Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Hergest Unit
Ysbyty Gwynedd
Betsi Cadwaladr University Health Board
Inspection date: 15, 16 and 17 May 2023
Publication date: 22 September 2023

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

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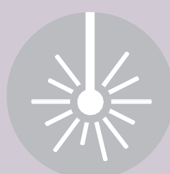

Staff reported there had been recent improvements in the unit's culture, morale and working practices but we noted there was a high number of staff vacancies at the time of our inspection.

Overall, we found staff were committed to providing safe and effective care and there were suitable protocols in place to manage risk, health and safety and infection control. However, improvements were required to prevent patients from bringing items that posed a safety risk onto the wards.

Other areas for improvement included the provision of therapeutic activities for patients and overall staff mandatory training compliance.

Patient care plans reflected individual needs and risks and were being maintained to a good standard. The statutory documentation we saw verified that the patients were appropriately legally detained.

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 Hergest Unit, Ysbyty Gwynedd, Betsi Cadwaladr University Health Board on 15, 16 and 17 May 2023. The following hospital wards were reviewed during this inspection:

- Aneurin - Female acute mental health admission ward
- Cynan - Male acute mental health admission ward
- Taliesin - Psychiatric Intensive Care Unit (PICU).

Our team for the inspection comprised of two HIW Healthcare Inspectors, four clinical peer reviewers and one patient experience reviewer.

The inspection was led by a HIW Senior Healthcare Inspector. 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

Staff interacted and engaged with patients appropriately and with dignity and respect. The majority of patients who we spoke to during the inspection and who completed our questionnaire confirmed that staff were polite, supportive, and helpful. Patients had their own programme of care that reflected their individual needs and risks. However, we found a lack of dedicated therapeutic patient activity programmes in place for patients and noted there were Occupational Therapist (OT) staffing vacancies on the unit. Satisfactory arrangements were in place to promote and protect patient rights but we found that the dormitory sleeping arrangements for patients compromised their privacy, dignity and safety.

Where the service could improve

- The health board must implement a formal process which ensures that patient, family and carer feedback is routinely captured, documented and acted upon as necessary
- The health board must make continued efforts to recruit to vacant OT posts to ensure the provision of meaningful therapeutic activities for patients
- The health board must develop a comprehensive therapeutic activity timetable for patients which includes activities on evenings and weekends
- The health board must ensure that patients can access functional equipment and facilities which encourage health promotion and improvement
- The health board must consider opportunities for single person accommodation to improve the patient experience on the unit.

What we found this service did well

- Unit staff were strongly encouraged and supported to complete Welsh language training

Delivery of Safe and Effective Care

Overall Summary

Patient care plans were being maintained to a good standard. We generally found suitable protocols in place to manage risk, health and safety and infection control. The statutory documentation we saw verified that the patients were legally detained. We were assured that there were sufficient staff numbers to provide safe and appropriate patient care but many staff members voiced concerns that patients could no longer access dedicated inpatient psychology or consultant support on the unit. Staff appeared committed to providing safe and effective care but some patients told us they felt unsafe from other patients and staff. Staff told us they could not always prevent patients from bringing restricted items which posed a safety risk onto the wards. The unit's paper records were generally well-organised and well-completed but some improvements were required to ensure the full completion of documentation including clinic room temperature checks, Positive Behaviour Support plans and medication records. Staff expressed that their working practices would be improved with the introduction of an electronic health record system.

Where the service could improve

- The health board must review its existing policies and procedures with a view to making any additional improvements which can prevent restricted items being brought into the ward to ensure the safety of patients, staff and visitors
- The health board must ensure that the unit washing machines are fully functional and fit for purpose. The health board should consider providing additional washing machines to support the number of patients on the unit
- The health board must ensure that Medication Administration Records are fully completed to include patient legal status information. Additional training should be provided to ensure that medical staff understand their role and responsibilities when completing the charts
- The health board must undertake robust measures to recruit to vacant consultant and psychology posts on the unit to ensure the provision of effective care for patients.

What we found this service did well

- The unit's Mental Health Act team showed a high level of competence, organisation and efficiency and had a good relationship with external agencies.

Quality of Management and Leadership

Overall Summary

The majority of staff who completed HIW questionnaires provided positive feedback about working on the unit. We saw evidence of good collaborative working across the health board to support improvements and disseminate quick learning from incidents and serious untoward events. Established governance arrangements were in place to provide oversight of clinical and operational issues. The leadership team was approachable and supportive to staff and had a good understanding of patient needs but there was no formal staff meeting process to engage staff, discuss issues and encourage staff feedback. Most staff told us they felt there were not enough staff on the wards to enable them to do their job properly and we noted that there were a high number of staff vacancies at the time of our inspection. We saw evidence that staff who were untrained or non-compliant with their mandatory Restrictive Physical Intervention (RPI) training had been involved in patient restraints but were assured that all unit staff would be fully compliant with their training by September 2023.

Where the service could improve

- This health board must consider ways of retaining and developing existing staff members on the unit in order to ensure the stability and expertise of the workforce
- The health must actively focus on the recruitment of staff into outstanding permanent vacancies on the unit
- The health board must conduct a review of staff mandatory training compliance to ensure that all outstanding mandatory training is completed, regularly monitored and that staff are supported to attend the training
- The health must implement a formal staff meeting process to obtain staff feedback and strengthen staff working relationships.

What we found this service did well

- We were informed there had been improvements in the culture, morale and working conditions for staff since our last inspection of the setting.

Staff told us:

> *"At times, understaffing means people have to compensate and work much harder to cover and complete all tasks."*

> *"Colleagues are hard working and professional. They are dedicated to serving patients well. However, I do not sense that clinical activity is underpinned by sufficient reference to external bench-marking relating to standards and procedures. Adherence to such guidelines would require better clinical staffing across all disciplines. A sense of 'this is how we have always done it and it seems to be okay' prevails. Clinical managers in the teams are accessible and supportive. Managers higher up are invisible, to me at least. I do not know their names except from occasional emails that I may be copied into. I certainly would not recognise them in the corridor."*

We asked what could be done to improve the service. Comments included the following:

> *"There is a good culture of care within staff on the unit. Improved medical staffing (consultants) would improve patient care with more regular review."*

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.