Welsh measure had been taken out of the CTPs, and the documentation was labelled as Care Programme Approach (requirements for England) rather than CTP (requirements for Wales).

**The health board must 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.**

Patients were being regularly reviewed through established ward round arrangements. MDT participation was evident and included the involvement of patients, external agencies and community professionals where required.

We saw evidence of discharge and aftercare planning with discussions being held on future appropriate placements. We saw examples of this recorded within patient records, but not always. The health board should ensure that all discharge arrangements are documented contemporaneously.

# Quality of Management and Leadership

## Staff feedback

Staff responses to the HIW questionnaires were mostly positive, with the majority of staff members recommending the ward as a place to work and all staff members confirming that they would be happy with the standard of care provided for their friends or family.

The majority of staff members agreed that their current working pattern allowed for a good work-life balance. However, three out of the ten respondents stated that in general, their job was detrimental to their health.

**While staff confirmed that they were aware of the occupational health support available to them, the health board must engage with staff to ensure their health and wellbeing is being protected.**

## Leadership

### Governance and leadership

It was positive that throughout the inspection staff were receptive to our views, findings and recommendations. The majority of staff members that completed a questionnaire told us that the health board was supportive and takes swift action to improve when necessary. All staff felt care of patients was the health board's top priority.

There appeared to be appropriate governance and oversight processes in terms of activities and meetings to discuss issues related to patient care and identify improvements. The MDT was well established, and we observed everyone working well together throughout the inspection.

Staff members provided positive feedback to us about their immediate line managers. The majority of staff felt that their manager could be counted on to help with difficult tasks at work and that they asked for their opinion before making decisions that affected their area of work.

While most staff members felt that senior management were visible, a number of staff felt that communication between senior management and staff was not effective. The health board should reflect on this aspect of feedback and investigate whether improvements in relation to communication with staff could be made.

## Workforce

### Skilled and enabled workforce

Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. The majority of staff members that completed a questionnaire agreed that they were able to meet the conflicting demands on their time at work. However, six out of the ten respondents felt that there were not enough staff on the ward to enable them to do their job properly. We were informed by senior staff that work was being undertaken to review the staffing establishments on the ward to ensure they provide appropriate nurse staffing levels. We were also made aware that a recruitment campaign had recently been completed and four new healthcare support workers were due to start their roles shortly on the ward. However, the health board should reflect on the staff feedback when reviewing the nurse staffing levels to ensure nurses have the time to provide patient centred care.

It was clear from discussions with senior staff that agency staff have been used to fulfil some shifts, although this did not appear to be at excessive levels. The health board should ensure that if agency staff are required, then the same agency staff members are used wherever possible to provide consistency for patients.

We saw that suitable processes were in place for senior staff to monitor compliance with mandatory training. It was positive to note that overall mandatory training compliance rates were high among staff on the ward. The majority of staff members that completed a questionnaire felt that they had received appropriate training to undertake their role.

At the time of the inspection, we saw that 83 per cent of staff had received their annual appraisal. However, three of the ten staff members that completed a questionnaire said that they had not had an appraisal in the last 12 months. Furthermore, we were told that formal clinical supervision sessions were not being undertaken with nursing staff as required.

**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.**

We were told that the second Consultant Psychiatrist did not have an office of their own which meant they found it difficult to undertake their administrative duties. The health board should find a suitable space for the second Consultant Psychiatrist to be able to work efficiently.

## Culture

**People engagement, feedback and learning**
Every Friday staff held a meeting with patients which provided an opportunity for patients to raise any issues with staff. We were told that patient satisfaction surveys are sent to patients after they have been discharged to help identify areas for improvement. However, we did not see any evidence of changes that had been made as a result of formal patient feedback. For example, the ward did not have a 'You said, we did' board.

**While patients are typically only on the ward for a short period of time, the health board must ensure patients are kept informed of the outcomes of their feedback and any changes or improvements implemented as a result.**

We also found no reference or information available to patients on the Putting Things Right process to inform patients how they could make a complaint should they wish to do so.

**The health board must ensure that information on the Putting Things Right process is made available to patients.**

We saw that information had been provided to staff on the new Duty of Candour requirements. The majority of staff members that completed a questionnaire agreed that they understood the Duty of Candour and their role in meeting the Duty of Candour standards. All respondents agreed that the health board encouraged staff to raise concerns when something has gone wrong and to share this with the patient. Staff also told us that they would feel secure raising concerns about patient care or other issues at the hospital and felt confident that the health board would address their concerns. A whistleblowing policy was in place to provide guidance on how staff can raise concerns. However, some staff members we spoke with did not know about the whistleblowing policy.

**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.**

## Information

**Information governance and digital technology**
The training statistics showed a high level of staff compliance with information governance training at 88 per cent.

We saw that the patient status at a glance board was located in the nursing office on the ward. While it was not visible from outside the room, the board was not

covered which meant patient confidentiality could be compromised should a patient or visitor enter the room. It was disappointing that we found the same issue on our last inspection of the ward in May 2017. Furthermore, due to an increase in patients, we noted that there was not enough space provided on the board to capture information about each patient; information was squashed on to one board and also had to be inputted on a separate board. This meant that it was not easy to understand the information presented; for example, it took a while on the first night of the inspection to work out with staff how many patients were onsite. We raised this with senior staff who informed us that an electronic patient safety system called Signal is due to be installed on the ward imminently which would resolve these issues. While this is a positive step, the health board should ensure patient information is easily accessible and able to be understood by staff in the meantime.

## Learning, improvement and research

**Quality improvement activities**
It was clear from our discussions with senior staff that the health board was reviewing the provision of the service on the ward. Improvement work such as the implementation of Signal and the anti-ligature refurbishments are all positive initiatives that will help to enhance the environment and efficiency of the service.

We were provided with a copy of the mental health directorate's quality assurance framework which set out 'how safe, effective, person centred health services are monitored and continually improved through governance, leadership and accountability'. The framework set out a number of ways in which this would be achieved. For example, through outcome measurement and monitoring, clinical audits, and 15 step reviews.

**We have recommended a number of improvements as a result of our inspection and the health board must ensure that the tools used in the quality assurance framework are working effectively and as intended.**

# 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 |
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| No immediate concerns were identified on this inspection. | | | |

# Appendix B – Immediate improvement plan

**Service:** Ward F, Neath Port Talbot Hospital

**Date of inspection:** 22, 23 and 24 May 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.

| Risk/finding/issue | Improvement needed | Service action | Responsible officer | Timescale |
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| No immediate assurances were issued during this inspection. | | | | |

# Appendix C - Improvement plan

**Service:** Ward F, Neath Port Talbot Hospital

**Date of inspection:** 22, 23 and 24 May 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.

| Risk/finding/issue | Improvement needed | Service action | Responsible officer | Timescale |
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| We were not assured that appropriate arrangements were in place to meet the physical health care needs of patients. | The health board must ensure that physical healthcare care plans are developed for patients when required. | The lead nurse undertakes quality audits which includes reviewing the notes and the physical health screening. This will be used as an ongoing assurance mechanism for the completion of physical healthcare care plans when required.<br>The service group will also scope out opportunities to deliver training on the importance of physical health care plans, this may include doctor inductions and wider professional forums. | Lead Nurse,<br>Clinical Director | 30/09/23 |

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| No health promotion information was on display for patients. | The health board must ensure health promotion information is available to support patients to make decisions that impact positively on their health and wellbeing. | Information to be presented on the wall, which includes information on healthy eating, exercise, sleep hygiene. MDT exploring specific male and female health and wellbeing promotion.<br>Awaiting translation for Welsh versions. | Clinical Lead<br>Clinical Lead | 21/08/2023<br>21/11/2023 |
| Throughout the inspection we observed patients smoking in the garden. | The health board must ensure that patients adhere to the Welsh Government smoking legislation on hospital grounds. | The Service Group are identifying a transition plan to ensure the Welsh Government legislation is met, at present this includes support from the 'Help Me Quit' programme to engage patients in those conversations around stopping/reducing smoking. | Assistant Head of Operations | 31/12/2023 |
| We saw numerous discarded cigarette butts on the floor in the garden. | The health board must ensure that the garden is kept clean at all times. | A garden group has been established and is led by the Activities Coordinator, which will revise its focus to include keeping the garden clean and share the importance of taking responsibility of looking after the communal environment.<br>To develop the ward duty checklist. | Activities Coordinator<br>Health Care Support Worker and Ward Manager | 14/07/2023<br>18/08/2023 |

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| | | Ward Task Schedule Timetable to be developed, inclusive Garden checks | Clinical Lead | 25/08/2023 |
| We found limited information was available to help patients and their families understand their care. | The health board must ensure patients are provided with relevant and up-to-date information about their care and the services and support available on the ward. | Ward F MDT are developing a new leaflet to share with patients and families regarding the services to ensure it is up to date.<br><br>A Welcome Board will be created, this will include information in relation to staff names, the Mental Health Act, what to expect from the team and the ward, HIW and how patients can make a complaint.<br><br>Families and carers are invited to routine MDT meetings and discharge planning meeting to discuss the care and treatment of their family member. This allows for any concerns to be explored fully and creates opportunity for information to be shared effectively. | Ward Manager – Patient Leaflet<br>Psychologist – Carer / Family Leaflet<br><br>Psychologist & Assistant Psychologist<br><br>Ward Manager | 31/08/2023<br><br>31/08/2023<br><br>31/07/2023 |
| We were told that there were an insufficient number of rooms available for Consultant Psychiatrists | The health board must ensure adequate provision of rooms or | Directorate Manager will escalate to Neath Port Talbot hospital operations team to explore wider | Directorate Manager | 31/10/2023 |

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| to hold confidential conversations with patients. | spaces where staff can hold conversations with patients in private to protect patient confidentiality. | hospital environments as there is no space on the Assessment Unit. | | |
| During our review of patient records, it was not clear what therapeutic interventions had been put in place for each patient to aid their recovery. | The health board must do more to ensure that patients are able to participate in a range of individualised therapeutic and social activities to aid in their recoveries. These interventions must be documented in a care and treatment plan as set out by the Mental Health Measure Wales 2010 to provide clarity on what outcomes are set to be achieved. | Activities schedule has been developed and in situ and regularly reviewed.<br><br>All inpatients who are care managed or have been admitted to Ward F for 2 weeks onwards require care and treatment plan. To develop a standardised CTP for use in inpatient wards.<br><br>Recovery star has been identified as the outcome measure tool for unscheduled care. The training has been completed. The use of this tool will aid the identification of therapeutic intervention to support the recovery process. | Activity Coordinator<br><br>Clinical Leads<br><br>Clinical Leads | 18/07/2023<br><br>31/08/2023<br><br>31/08/2023 |
| No bilingual patient information was on display throughout the ward. | The health board must ensure that bilingual patient information is | All new display boards have been set up as bilingual, the team have requested the welsh language | Occupational Therapist & Ward Manager | 31/10/2023 |

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| | available to ensure Welsh speakers are offered language services that meet their needs as a natural part of their care. | versions of the posters from the relevant agencies | | |
| The environment of the ward was tired, well-worn and in need of redecoration. | The health board must liaise with the contractors to ensure the environment of the ward is refurbished and repaired to a suitable standard to provide a safe environment of care for the patients. | Ward F has been decorated and this action is complete. | Lead Nurse | 14/07/2023 |
| A ligature knife was available in the event of a self-harm emergency. | The health board must ensure a specialised wire cutter for ligatures is also available. | Approved ligature cutters are available on Ward F. Further anti-ligature measures will be discussed within the August Quality and Safety Committee Meeting. | Deputy Nurse Director | 31/08/2023 |
| Some ligature risks had been recommended for anti-ligature work in 2020 but still hadn't been completed. | We recommend the health board completes the anti-ligature refurbishment work on the remaining bedrooms and undertakes the anti- | Ligature Risk Assessment to be repeated as the ward has undergone extensive refurbishment. | Ward Manager | 01/08/2023 |

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| | ligature refurbishments identified in the ligature risk assessment. | | | |
| We were told that plans were in place to replace the interior door that separated the ward from the main reception and waiting area, and make further improvements to the adjacent area to make it more secure. | We recommend the health board undertakes this work as a matter of priority to help ensure patients are kept safe. | Ward entrance door has been replaced and is due to be operational as of week commencing 24/07/23.<br><br>Furniture purchased and installed for outside of Ward F to make it more welcoming. | Lead Nurse<br><br>Lead Nurse | 31/08/2023<br><br>28/07/2023 |
| We noted throughout the inspection that staff were not wearing personal alarms or radios. Furthermore, no policy on the use of personal alarms was in place. | The health board must develop a policy that details the expectations on staff security in relation to personal alarms and staff radios and ensure staff are aware and adhere to it. | Policy regarding staff security to be discussed in the Service Group Policy Review Group to ensure there is a standardised approach which is then delivered locally.<br><br>Exploration of extending the communication system on Ward F which is currently in situ via Care Com. Hospital Manager to request survey and costings.<br><br>Ward F have personal alarms and access to radios. A Standard Operating Procedure is required to | Directorate Manager<br><br>Hospital Manager & Ward Manager<br><br>Ward Manager | 26/09/2023<br><br>30/09/2023<br><br>30/09/2023 |

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| | | for the use of personal alarms and radios. This is to be developed. | | |
| Following the anti-ligature refurbishment work undertaken in the patient bedrooms, the beds were now situated far away from the nurse call alarms. | The health board must review the location of the nurse call alarms in the refurbished patient bedrooms. | A survey and costing is to be requested from Care Com | Hospital Manager & Ward Manager | 30/09/2023 |
| We noted that the suite was in need of some improvements to ensure it would meet best practice guidelines. | The health board must review the environment of the Section 136 suite and ensure it meets best practice guidelines to provide a place of safety for staff, patients and police officers. | Chairs have been changed reducing the risk of being used as a weapon – completed 23/07/2023<br><br>A request has been made to Kier to fix the desk – completed 25/07/2023<br><br>Fire Officer has assessed extinguishers in the 136 suite – cabinet ordered as per advice – ordered 25/07/2023 | Clinical Lead<br><br>Clinical Lead<br><br>Fire Officer | 23/07/2023<br><br>25/07/2023<br><br>30/09/2023 |
| The cleaning checklist was not always being completed correctly. | The health board must ensure the checklist is maintained appropriately to document the cleaning tasks undertaken across the ward. | Ward manager to circulate reminder to Ward F staff team. Cleaning checklist audit to be confirmed as complete on Health Metrics. | Ward Manager | 25/07/2023 |

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| We noted areas of the ward were cluttered and needed to be tidied. | The health board must ensure all clutter is removed from the ward and the communal bathrooms must be kept clear at all times for patients to use. | A review of equipment has been completed, items not required have been returned.<br>Ward Manager to contact hospital operations to explore central storage and whether Ward F are able to access this. | Clinical Lead &<br>Hospital Manager | 31/08/2023 |
| We noted that the medication trolley had a crack on the front of it which raised a doubt over how secure it was. | The health board must ensure that the medication trolley is either repaired or replaced to make it more secure. | Two replacement cabinets have been ordered – 24/07/2023 | Directorate Manager | 31/08/2023 |
| The current MHA legal status for patients was not always recorded on the MAR chart. We also found instances where consent to treatment certificates were not being stored alongside the MAR chart. | The health board must ensure that the MHA legal status is recorded for each patient and that consent to treatment certificates are stored alongside the MAR chart for each patient. | Hospital e-Prescribing and Medicines Administration (HEPMA) to be introduced week commencing 27/07/23.<br><br>A patient file has been developed to include MHA paperwork, Consent to treatment certificates and antipsychotic monitoring. These are stored in the clinical room. | Digital Team<br><br>Ward Manager | 27/07/2023<br><br>27/07/2023 |
| While staff were aware of how to identify potential triggers and manage patients effectively, we did | The health board must ensure PBS plans are developed with patients | Model of care for therapeutic intervention regarding strategies similar to PBS to be discussed at a | Medical Director<br>Lead Nurse | 30/09/2024 |

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| not see this documented within the patient records we reviewed. | that contain proactive and reactive strategies to understand what things are important to patients and help staff identify when they may need to intervene to de-escalate challenging behaviour. | senior level. Additionally, support has been requested from the service improvement learning hub to explore how similar strategies can be delivered.<br>The Ward based MDT develop individualised management plans to support the reduction of risks to identify proactive and reactive strategies to understand how best to support the patient and help staff identify when they may need to intervene to de-escalate challenging behaviour. | Psychologist Lead<br>Lead OT<br><br>Clinical Leads<br>AHPs | <br><br><br>30/09/2023 |
| We noted a delay in uploading information relating to a patient incident during the inspection. Important details regarding other incidents were also missing from an incident form we reviewed. | The health board must ensure all incidents are recorded on the electronic system in a timely manner and ensure all relevant information in relation to the incident is captured accurately. | All staff reminded of the importance of recording incidents. Ward manager and lead nurse monitoring the timeliness and quality of information inputted.<br><br>Lead Nurse and Directorate review and report on Datix activity monthly | Ward Manager<br><br>Lead Nurse | 30/06/2023<br><br>27/07/2023 |
| We noted that one MAR chart did not clearly indicate to staff where IM | The health board must ensure that MAR charts indicate to staff where IM injections should be | HEPMA to be introduced week commencing 27/07/23, this does not include a site specific box. | Ward Manager | 30/07/2023 |

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| injections should be administered for that patient. | administered for each patient. | All staff informed site of IM to be recorded in the clinical record. | | |
| We looked at the seclusion arrangements in place and identified a number of concerns. | The health board must review the seclusion arrangements in place on Ward F and make improvements to address our concerns and ensure they adhere to the health board policy and best practice standards. | Ward Manager to create a care plan template.<br>Seclusion room risk assessment and audit on seclusion room completed and will be completed annually.<br>Order safety pillow, blanket and Clock.<br>Environmental issues within the seclusion room are included on the service group risk register I.D. 3226.<br>Additional bid to be proposed and submitted to senior management team to share with capital colleagues for capital funding for full refurbishment as per plans drawn up previously with reference to Welsh Health Building Note for Adult Acute Mental Health Units and the Mental Health Act: Code of Practice and 6.1.11 RCPysch Standards for Inpatient Mental Health Services. | Ward Manager<br>Ward Manager<br>Directorate Manager<br>Directorate Manager<br>Directorate Manager | 31/07/2023<br>31/07/2023<br>24/08/2023<br>24/08/2023<br>30/09/2023 |

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| We found the patient records to be hard to navigate with some information limited to certain members of staff. | The health board should review the way patient records are being maintained to make sure all staff have access to key information about each patient and that the information is easy to find. | Ward F will be provided with read only access to the Welsh Community Care Information System (WCCIS) which will enable access to patient records recorded in Community Mental Health Teams (CMHTs), Community Drug and Alcohol Teams (CDAT), Crisis Resolution and Intensive Home Treatment (CRIHT) service, and some voluntary services. Ward F staff will be able to upload key documents to share with relevant community practitioners/teams.<br><br>A notes audit has been implemented and identified a training need for the ward team including the admin support. Arrange the appropriate training for health record keeping. | Head of Operations<br><br>Ward Manager and Business Improvement Manager | 30/09/2023<br><br>30/09/2023 |
| We did not find evidence within patient records that patients were being supported to meet their individual dietary needs. | The health board must ensure that the nutritional and hydration needs of patients are assessed on admission and care plans developed to detail how these | Clinical lead to review current practice of filing nutritional and hydration forms in a separate file. Whilst these are added to the health record on discharge and transfer there is room for error. | Clinical Lead | 31/08/2023 |

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| | needs will be managed if required. | Nutritional assessment, including weight over the last 3 months is assessed and following this a care plan is developed. | | |
| The décor of the dining room was in need of improvement. | The health board must provide a suitable and pleasant environment for patients to eat their meals. | Ward has been undergoing a period of redecoration. | Lead Nurse | 25/07/2023 |
| We were not assured that the care and treatment arrangements in place were in line with the Mental Health (Wales) Measure 2010. | The health board must 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. | All inpatients who are care managed or have been admitted for 2 weeks assessment period will receive a care and treatment plan.<br><br>All registered staff will receive the Care and Treatment Planning Training. | Ward Manager<br><br>Ward Manager | 30/09/2023<br><br>30/11/2023 |
| Some staff members felt that in general, their job was detrimental to their health. | The health board must engage with staff to ensure their health and wellbeing is being protected. | Staff engagement meetings have been facilitated.<br><br>Information generated has been entered on to a ‘you said, we did’. | Psychologist<br><br>Ward Manager | 20/07/2023<br><br>31/08/2023 |

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| | | Engagement meeting with SMT has been arranged. | Associate Service Group Director & Deputy Nurse Director | 17/08/2023 |
| | | Staff Well Being Board refresh. | Ward Manager | 24/07/2023 |
| | | Staff team to identify Well Being Champion, Ward Manager to release to attend the training. | Ward Manager | 31/08/2023 |
| | | Nursing Staff Resource increased from 6/6/5 to 7/7/6 and a RN mid shift Mon to Fri to support with MDT work. | Lead Nurse & Finance Partner | 21/07/2023 |
| | | Improvement to staff rest room and breaks are allocated by the nurse in charge to ensure rest is taken. | Clinical Lead | 31/08/2023 |
| | | The following opportunities are offered to staff within Ward F: Trauma Risk Management (TRiM), the wellbeing service, occupational health, MHLD Staff Counsellor | | |

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| | | involvement, Ward F psychologist is undertaking supervision. | | |
| Some staff members indicated that they had not had an appraisal in the last 12 months. We were also told that formal clinical supervision sessions were not being undertaken with nursing staff as required. | 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. | PADRs have been addressed as a priority and these are being completed by the ward manager and clinical leads.<br><br>Ward F has 4 Band 6 clinical leads who will provide supervision to staff within their group or upon request by staff member. This supervision can be both clinical and managerial.<br><br>Supervision audit to be implemented in line with the MHLD Service Group Policy | Ward Manager<br><br>Clinical Leads<br><br>Ward Manager | 30/09/2023<br><br>31/07/2023<br><br>31/08/2023 |
| We did not see any evidence of changes that had been made as a result of formal patient feedback. | The health board must ensure patients are kept informed of the outcomes of their feedback and any changes or improvements implemented as a result. | Ward F will create 'You said, we did' board for both staff and patient perspective.<br><br>Adult Mental Health Directorate received reports from the patient feedback team regarding patient experience, these reports are to be shared with Ward F. | Ward Manager<br><br>Directorate Manager<br>Patient Feedback | 31/07/2023<br><br>31/08/2023 |

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| | | Learning from any complaints submitted via PTR are shared with the appropriate team members within Ward F and actions are developed. | Directorate Manager | 31/07/2023 |
| We found no reference or information available to patients on the Putting Things Right process. | The health board must ensure that information on the Putting Things Right process is made available to patients. | Completed and PTR posters now on the ward and to be put back on the walls following decoration. | Ward Manager | 30/05/2023 |
| Some staff members we spoke with did not know about the whistleblowing policy. | 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. | Ward manager has circulated the policy to the staff team.<br>Ward Manager has displayed posters about the Guardian Service within staff areas | Ward Manager | 20/07/2023 |
| We have recommended a number of improvements as a result of our inspection. | The health board must ensure that the tools used in the quality assurance framework are working effectively and as intended. | Ward F is compliant with the Quality Assurance Framework and has a current action plan.<br><br>Ward F are required to improve their compliance with audit frequency to ensure monthly assessments are undertaken. | Lead Nurse<br><br>Ward Manager | 30/09/2023<br><br>31/08/2023 |

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| | | The audits within the MHLD Quality Assurance Framework are subject to current review within the Service Group to enable these to be more meaningful and effective. | Head of Nursing | 31/10/2023 |

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):** Stephen Jones

**Job role:** Service Group Nurse Director (MHLD)

**Date:** 27 July 2023 (Updated 02 August 2023)