Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Ablett Unit, Glan Clwyd Hospital, Betsi Cadwaladr University Health Board

Inspection date: 17, 18 and 19 July 2023

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

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We observed staff treating patients with respect and supporting patients on Tegid Ward with personal care needs in a dignified and sensitive way. The patients we spoke with were complimentary about the care provided and about their interactions with staff.

The patient records we reviewed during the inspection were comprehensive and of good quality.

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.

We identified issues in relation to the physical layout, location and staffing requirements of the Section 136 suite. We found similar issues during our previous inspection of the Ablett Unit in January 2019. We have asked the health board to undertake a review of the use of the Section 136 suite to identify resolutions to the environmental issues and to the staffing requirements to provide safe cover to staff in the Section 136 suite as well as maintaining safe staffing levels on the wards.

We were informed that a new mental health facility is due to be operational from 2026 which would rectify some of the issues identified during this inspection. However, we have asked the health board to provide assurance on what actions will be taken in the meantime to improve the environment and quality of care being provided to patients at the unit before the new facility is opened.

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 of the Ablett Unit at Glan Clwyd Hospital, Betsi Cadwaladr University Health Board on 17, 18 and 19 July 2023. The following wards were reviewed during this inspection:

- Tegid Ward – A 10 bedded mixed gender older person's mental health ward
- Dinas Male Ward – A 10 bedded male acute admissions ward
- Dinas Female Ward – A 10 bedded female acute admissions ward

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.

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

Patients received appropriate physical healthcare assessments in addition to their mental healthcare. This was particularly evident on Tegid Ward where some patients had acute physical needs.

There were opportunities for patients to engage in activities during their stay at the unit. We saw information displayed on the wards to inform patients of their rights under the Mental Health Act. The physical environment of the wards did not help to fully maintain the privacy and dignity of patients. For example, while the majority of patients had their own room, some patients had to share a bedroom. We also felt that it would benefit patients to be able to personalise their rooms to create a space that can express their personality and help promote wellbeing.

Where the service could improve

- The garden on the Dinas Female Ward needs maintenance work to improve its appearance
- The smoking arrangements for patients on Section 17 leave must be reviewed to ensure the health and wellbeing of staff is fully protected
- The laundry room must be tidied and patient clothes should be stored and labelled appropriately
- Health promotion information must be made available to support patients to make decisions that impact positively on their health and wellbeing.

What we found this service did well

- The language preference of each patient was recorded on the patient status at a glance board on each ward which we noted as good practice.

Delivery of Safe and Effective Care

Overall Summary

We found that there were policies and procedures in place to help staff provide safe and effective care. The environment of each ward was clean and tidy and had appropriate fixtures and fittings for the patient group. There were established health board policies and processes in place to ensure that staff safeguarded vulnerable patients with referrals to external agencies as and when required. We found suitable IPC arrangements in place at the unit.

Principles of positive behavioural support were being used to determine level of risk and encourage positive risk taking. We were assured that the health board's responsibilities under the Mental Health Act (the Act) were being upheld.

Where the service could improve

- The health board must develop a policy that details the expectations on staff security in relation to wearing personal alarms
- Soiled clothing or bedsheets must be handled, transported and decontaminated in line with the Welsh Health Technical Memorandum 01-04 guidance
- Ensuring specialised weighing apparatus is available to take weight measurements for bed bound patients
- Medication Administration Records (MAR charts) must be fully completed and written clearly to avoid confusion by staff and reduce the risk of a medication error.

Quality of Management and Leadership

Overall Summary

The majority of staff said they would recommend the unit as a place to work and that they would be happy with the standard of care provided by the unit for themselves or their friends and family. However, some staff members also raised concerns about the staffing levels at the unit and felt that senior management were not visible and that communication between senior management and staff was not effective. We have asked the health board to provide assurance to HIW on whether the current staffing establishments will be reviewed in light of the issues raised.

Where the service could improve

- The health board must reflect on the staff feedback and provide assurance on how it will engage and listen to staff and improve the visibility of senior management to provide more support to ensure staff can fulfil their responsibilities to provide high quality care to patients.

What we found this service did well

- We saw evidence of appropriate discharge and aftercare planning, with good involvement from the MDT, care co-ordinators and mental health teams from the local community
- Mandatory training compliance rates were high among staff at the unit.

Staff told us:

"The ward manager is doing an incredible job, supporting staff and highlighting that more staff are needed in order to ensure that patients remain safe on the ward and the increasing paperwork is being completed in a timely manner."

"The ward managers are very supportive and go above and beyond however the Senior Leadership Team are not very approachable and do not provide enough support and do not support the wards when they are challenging or running on an unsafe staffing level."

"The staffing is poor on the ward meaning staff on shift are having to stay late and work extra because if they left at the end of the shift it would leave the ward unsafe."

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.