Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Cedar Parc Ward, Ysbyty'r Tri Chwm, Aneurin Bevan 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 Ysbyty'r Tri Chwm Hospital, Aneurin Bevan University Health Board on 07, 08 and 09 August 2023. The following hospital ward was reviewed on this inspection:

- Cedar Parc Ward - fourteen beds providing specialist assessment and treatment of dementia patients.

Our team for the inspection comprised of two HIW Healthcare Inspectors, three clinical peer reviewers and one patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of six patient questionnaires and four family/carer questionnaires were completed. We also spoke to staff working at the service during our inspection. Feedback and some of the comments 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:
Staff interacted and engaged with patients appropriately and treated patients with respect. All patients who we spoke to during the inspection and who completed our questionnaire confirmed that staff were polite, supportive, and helpful. We saw evidence that patients were provided with a varied programme of therapeutic activities which were tailored to their individual needs. Patients had access to a mental health advocate who provided information and support with any issues they may have regarding their care.

However, we identified several issues that were compromising the privacy and dignity of patients during the inspection. The ward had insufficient washing facilities and there were no designated toilets and washing facilities for male and female patients. The covered vision panels within patient bedroom doors prevented staff from conducting patient therapeutic observations without opening the door and potentially disturbing patients. We witnessed patients receiving personal care in their bedrooms with their bedroom doors left open, which compromised their privacy and dignity.

This is what we recommend the service can improve:

- The ward must be tidied and de-cluttered to ensure staff and patient safety
- A full assessment must be conducted of the ward environment to ensure the bedroom fixtures and fittings allow patients to rest and sleep in comfort
- The health board must ensure that patient information boards are fully completed and that relevant and up to date information is displayed in the communal areas of the wards for the awareness of patients and visitors
- The health board must ensure that only Welsh speaking staff are issued with uniforms which identify them as a Welsh speaker.

This is what the service did well:

- We observed staff using innovative ideas and techniques to engage patients during the inspection, which we identified as good practice.

Delivery of Safe and Effective Care

Overall summary:

Patient records evidenced detailed and appropriate physical assessments and monitoring. Patient Care and Treatment Plans (CTPs) were individualised, person-centred and reflected the needs and risks of the patients in the hospital. The statutory documentation we saw verified that the patients were legally detained. However, we identified several potential risks to patient safety and found a lack of robust governance oversight of environmental risks and audit processes within the hospital. For example, we saw four missing handrails in the ward corridors with exposed sharp edges which posed a risk of injury to patients, staff and visitors. Various ward-based audits were also not completed within set timescales and we noted a number of IPC improvements were required to ensure the safety of patients, staff and visitors.

Immediate assurances:
During the inspection HIW could not be assured that the health, safety and welfare of patients, staff and visitors at Ysbyty'r Tri Chwm was being actively promoted and protected. In addition, potential risks of harm were not being identified, monitored and where possible, reduced or prevented. The following issues required immediate action by the health board:

- The glass in the main door of Cedar Parc ward was damaged and boarded up. We saw evidence that this matter was escalated to estates on two occasions prior to 4 July 2023 but had still not been repaired by the time of our inspection. We identified that the damaged door posed a fire and a health and safety risk
- We observed that the call bells within patient bedrooms were not easily accessible for patients. Some call bells were located across the room from patient beds and others were positioned where they could not be reached by patients whilst lying down in bed. The call bell buttons were visibly small and therefore not appropriate for the patient group
- There was no emergency pull cord within four of the six patient toilets on the ward. We further noted that whilst all the toilets had emergency call buttons, these were positioned near to the toilet door where they were not easily accessible for patients
- There were sufficient personal alarms for staff but staff were not using them during our inspection. Staff told us they had stopped using the alarms and outlined additional issues regarding staff taking alarms home and not returning them to the hospital. We further noted that there was no personal alarm policy in place to support staff in their roles. After advising staff of the requirement to use the alarms to ensure staff and patient safety we still witnessed staff not using the alarms throughout the inspection. Staff did not address the seriousness of the issue and the remedial action required
- We saw five examples of patient Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms being stored loosely within patient paper

files. This posed a risk to patient safety as the forms could be lost or mislaid and were not easily accessible for staff in the event of an emergency
- We noted that staff compliance with Prevention and Management of Violence and Aggression (PMVA) (Module C) was 91 per cent. We were provided with restraint data which indicated that within the past three months, four patient restraints had been conducted by staff who were non-compliant or had not completed their PMVA training. Furthermore, the health board's 'Use of Restrictive Physical Intervention' policy was out of date; the review date for the policy was 26 September 2019
- Restraint incidents were being recorded on the electronic Datix system. However, we were informed that staff were not always recording restraint incidents under the correct sub-category of 'restraint' within Datix. As a result, the system could not be filtered to produce accurate restraint data and posed considerable difficulty for supervisory staff to provide robust governance oversight of restraint incidents
- We were not assured that the hospital's medication management processes were sufficiently robust or safe. We identified a number of serious issues which required immediate action by the health board to prevent significant harm to patients.

Our concerns regarding these issues were dealt with under our immediate assurance process. Further information on the improvements we identified, and the actions taken by the health board, are provided in Appendix B.

This is what we recommend the service can improve (in addition to the above immediate assurance issues):

- The health board must ensure that ligature cutters are easily accessible for staff to ensure patient safety
- The health board must implement a robust programme of governance oversight to ensure the hospital's maintenance issues are recorded appropriately and resolved promptly and effectively, and that audits are fully completed within set timescales to ensure the safety of patients, staff and visitors
- The health board must review the hospital record keeping arrangements to ensure patient records are well-organised, securely stored and easy to navigate
- The health board must review its communication processes between senior management and hospital staff regarding the dissemination of information, feedback and learning to all staff following patient safety incidents
- The health board must review the hospital Mental Health Act (MHA) document completion and filing processes to ensure that information is appropriately and securely stored and accessible for all staff

- Staff must be provided with additional Welsh Community Care Information System (WCCIS) training to ensure understanding and consistency in MHA administration processes
- The health board must ensure that patients are reliably informed of their rights on an ongoing and regular basis and that relevant documentation is fully completed and shared as appropriate.

Quality of Management and Leadership

Overall summary:
We were advised that there were no permanent staff vacancies at the time of our inspection and found staffing levels were appropriate to maintain patient safety. However, some staff felt there were not enough staff to meet fluctuating staff needs and increased patient demand on the ward. Overall staff mandatory training compliance was generally high at 81 per cent but improvements were required to improve compliance with several mandatory training courses. Staff confirmed there is a governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care. However, we were not assured that the governance structure provided strong operational support, clear leadership and accountability to ward staff. We were not assured that the hospital governance systems supported continuous improvements and shared learning from incidents and serious untoward events.

Immediate assurances:
During the inspection we identified a lack of governance oversight and communication between senior staff and ward staff in relation to ward-based systems, audit processes and opportunities for shared learning. Therefore, we were not assured that key issues were being effectively investigated, escalated, supervised and scrutinised to prevent reoccurrence and drive quality improvement.

The health board must:

- Undertake robust measures to ensure patient safety and strengthen the leadership and management systems within the hospital
- Provide ongoing senior management scrutiny of the hospital's systems and audit processes to ensure they are completed in a timely and effective manner and drive quality improvement
- Identify any additional staff training and development needs and implement training accordingly
- Strengthen quality governance and leadership to ensure effective communication between senior management and ward staff.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

This is what we recommend the service can improve:

- The health board must conduct a review of staff mandatory training compliance to ensure that all mandatory training is fully completed, regularly monitored and that staff are supported to attend the training
- 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 ensure staff meetings are conducted on a regular basis to engage staff, discuss issues and encourage staff feedback
- The health board must review any outdated policies to support staff in their roles.

3. What we found

Quality of Patient Experience

Patient Feedback

We invited patients, family and carers to complete HIW questionnaires to obtain their views on the service provided at the hospital. At the time of the inspection there were fourteen patients on the ward and we received six completed patient questionnaires and four family/carer questionnaires. Of those who contributed, the responses were positive across all areas. All patients and family/carers who responded felt that the service provided by the hospital was 'good' or 'very good.' Some of the comments provided by patients and family/carers are outlined below, and further questionnaire results appear throughout this report.

"Staff very kind. Nice and clean areas"

"All good. Quite happy"

"I feel safe and cared for"

"Better than a 5 star hotel"

"Staff are very kind and care so well."

Person centred

Health Promotion
We found strong evidence that patient physical health needs were prioritised and effectively monitored within patient records. Patients received appropriate physical assessments upon their admission in addition to their mental healthcare. Patients had physical healthcare plans which documented any required ongoing health promotion and preventative interventions, such as specialist support and access to GPs.

During the tour of the hospital we noted there was plentiful health promotion and improvement information displayed on the wards for patient and visitor awareness. The ward was generally clean and provided a relaxed environment of care for patients. However, we identified that some areas would benefit from being tidied and de-cluttered, including the staff office, the day room, the clinic room and 'Singing Kettle' room.

The ward must be tidied and de-cluttered to ensure staff and patient safety.

Patients had access to their bedrooms, communal areas and a pleasant, enclosed garden. The hospital had a dedicated Occupational Therapist (OT) and we saw evidence that patients were provided with a varied programme of therapeutic activities which were tailored to their individual needs. This included indoor and outdoor activities, physical exercise, afternoon tea, movie nights and pet therapy. All patients who completed our questionnaire agreed there were sufficient and appropriate recreational and social activities and that they were able to go outside for exercise and wellbeing as needed.

Dignified and Respectful Care

Throughout the inspection we observed committed and respectful interactions between staff and patients. Staff demonstrated a caring and understanding attitude to patients and communicated using appropriate and effective language. Patients and family/carers whom we spoke with during our inspection and who completed our questionnaire confirmed that staff were polite, responsive and supportive. Nursing staff were very knowledgeable about patients, and it was clear that good professional relationships had been developed to support patient health and wellbeing. However, we identified that several improvements were required in order to protect patient privacy and ensure dignified and respectful patient care.

During our previous inspection of the ward in 2018, we identified a number of issues that were compromising the privacy and dignity of patients. It was therefore disappointing that we again found similar improvements were required to protect patient privacy and dignity. We noted that each patient had their own bedroom which supported their privacy but there was only one ensuite bedroom on the ward and there were no designated toilets and washing facilities for male and female patients. The ward provided two communal baths and one shower for all fourteen patients and the toilets were located separately from the bathrooms. Staff told us this arrangement posed considerable difficulty for them when administering personal care to patients.

The health board must review the ward bathroom and toilet arrangements with a view to providing additional and more appropriate washing facilities.

The health board must ensure the provision of separate toilets and washing facilities for male and female patients.

Since our previous inspection we found that the clear glass vision panels within patient bedrooms had been covered with a reflective coating which ensured patients could not be seen from outside and protected their privacy and dignity. However, this arrangement prevented staff from conducting patient therapeutic

observations without opening the door and potentially disturbing patients. We further noted that one patient bedroom had a clear glass window fitted with partially damaged blinds which had been left open. The window overlooked the nursing station of the ward and allowed light into the bedroom even with the blinds closed. This compromised patient privacy and dignity and posed a risk of potentially disturbing the patient.

The health board must implement measures to ensure all patient bedroom vision panels and windows support their privacy and dignity.

A full assessment must be conducted of the ward environment to ensure the bedroom fixtures and fittings allow patients to rest and sleep in comfort.

During the inspection we noted that the personal care of patients was administered in the bedrooms or communal bathrooms but witnessed two patients receiving personal care in their bedrooms with their bedroom doors left open, which compromised their privacy and dignity.

The health board must ensure that patient privacy and dignity is maintained and respected when administering personal care.

We observed that the bedroom and main communal areas of the ward were separated by locked doors. We noted that the daily patient routine appeared to be institutionalised in nature, in that all patients were transferred to the communal area after being woken in the morning and remained there throughout the day. The doors between the communal and bedroom areas were kept locked and the patients could not freely access their own bedrooms during this time. Whilst we noted there were some rooms within the main communal area that patients could access for privacy, we identified that this arrangement compromised patient privacy and dignity.

Patients must be provided with free-flow access to their own bedrooms to support their privacy and dignity, subject to individual risk assessment.

Patient information

We found a wide variety of appropriate information displayed for both visitors and patients within the Cedar Parc reception area but noted that the leaflet display was very untidy and some of the information provided was out of date. Throughout the hospital we found appropriate and relevant patient information displayed on the following topics:

- Advocacy services
- Information about the role of HIW and how patients can contact HIW

- Mental Health Act information
- How to raise a concern or complaint.

However, the following patient information boards displayed outdated or incomplete information:

- Meet the team boards
- Patient menu boards
- Patient activity boards.

The reception area leaflet display must be tidied and kept up to date.

Patient information boards must be fully completed and kept up to date.

Individualised care

We reviewed the Care and Treatment Plans (CTPs) of five patients. The plans were person centred and each patient had a programme of care that reflected the needs and risks of the individual patients. More findings on the Care and Treatment Plans can be found in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

We found strong evidence that patients were supported to make their own decisions about how they cared for themselves. Where possible, patients could make their own food and clothing choices and were supported to carry out everyday tasks to promote their independence, including attending to personal hygiene and using the laundry room whilst supervised. We noted that patients had access to aids which promoted their independence and quality of life including hearing aids and walking aids as appropriate.

Patients could personalise their rooms and store personal items as they wished. Rooms were also available for patients to spend time away from other patients according to their needs and wishes. The ward had appropriate visiting rooms where patients could see their families in private. All patients who desired family contact and who completed our questionnaire told us they had had contact with friends or family within the past month.

Timely

Timely Care

We found strong evidence that patients were regularly monitored and received timely care in accordance with individual and clinical need. We witnessed staff managing and prioritising patient care and treatment in a timely and effective

manner. We found appropriate systems in place to identify, review and action any patient care needs.

The ward held twice daily handover meetings to share information and discuss individual patient cases. There were regular multidisciplinary team (MDT) meetings during which information was shared to ensure the timely care of patients. There were additional meetings and processes that supported patient care and monitored the progress of patients who were awaiting discharge and community placements.

The hospital had a visible MDT including a full time Senior House Officer (SHO) who worked alongside the consultant psychiatrist to prioritise patient care and treatment. There were policies in place to manage escalating patients including those requiring enhanced observations, dynamic risk assessments for health care and access to out-of-hours emergency services.

Equitable

Communication and language
We witnessed staff treating patients with respect and kindness throughout the inspection. Patients appeared confident in approaching staff to engage in discussions. There were suitable areas where patients could speak privately with staff if required.

The hospital used digital technology as a tool to support effective communication by way of online meetings and electronic information sharing to ensure timely patient care. Some patients had access to their own mobile phones based on individual risk assessment. Hospital electronic devices were available for patient use including an interactive projection system which provided a range of therapeutic activities for patients. The ward had dedicated Occupational Therapy and Speech and Language Therapy (SALT) provision and we observed staff using innovative ideas and techniques to engage patients during the inspection, which we identified as good practice.

Staff showed understanding of the importance of speaking with patients in their preferred language. We noted that ward staff completed mandatory Welsh language training but found that overall compliance with Welsh Language and Welsh writing training was low at 64 per cent. We were told that Welsh speaking staff members were identified by an embroidered logo on their uniforms for patient awareness. However, we were told that some non-Welsh speaking staff had been provided with uniform which identified them as a Welsh speaker due to a uniform shortage. We identified that this could cause confusion for patients, staff and visitors who wished to converse in Welsh.

The health board must undertake measures to improve mandatory Welsh language training compliance.

The health board must ensure that only Welsh speaking staff are issued with uniforms which identify them as a Welsh speaker.

Rights and Equality

We reviewed four patient records of individuals that had been detained under the Mental Health Act. The legal documentation we reviewed was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code). However, we did not find strong evidence that patients were being kept informed of their rights on a regular and ongoing basis. Further information on our findings on the legal documentation is detailed in the Mental Health Act Monitoring section of this report.

We generally found satisfactory arrangements in place to promote and protect patient rights. Reasonable adjustments were in place so that everyone could access and use services on an equal basis. Overall staff compliance with mandatory Equality, Diversity and Human Rights training was 89 per cent on the ward. However, we noted that the health board Equality and Diversity Policy had expired in November 2021.

Regular ward meetings were held to review and discuss practices to minimise the restrictions on patients based on individual patient risks. Patient care was consistent in accordance with the patient age group and requirements. We were assured that patients had access to a mental health advocate who can provide information and support to patients with any issues they may have regarding their care.

Delivery of Safe and Effective Care

Safe

Risk management
During the inspection we were not assured that the health, safety and welfare of patients, staff and visitors at Ysbyty'r Tri Chwm was being actively promoted and protected. In addition, potential risks of harm were not being identified, monitored and where possible, reduced or prevented. We saw examples of potential risks to patient safety which had not been appropriately identified, escalated or addressed.

Our concerns regarding these issues were dealt with under our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Further information on the improvements we identified, and the actions taken by the health board, are provided in Appendix B.

We also identified a number of additional potential risks to patient safety during the inspection. On the first evening of the inspection, we were told that ligature cutters were available to staff, but we found that they were being kept in a locked drawer within the medication trolley in the clinic room. We identified that this arrangement was inappropriate and unsafe as not all staff members had access to the clinic room nor the locked drawer. Therefore, not all staff members would be able to easily access the ligature cutters in the event of an emergency. We also identified issues regarding staff access to ligature cutters on our previous inspection of the ward in 2018. It was therefore disappointing to note that this issue had not been rectified. We further observed there was ward signage to indicate where the ligature cutters should be located, including a designated shelf for the ligature cutters within the nurses station in the bedroom area of the ward, but found no ligature cutters present.

We advised staff of the necessity for the ligature cutters to be moved to a more accessible location for ease of access. However, on the final day of the inspection this had not been actioned. We again engaged with staff and were again told they were kept in the clinic room in the locked drawer. We were shown inside the drawer in which there were two pairs of ligature cutters. After discussing this matter with staff, the ligature cutters were moved from the clinic room drawer to the allocated shelf within the nurses' station. The staff we spoke to showed no awareness of any additional ligature cutters on the ward.

The health board must ensure that ligature cutters are easily accessible for staff to ensure patient safety.

During our tour of the ward we saw that the ends of four handrails on the ward corridors were missing, leaving sharp, exposed edges which posed a risk of injury to patients, staff and visitors. We noted that this issue had been previously recorded in the 'Works and Estates Handyman Log Book' in March 2022 and had also been identified as an ongoing issue in the hospital ligature audit since 2019.

Due to the potential risk to patient safety, these concerns needed to be addressed straight away during the inspection. Further information on the actions taken by the health board is provided in Appendix A.

We further examined the Works and Estates Handyman Log Book completed since 2021 and found that many of the recorded descriptions of faults were insufficient and did not indicate the full nature of the fault nor the risk it posed. Some examples of the descriptions included: '*fire doors', 'door-day room'* and '*tumble dryer'*. We further found that the 'reference number' and 'date completed' sections contained numerous gaps, so it was not always possible to identify whether the work had been completed by Works and Estates. We highlighted this issue to senior staff who could not confirm whether these matters had been addressed and could not provide clarity surrounding the governance oversight of these matters. We requested that a full audit must be conducted of the log book to establish which faults remained outstanding. This action was completed by staff over the course of our inspection, at which time it was established that there were three outstanding actions as follows:

- One patient bedroom had experienced a leak and required redecoration following repair. This was first recorded in December 2022 and again in March 2023 but had not been repaired at the time of our inspection
- The bar of the window frame within the day room was loose and had not been repaired since first being recorded in May 2022
- We were told that the ambient temperature of the ward was too high in the summer months and too low in winter. This was an ongoing issue first recorded in September 2021, but had not been addressed.

We further noted additional environmental issues which required repair during our inspection. The light above the staff kitchen had no cover and posed a safety risk. The venepuncture chair in the clinic room was damaged, in that the arm had come loose from the chair.

The health board must implement robust programme of governance oversight to ensure the hospital's maintenance issues are recorded appropriately and resolved promptly and effectively.

The hospital's outstanding maintenance and environmental issues must be addressed to ensure the comfort and safety of patients, staff and visitors.

The light above the staff kitchen and the venepuncture chair in the clinic room must be repaired or replaced.

Infection prevention and control (IPC) and decontamination
All patients and family/carers who completed our questionnaire felt that the hospital was 'very clean.' The hospital had an appointed IPC lead and a range of up-to-date policies were available that detailed the various IPC procedures to keep staff and patients safe. Staff compliance with mandatory IPC training was high at 89 per cent. Staff we spoke to during the inspection showed awareness of their role and responsibilities in relation to IPC. However, we found a number of IPC improvements were required to ensure the safety of patients, staff and visitors.

We observed that the majority of hospital cleaning schedules were, for the most part, sufficiently completed. However, the Ystbty'r Tri Chwm (YTC) Ward Cleaning Schedule outlined the daily cleaning requirements of the ward but was completed and signed on a weekly basis rather than a daily basis.

Staff had sufficient access to Personal Protective Equipment (PPE) to support individual patient care. During our inspection we saw that one patient was being barrier nursed whilst under one-to-one therapeutic observations and noted that the nursing staff wore full PPE as appropriate. However, we found that the ward's Daily Personal Protective Equipment checks had not been completed since 06 February 2023.

We found appropriate hand washing and infection control signage and facilities on the ward and witnessed staff actively encouraging patients to practice good hygiene. However, the monthly ward hand hygiene audits were not completed between September and December 2022 and had not been completed since 09 March 2023.

During our discussions with senior staff they could not account for why the above checks and audits were not fully completed. We identified a general lack of robust governance oversight in respect of the hospital's established processes and audits which posed a potential risk to patient safety.

The health board must implement a robust programme of governance oversight which ensures that the hospital's established processes and audits are fully completed within set timescales to ensure the safety of patients, staff and visitors.

During our tour of the ward we observed that the washing machine was leaking, and there were towels on the floor of the utility room to capture the leaking water.

The washing machine must be repaired or replaced to support effective IPC and ensure the safety of patients and staff.

We further observed multiple stains and watermarks on the ward's communal bath and found no decontamination stickers on any of the communal patient facilities and equipment to indicate they had been cleaned and were safe to use.

The bathing facilities must be cleaned after each use.

The health board must ensure the use of decontamination stickers to indicate whether communal equipment has been cleaned and is safe for use.

During the inspection we examined the hospital kitchen areas. Within the patient kitchen we found communal patient foods and cereals which were open but unlabelled so the expiry date and date of opening could not be ascertained. We also found open and unsealed foods in the fridge which displayed no date of opening. We identified that this posed a risk to patient safety.

We examined the staff kitchen and found it to be in an untidy and generally unclean state. We viewed the staff fridge and found that the freezer compartment had completely frosted over and could not be opened.

The health board must ensure that patient foods are regularly checked and appropriately labelled so that the opening and expiry date can be viewed.

The staff kitchen must be tidied and maintained to ensure staff safety.

The staff fridge must be reviewed and repaired or replaced as appropriate.

Safeguarding children and adults
The hospital's 'Adult Safeguarding Guidance, To Report or Not to Report' was found to be out of date with a review date of April 2022. Staff we spoke to during the inspection had access to the hospital's safeguarding procedures and showed awareness of their safeguarding responsibilities and the process of making a safeguarding referral. Compliance among staff with Level 1 and 2 Safeguarding Adults training was high at 92 per cent.

At the time of our inspection we were aware of a recent safeguarding incident which was under ongoing investigation within the hospital. Following the incident,

senior staff members had been allocated to observe and support ward staff on a 24-hour basis for the following six weeks. However, we were told that there was limited communication between senior managers and ward staff regarding the matter during this period. Ward staff told us that the sudden, unexplained and ongoing presence of the senior management team had caused them alarm and distress throughout this time, and that the support was later withdrawn without full explanation.

Some senior staff told us that they had not been invited to relevant health board safeguarding meetings which related to the ongoing investigation and felt disconnected from the matters being discussed at the meetings and fed back to ward staff. Additionally, some ward staff told us they did not receive feedback and opportunities for shared learning from incidents after safeguarding referrals had been made.

Putting Things Right and Quality, Patient Safety Patient Experience meetings took place to share concerns and learning opportunities across the service. We viewed meeting minutes which evidenced that safeguarding was discussed as a standing agenda item to help identify any themes and lessons learned. However, ward staff told us they were not invited to the meetings and were not provided with the meeting minutes.

We identified a general lack of communication between senior management and hospital staff in relation to safeguarding issues and discussed this matter with senior staff. They agreed that improvements were required in respect of the communication between senior management and ward staff and the dissemination of feedback and learning to all staff following patient safety incidents.

The health board must review its communication processes between senior management and hospital staff regarding the dissemination of information, feedback and learning to all staff following patient safety incidents.

During the inspection we reviewed a sample of recent safeguarding concerns which were not related to the concern under investigation and found they were recorded and addressed appropriately.

Medicines management

We saw evidence of regular medication reviews completed during weekly ward rounds. Patients had individualised medication management plans and we observed sensitive and appropriate prescribing of medication in accordance with patient needs. We were told that patients were involved in decisions about their medication and were helped to understand their medication wherever possible.

The ward was supported by pharmacy staff who conducted twice weekly visits to the hospital.

However, during the inspection we looked at the arrangements in place for the safe management, storage and administration of medication and were not assured that the processes were sufficiently robust and safe. We identified a number of serious issues which required immediate action by the health board to prevent significant harm to patients:

- The clinic room was found to be in a disorganised and cluttered state
- The hospital's medication storage arrangements posed a risk to patient safety. We found medication insecurely stored in unlocked cupboards and also within a cupboard located under the sink, which posed a risk of medication damage. We further found the medication trolley was not secured to the wall as appropriate
- There were numerous gaps in the drugs fridge temperature monitoring and the clinic room ambient temperature monitoring checklists
- We noted several recorded occasions when the ambient clinic room temperature had exceeded recommended guidelines, which posed a risk of medication damage. Staff were leaving the clinic room window open to maintain the room temperature, which posed a risk of IPC issues within the clinic room
- We found items of unused medical equipment including syringes and wound care equipment had been removed from their original boxes and placed in plastic baskets, which prevented the expiry date of each item being viewed
- We found multiple missing staff signatures within the medication charts we viewed. We further reviewed the ward's weekly medication chart audit completed since 2020 and saw instances when it had not been completed within the set timescales. This audit documented numerous missing signatures with accompanying comments that the staff concerned had been informed or emailed. The monthly Controlled Drugs audit also identified missing staff signatures. During our discussions with staff they were not able to describe any additional governance oversight nor processes implemented to prevent reoccurrence of this error and encourage shared learning. We notified staff of this issue but still found an additional six missing signatures within the medication records over the course of the inspection. Staff did not address the seriousness of the issues present and the remedial actions required. Therefore, we were not assured that patients were being fully protected from harm
- The patient legal status section of the medication record was not completed within three of the records we viewed
- Some staff we spoke with during the inspection were not aware of the legal requirement for C02 Certificate of Consent to Treatment and C03

Certificate of Second Opinion forms when administering medication, which posed a risk to patient safety.

Our concerns regarding these issues were dealt with under our immediate assurance process. Further information on the improvements we identified, and the actions taken by the health board, are provided in Appendix B.

Challenging behaviour

During the inspection we observed a range of therapeutic activities and interventions being provided to patients. We observed staff responding to patient needs in a timely manner and managing patient risks through therapeutic observation and engagement. We saw staff undertaking safe and supportive therapeutic patient observations and found patient observations were conducted and recorded in line with hospital policy. The staff we spoke to understood their roles, and we noted a high percentage of staff compliance with mandatory therapeutic observation training at 91 per cent.

During our discussions with staff they showed understanding of the restrictive practices available to them as well as appropriate preventative measures which can reduce the need for restrictive responses to challenging behaviour. We reviewed recent restraint incidents and noted there had been 21 incidents recorded in the last three months. The majority of the recorded incidents were lower level safeholds and redirection of patients, which demonstrated that restrictive practices were used as a last resort after other methods of de-escalation had proved unsuccessful.

We noted that each patient bedroom had helpful individual information boards which assisted staff to provide appropriate care by detailing important patient information such as likes and dislikes, mobility level and preferred method of engagement. However, we saw four examples of patient information boards which had not been completed and were left blank.

Individual patient information boards must be fully completed to ensure the provision of appropriate and individualised patient care.

Incidents of restrictive practices were reported through the Datix system which incorporated a hierarchy of investigation process and incident sign-off. There was an established governance structure in place to investigate and review restraint incidents including inpatient, ward manager and service leads meetings. However, we identified that further improvements were needed to ensure that themes, trends and opportunities for shared learning were routinely shared with hospital staff. We noted that relevant matters were discussed in the health board's Quality Safety and Patient Experience meetings which were not attended by ward staff.

During the inspection we noted that staff compliance with Prevention and Management of Violence and Aggression (PMVA) was 91 per cent. However, we were informed that within the past three months, four patient restraints had been conducted by staff who were non-compliant or had not completed their PMVA training.

We also found that staff were not recording restraint incidents under the correct sub-category of 'restraint' within Datix. As a result, the system could not be filtered to produce accurate restraint data and presented barriers for supervisory staff to review and provide robust governance oversight of restraint incidents.

Our concerns regarding these issues were dealt with under our immediate assurance process. Further information on the improvements we identified, and the actions taken by the health board, are provided in Appendix B.

Effective

Effective care

The ward had a manager and deputies who were supported by a committed ward and multidisciplinary team. Staff we spoke to during the inspection told us that the team provided good peer support to each other and put the patients at the forefront of their duties. 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 incidents could be monitored and analysed. The majority of staff we spoke with during the inspection confirmed that they knew how to access the relevant clinical policies, procedures and professional guidelines to assist them in their roles. However, improvements were required to ensure the effectiveness of patient care in relation to governance and oversight of incidents, medications management and audit activities as outlined throughout this report.

We found sufficient staff numbers to care for the patients on the ward which met health board staffing templates and were told that staffing was proportionate to ensure patient safety. However, some staff members felt they would benefit from additional staff on the ward. Staff told us the isolated location of the hospital presented difficulties when arranging routine appointments or ambulance transport for patients. During the inspection we noted that one patient had a routine external appointment and was accompanied by two members of staff, leaving the ward short-staffed during this period. The health board may wish to review the hospital's staffing template to ensure the staffing levels continue to be appropriate to provide safe and effective patient care.

Patient records
The hospital had recently adopted a new electronic health record system which demonstrates that the health board is working towards putting effective systems and processes in place which will improve long term quality and performance. There were secure file storage arrangements in place to prevent unauthorised access and breaches in confidentiality. In the nurses' office there was a patient status board displaying comprehensive and confidential information regarding each patient being cared for on the ward. The information was hidden when not in use, indicating that staff placed an emphasis on protecting patient confidentiality.

At the time of our inspection there were two information recording systems in operation, the electronic Welsh Community Care Information System (WCISS) and a paper-based folder system. Patient records were stored electronically on WCCIS and the paper records were securely stored in the nursing office of the ward. However, we found that the paper records were poorly organised, mixed together and not filed in chronological order. The documents were loosely stored within the folders where they could easily become lost or mislaid. We found the patient records very difficult to navigate throughout our inspection.

The health board must review the hospitals record keeping arrangements to ensure patient records are well-organised, securely stored and easy to navigate.

Nutrition and hydration
Our examination of case notes and clinical entries found that patients were supported to meet their individual dietary needs and provided with diets in accordance with their medical needs. Patient nutritional and hydration needs were assessed, recorded and addressed. Patients could access dietetic specialist services as required. We saw evidence of SALT involvement in individual patient risk assessments and care plans as appropriate.

During the inspection we observed that staff were supportive of individual patient food choices. Patients were supported to choose meals from a varied menu which rotated on a two-weekly basis. There were six set times for drinks, snacks and meals throughout the day and we were told that patients could access additional drinks on request. All patients who completed our questionnaire and whom we spoke with during the inspection told us the hospital food was good and met their dietary requirements and they were able to access a drink when needed. We observed food being served to patients during the inspection and found it appeared to be hot, appetising and of good quality.

However, on viewing the ward’s weekly food supplements audit completed since January 2022, we found that it not been completed since 26 June 2023 and there

were multiple occasions when the checks were not completed on a weekly basis, with gaps of up to two months between checks.

The health board must ensure the weekly food supplements audit is fully completed within set timescales.

Mental Health Act Monitoring
The hospital had a dedicated Mental Health Act Administrator and Mental Health Act Champion. We reviewed the statutory detention documents of four patients currently residing on the ward. This included three patients detained under the Mental Health Act (MHA), and one patient under a Deprivation of Liberty Safeguards (DoLS) authorisation. Patient detention was found to be legal according to the legislation and there was good support available for patients from the local Independent Mental Health Advocacy service. The records were generally compliant with the requirements under the Act, but some improvements were required in respect of MHA monitoring.

During the inspection we found the MHA records were poorly organised and difficult to navigate both electronically and in paper format. Information was being recorded within the WCCIS system and within paper-based folders held at ward level. On viewing the paper files, we observed that the legal documentation was loosely stored in a disorderly manner within the folders. The paperwork was disorganised, mixed with unrelated documents and not connected to the folders. This presented a risk of documents being lost or mislaid.

We discussed these issues with staff who agreed that the current paper filing system was not fit for purpose and advised that the electronic WCCIS MHA process was new and unfamiliar to staff. We were informed that staff had received email instructions regarding the process but staff we spoke to during the inspection were not aware of this. We saw conflicting information regarding the process of uploading relevant MHA documents to WCCIS which could cause confusion for staff. We further noted that staff could upload patient detention documentation to a specific MHA tab within WCCIS, but not any associated forms. These could only be uploaded under a separate ‘attachments’ tab where various, unrelated documents were also stored. This created difficulty in locating specific MHA documents within WCCIS.

Consequently, we found that some relevant MHA documentation including Section 132 patient rights, Section 17 leave forms and Consent to Treatment forms were either missing or not easily accessible within the paper folders and WCCIS.

The health board must review the hospital's MHA document completion and filing processes to ensure that information is appropriately and securely stored and accessible for all staff.

The WCCIS system must be reviewed to ensure that it supports consistent and accessible filing of MHA documentation.

Staff must be provided with additional WCCIS training and support to ensure understanding and consistency in MHA administration processes.

During our examination of patient MHA records we noted an instance when there had been a delay in staff completing Consent to Treatment forms for a detained patient and a further delay in staff requesting a Second Opinion Appointed Doctor (SOAD) to address this issue. This had later resulted in the requirement for an urgent treatment authorisation under Section 62 of the Act. Given that some nursing staff were unaware of the legal requirement for Certificate of Consent to Treatment and Certificate of Second Opinion forms when administering medication, we identified that additional training and instruction was required to prevent reoccurrence of this error in future.

The health board must implement additional MHA training for staff which encompasses the legal requirements for C02 Certificate of Consent to Treatment and C03 Certificate of Second Opinion forms when administering medication.

During the inspection we found that Section 17 leave arrangements were not in place for all patients to authorise unexpected or emergency leave from the hospital.

The health board should consider the completion of Section 17 leave forms for all patients as a matter of good practice.

During the inspection we did not see evidence that patients were reliably informed of their MHA rights on an ongoing and regular basis. We reviewed patient rights documentation and saw instances where the relevant forms had been appropriately completed. However, we did not find evidence that patient rights were re-presented on a regular basis and there was no indication that copies of the documentation had been provided to relevant parties as required.

The health board must ensure that patients are reliably informed of their rights on an ongoing and regular basis and that relevant documentation is fully completed and shared as appropriate.

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 reviewed five patient Care and Treatment Plans (CTPs) and found that they were completed in accordance with the Mental Health (Wales) Measure 2010.

Overall, we observed a good standard of clinical record keeping which reflected the needs and risks of the patients in the hospital. Within all the records there was evidence of comprehensive physical health assessments, dynamic risk assessments and National Early Warning Score (NEWS) observations. These were completed and reviewed on a daily or weekly basis as required. Each patient record included a detailed CTP and risk management plan. We found a good standard of factual daily records made by the MDT within WCCIS that provided a comprehesive account of the patient presentation and interventions being offered. Weekly MDT reviews were held on the ward and were complimented by discharge planning meetings which were attended by external professionals and patient representatives as required.

However, whilst the care plans were completed to a good standard, improvements were required in respect of the organisation of the paper records as outlined previously in this report. We found navigation of the patient care plans to be both difficult and time consuming due to the disorganisation of the paper folders and multiple recording formats. We identified that this issue could pose a risk to patient safety as any new or unfamiliar staff would not have prompt access to patient records.

The health board must improve the hospital's care planning filing processes to ensure patient safety and ease of access for all staff.

Quality of Management and Leadership

Leadership

Governance and leadership
Staff confirmed there is a governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care. However, we were not assured that the governance structure provided operational support and clear lines of management and accountability to ward staff. During the inspection it was concerning to observe a general lack of robust governance oversight in relation to aspects of staff and patient safety, environmental risks, audit processes and medications management, as detailed throughout this report. We were not assured that key issues were being effectively investigated, escalated, supervised and scrutinised to prevent reoccurrence. We were not assured that the hospital governance systems and arrangements supported continuous improvements and shared learning from incidents and serious untoward events.

Staff were receptive to our views, findings and recommendations throughout the inspection, but failed to address the seriousness of some of the concerns we raised during the inspection and the remedial actions required. Therefore, we were not assured that patients, staff and visitors were being fully protected from harm on the ward.

During the inspection, ward staff confirmed that the senior management team were approachable and contactable when needed but we identified a lack of effective support and communication between senior staff and ward staff. We noted that senior management team members had recently provided around-the-clock support to ward staff for a period of approximately six weeks as a result of the recent safeguarding incident under investigation. However, prior to this staff felt there was very little senior management visibility and involvement on the ward. Many staff told us they felt the ward was isolated in terms of location, support and communication from the senior management team. Senior staff we spoke with during the inspection confirmed they were not able to visit nor spend as much time on the ward as they wished, due to their high workload and level of responsibilities.

We discussed the lack of governance oversight and senior management scrutiny of ward-based audits, processes, incidents and activities with senior staff. We were told that due to the conflicting demand of their own workloads it was not always possible for senior management to oversee and scrutinise ward-based systems and processes, which were the responsibility of ward staff. Senior staff confirmed that

these processes had not been reviewed nor scrutinised by the senior management team during their recent extended presence on the ward, and the issues we noted during our inspection had not been identified over this period. We were informed that senior staff were instructed to provide a visible presence and reassurance by observing staff, rather than providing robust governance oversight and scrutiny of the ward during this period. Therefore, we were not assured that there was an effective management and supervision process on the ward which provided robust scrutiny and clear guidance to staff.

Our concerns regarding these issues were dealt with under our immediate assurance process. Further information on the improvements we identified, and the actions taken by the health board, are provided in Appendix B.

Workforce

Skilled and enabled workforce

We were advised that there were no permanent staff vacancies at the time of our inspection and found staffing levels were appropriate to maintain patient safety with seven staff members on each shift. However, it was clear from our discussions with staff that bank or agency staff were used to fulfil vacant shifts in the hospital. Some staff we spoke with during the inspection told us that they felt there were not enough staff to meet fluctuating staff needs and increased patient demand on the ward. We were told of occasions when the ward had been short-staffed and they were unable to fill the vacant shifts despite offering them to bank and agency staff. The health board may wish to review the hospital's temporary bank and agency staffing arrangements to ensure they are sufficiently robust and reliable.

At the time of the inspection, we were informed that 79 per cent of staff had received their annual Performance Appraisal and Development Review. We were further informed that there was an appropriate induction process for all hospital staff. However, some staff whom we spoke with during the inspection told us they had not received an induction to the ward.

The health board must continue to improve Performance Appraisal and Development Review completion.

The health board must ensure all staff receive a full induction to the ward.

We found suitable processes in place for senior staff to monitor compliance with mandatory training. We were advised that the hospital had a dedicated Older Adult Mental Health Directorate education team which ensured compliance and provided additional training opportunities for staff. We were provided with evidence which

indicated that overall mandatory training compliance was generally high among ward staff at 81 per cent. However, we were told that staff found it difficult to complete mandatory training courses during their working day due to the demands of their role. We noted that overall staff compliance with the following mandatory training courses was low and required improvement:

- Moving and handling level 2 - 72 per cent
- Violence Against Women, Domestic Abuse and Sexual Violence – 72 per cent.

We also noted that staff compliance with other relevant non-mandatory training, such as Mental Capacity Act (58 per cent), Catheter Care (50 per cent) and SALT (73 per cent) was low.

The health board must conduct a review of staff mandatory training compliance to ensure that all mandatory training is fully completed, regularly monitored and that staff are supported to attend the training.

Culture

People engagement, feedback and learning
Patients could escalate concerns via the health board's Putting Things Right complaints procedure. Senior ward staff confirmed that wherever possible they would try to resolve complaints immediately and share learning from incidents appropriately.

During the inspection staff told us that patient, family and carer feedback was used to make informed decisions on the ward. Feedback forms were provided for relatives and carers within the reception area of the hospital and a 'you said we did' board outlined the hospital's responses to any complaints or suggestions made. We were informed that family and carers were invited to ward round meetings throughout the patient admission, where they could engage with staff and raise any issues. However, we were told that feedback was captured on an informal basis and there was no dedicated process in place to routinely capture patient and family/carer feedback on the provision of care on the ward.

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.

There was an established system in place for dealing with concerns and recording, reviewing and monitoring incidents, but improvements were required to ensure feedback and shared learning opportunities for staff. During the inspection we

noted that the ward had a dedicated bimonthly staff meeting process to share concerns and feedback and strengthen staff working relationships. We were informed that when meetings were held, the minutes were displayed and circulated for staff awareness. However, we found that the meetings did not take place on a regular basis and there had only been one staff meeting since December 2022.

The health board must ensure staff meetings are conducted on a regular basis to engage staff, discuss issues and encourage staff feedback.

We were informed that Quality Patient Safety and Patient Experience Group meetings took place on a monthly basis but ward staff did not attend the meetings and did not receive the meeting minutes. We were told that senior staff members with overall responsibility for the ward only attended meetings by invitation and we saw additional documentary evidence of senior staff requesting an invitation to future meetings.

All relevant members of staff must be invited to attend meetings to support effective communication, shared learning and quality improvement.

A whistleblowing policy was in place should staff wish to raise any concerns about issues on the ward. We were told there were various support systems available to staff including a Wellbeing Service and Occupational Health referrals.

We were informed that training had not yet been provided to staff on the new Duty of Candour requirements. Staff members we spoke with during the inspection were not able to describe the Duty of Candour and their role in meeting the duty, but showed awareness of how to raise concerns when something has gone wrong and the importance of sharing this with patients and their families. We were told that an online leaflet had been developed for staff awareness and that training would soon be implemented in respect of this.

Information

Information governance and digital technology

We found that paper records and data were being maintained in line with General Data Protection Regulation (GDPR) legislation and securely stored in locked areas. Information was accessible to all relevant staff and there were established processes to share information with partner agencies in safe and secure way. The training statistics showed a high level of staff compliance with Information Governance training at 86 per cent.

We found that several health board policies were out of date during our inspection. These included:

- Use of Restrictive Physical Intervention – review date September 2019
- Medicines Management – review date - October 2022
- Recruitment and Selection – expired in 2013
- Nurse Staffing Escalation - review date December 2021
- Lone Working Policy and Guidance – review date April 2020
- Equality and Diversity – review date November 2021
- Adult Safeguarding Guidance to Report or Not to Report – review date April 2022
- Disciplinary Policy and Procedure - review date May 2020
- A Guide to the Delayed Transfers of Care (DTOC) Reporting Process – review date May 2016
- Deteriorating Patient - review date June 2020
- NHS Wales Managing Attendance at Work – review date November 2021
- Policy for Managing and Supporting Staff following a Medication Error - review date January 2023
- Policy for the Control of Substances Hazardous to Health (COSHH) - review date October 2020

The health board must review any outdated policies to support staff in their roles.

Learning, improvement and research

Quality improvement activities

It was apparent from our discussions with senior staff that the health board was reviewing the provision of the service across the wider Older Adult Mental Health Directorate. During our discussions with senior staff they advised that many of the issues we had identified relating to communication, quality improvement and shared learning had already been recognised by the health board prior to our inspection. We were advised that the health board was in the process of developing a divisional improvement plan to address and improve these matters across the Division of Mental Health and Learning Disabilities, which includes the Older Adult Mental Health directorate. We were told that the health board had implemented and commenced workshops for senior staff in respect of this. At the time of our inspection we requested documentary evidence of the divisional improvement plan but were advised that the plan was not yet complete and had not yet been provided to staff.

We have recommended a number of improvements as a result of our inspection and the health board must ensure that these are incorporated into the divisional improvement plan upon completion.

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
During our tour of the ward we saw that the ends of four handrails on the ward corridors were missing, leaving sharp, exposed edges. We noted that this issue had been previously recorded in the 'Works and Estates Handyman Log Book' in March 2022 and had also been identified as an ongoing issue in the hospital's ligature audit since 2019. However, the handrails had still not been repaired at the time of our inspection.	This posed a risk of injury to patients, staff and visitors.	We engaged with staff and outlined the necessity for the handrails to be repaired as a matter of urgency.	The matter was appropriately addressed prior to the end of our inspection in that the handrails were repaired or removed as appropriate.

Appendix B – Immediate improvement plan

Service: Ysbyty'r Tri Chwm

Date of inspection: 07-09 August 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.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
During the inspection HIW could not be assured that the health, safety and welfare of patients, staff and visitors at Ysbyty'r Tri Chwm was being actively promoted and protected. In addition, potential risks of harm were not being identified, monitored and where possible, reduced or prevented. The following issues require immediate action by the health board:				
During our tour of the ward, we saw examples of potential risks to patient safety as follows: The glass in the main door of Cedar Parc ward was damaged and boarded up. We were advised that the electronic security of the door had been compromised since June 2023 and staff had to secure the door by key until it could be repaired. However, not all staff had a key for the door. We saw evidence that this matter was escalated to estates on two occasions prior to the 4 July 2023 but had not been repaired by the time of our inspection. We identified that the damaged door posed a fire and a health and safety risk. Therefore, we were not assured that patients and staff were fully protected from harm.				
1. The health board must repair or replace the main door of Cedar Parc ward to ensure the safety of staff, patients and visitors.		1) New door set has been ordered - lead time four weeks. Installation date for new door set in the main entrance to Cedar Parc Ward is 11th September 2023. There will also be a full fire safety inspection of the new door set on the same date.	Minor Works Dept	11/09/2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		2) Additionally, a further minor works request has been submitted for more keys to be cut. Awaiting keys.	Directorate Manager	18/08/2023
During our inspection we observed that the call bells within patient bedrooms were not easily accessible for patients. Some call bells were located across the room from patient beds and others were positioned where they could not be reached by patients whilst lying down in bed. We further observed that the call bell buttons were visibly small and therefore not appropriate for the patient group.				
2. The health board must ensure that patient call bells are easily accessible and appropriate for the patient group.		3) Call bells reviewed in all patient bedrooms. Beds have been moved to enable better access to the call bell when a patient is in bed.	Ward Manager	Complete 10/08/2023
		4) "Call Bell" signs have been added above the call bell to enable the patient to identify more easily.	Ward Manager	Complete 10/08/2023
		5) Minor Works costing request submitted to explore options around style/size of the call bell and appropriateness for patient group. To explore moving call bells to within patient reach whilst in bed.	Directorate Manager	Complete 10/08/2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		6) As a mitigation, bed alarms have been ordered for every bed, (previously these were only used for patients assessed as at risk of falling) such that any patient who attempts to leave the bed would alert an alarm and a staff member would attend.	Ward Clerk	Complete 11/08/2023
During the inspection we observed that there was no emergency pull cord within four of the six patient toilets on the ward. We further noted that whilst all of the toilets had emergency call buttons, these were positioned near to the toilet door where they were not easily accessible for patients. Therefore, we were not assured that patients are being fully protected from harm within the hospital.				
3. The health board must ensure that emergency pull cords are present in all toilets and easily accessible for patients.		7) Toilets without pullcords identified.	Ward Manager	Complete 10/08/2023
		8) Urgent works and estates request submitted to re-fit pull cords in toilets.	Ward Clerk	Complete 10/08/2023
		9) Pull cords re-fitted in toilets.	Works & Estates Dept	Complete 11/08/2023
		10) Spare pull cords ordered to keep on the ward.	Ward Clerk	Complete 10/08/2023
		11) Monitoring of emergency pull cords added to weekly environmental checklist devised by Ward Manager.	Ward Manager	Complete 11/08/2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		12) To complete every Monday with Ward Clerk and ensure any issues are reported and escalated in a timely manner.		
We were informed that there were sufficient personal alarms for staff but found that staff were not using them during our inspection. Staff told us they had stopped using the alarms over the past year and outlined additional issues regarding staff taking alarms home and not returning them to the hospital. We further noted that there was no personal alarm policy in place to support staff in their roles. After advising staff of the requirement to use the alarms to ensure staff and patient safety we still witnessed staff not using the alarms throughout the inspection. Staff did not address the seriousness of the issue and the remedial action required. Therefore, we were not assured that patients and staff were being fully protected from harm within the hospital.				
4. The health board must ensure that all staff use personal safety alarms. **5.** An audit process must be implemented to ensure alarms are returned at the end of each shift. **6.** An alarm policy must be implemented to support staff in their roles.		13) Discussion with staff around the use of personal alarms.	Ward Manager	Complete 10/08/2023
		14) All staff to use personal alarms on every shift going forward.	Ward Manager	Complete 10/08/2023
		15) Signing In and Out log reintroduced. To be audited weekly by Deputy Ward Manager.	Ward Manager	Complete 10/08/2023
		16) All staff to re-familiarise themselves with the Atus Operational Guidance for use of the personal alarms.	Ward Manager	Complete 10/08/2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		17) Minor works costing submitted to replace missing x 10 personal alarms. (However, there are still enough for each shift).	Ward Manager	Complete 10/08/2023
		18) Divisional procedure for the use of personal alarms on in-patient units to be produced in addition to manufacturers guidance.	Head of Quality & Improvement	31/8/23
We reviewed patient records and found them to be in a disorganised state. The paper documentation was held within loose files of mixed documents which posed a risk of documents being lost or mislaid. We saw five examples of patient Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms being stored loosely within patient paper files. This posed a risk to patient safety as the forms could be lost or mislaid and were not easily accessible for staff in the event of an emergency.				
7. The HB must ensure that DNACPR forms are kept in a fixed and accessible location within patient records to ensure patient safety.		19) The service is currently operating a paper-lite patient records system. Staff to ensure documentation, filed in the notes, requiring uploading to WCCIS are done promptly, to reduce the amount of paperwork in the paper-lite file.	Ward Manager/ Ward Clerk	Complete 14/08/2023
		20) DNACPR form for each patient to be attached to the inside cover of the paper-lite file, separate from all other documentation.	Ward Manager	Complete 14/08/2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		21) An audit of patient paper-lite files will be undertaken monthly and DNACPR forms will form part of this.	Ward Managers across the Division	31/08/2023
		22) Current paper-lite file clasps to be reviewed across MH&LD Division where they are in use.	Service Improvement Managers	30/09/2023
During the inspection we noted that staff compliance with Prevention and Management of Violence and Aggression (PMVA) (Module C) was 91 per cent. We were provided with restraint data which indicated that within the past three months, four patient restraints had been conducted by staff who were non-compliant or had not completed their PMVA training. Because staff had engaged in incidents of restraint after their PMVA training had expired or who had not received PMVA training, we were not assured that staff and patients are being fully protected and safeguarded against injury. Furthermore, the health board's 'Use of Restrictive Physical Intervention' policy was out of date; we noted the review date for the policy was 26 September 2019.				
The Health Board must:		23) Numbers of staff on each shift which are PMVA trained to be included in the daily ward staffing update to the Directorate.	Ward Manager	Complete 10/08/2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
8. Ensure all staff on Cedar Parc are compliant with PMVA training. **9.** Provide assurance that staff and patients will be fully protected to ensure only staff that are compliant with their PMVA training are involved in incidents of restraint.		24) Within the current substantive staffing cohort, all staff are PMVA trained with the exception of one staff member who has been on long term sick. They have been booked for training in October 2023 (first available).	Ward Manager	October 2023
		25) Mandate with Resource Bank that all regular Mental Health bank staff are compliant with PMVA training.	Divisional Nurse	22/08/2023
		26) Discuss all staff PMVA status at each shift handover and identify appropriately trained staff to respond if restraint is required during shift.	Ward Manager	This is established procedure, but handover books will explicitly record this from 8/9/2023
		27) New staff to be booked onto PMVA training whilst supernumerary to ward, as part of the induction.	Ward Manager	Complete 10/08/2023
		28) Refresher training for staff to be booked 3 months in advance of expiry – with lapses to be documented e.g,: maternity or long-term sickness.	Ward Manager	Complete 10/08/2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
10. Update the Health board's 'Use of Restrictive Physical Intervention' policy to provide clear guidance to staff.		29) The 'Use of Restrictive Physical Intervention Policy' has been reviewed and updated. It is currently being consulted upon across the Health Board.	Head of Health & Fire Safety	30/09/2023
During the inspection we observed that restraint incidents were recorded on the Datix system. We were informed that staff were not routinely and correctly recording restraint incidents under the sub-category of 'restraint' within Datix. As a result, the system could not be filtered to produce accurate restraint data and posed considerable difficulty for supervisory staff to provide robust governance oversight of restraint incidents. Therefore, we are not assured that patients and staff are being fully protected from harm within the hospital.				
11. The health board must ensure that robust processes are put in place to ensure restraint incidents are correctly recorded within Datix to support effective investigation, supervision and governance oversight.		30) Datix training to be sourced for all staff.	Senior Nurse	21/08/2023
		31) Guidance distributed to all staff regarding correct completion of Datix incidents ensuring inclusion of all staff involved in incident.	Ward Manager	Complete 14/08/2023
		32) Handover discussions with staff in regards labelling of restraints on Datix. This has been diarised for each handover for the next two weeks.	Ward Manager	Complete 10/08/2023
HIW was not assured that the hospital's medication management processes are sufficiently robust and safe. We highlighted the following serious issues, which require immediate action by the health board to prevent significant harm to patients:				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
12. The clinic room was found to be in a disorganised state and must be decluttered.		33) Clinic room has been decluttered and reorganised.	Ward Manager	Complete 10/08/2023
13. The medication trolley was not secured to the wall.		34) Medication trolley has been secured to the wall when not in use. All staff made aware of this requirement via handover. Sign added to trolley.	Ward Manager	Complete 10/08/2023
14. We found medication stored in unlocked cupboards which posed a risk to patient safety.		35) Medication removed from unlocked cupboard and stored in a temporary lockable cabinet. New lockable cabinet has been ordered which will be secured to the wall.	Ward Manager	Complete 10/08/2023
15. We found medication being stored in a cupboard located under the sink, which posed a risk of medication damage.		36) All medication has been removed from the under the sink cupboards and stored in the temporary lockable cabinet.	Ward Manager	Complete 10/08/2023
16. There were numerous gaps in the drugs fridge temperature monitoring checklist which posed a risk to patient safety.		37) Daily fridge temperature monitoring checklists have been secured to the front of the fridges. These will be filed on a weekly basis. Deputy Ward Managers to audit weekly.	Ward Manager	Complete 10/08/2023
17. There were numerous gaps in the clinic room ambient temperature checklist which posed a risk to patient safety.		38) Weekly room temperature monitoring checklist now in place. These will be filed on a weekly basis. Deputy Ward Managers to audit weekly.	Ward Manager	Complete 10/08/2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
18. We noted that the ambient temperature of the clinic room must not exceed 25 degrees Celsius but saw several recorded occasions when the temperature had risen to 28 degrees Celsius. During our inspection on 8 August 2023, we again witnessed that the ambient temperature of the clinic room was 28 degrees Celsius. This posed a risk of medication damage.		39) An ALERT is now displayed stating "If clinic room temperature exceeds 25°C contact Pharmacy IMMEDIATELY [phone numbers included in & out of hours] for advice and submit a Datix" as per Health Board policy. Additional actions will be completed as per advice from pharmacy.	Ward Manager	Complete 10/08/2023
		40) Alert poster has been provided for display in clinic rooms in all MH&LD in-patient units	Lead Nurse	Complete 30/8/2023
		41) Additional Dyson fan has been added to the clinic room. See also no. 39 and associated actions below.	Ward Manager	Complete 11/08/2023
19. Staff had to leave the clinic room window open to maintain the room temperature, which posed a risk of		42) Discussion with IPAC Lead with regards to possible installation of air conditioning system in the clinic room. IPAC Lead has agreed for this.	Ward Manager	Complete 14/08/2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Infection Prevention and Control issues within the clinic room.		43) Review by Works & Estates officer on 24/08/23. Air handling unit has been isolated to limit room temperature. Building Management System Engineer attended on 30/8/23 & new parts fitted.	SIM	Complete 30/8/23
		44) Minor Works costings request submitted for the installation of an air conditioning system for the clinic room.	Directorate Manager	Complete 14/08/2023
20. We found items of unused medical equipment including syringes and wound care equipment had been removed from their original boxes and placed in plastic baskets which prevented the expiry date of each item being viewed. This posed a risk to patient safety.		45) All items checked and removed. Only items with visible expiry dates to be kept on the trolley. Items with expiry dates to remain in boxes.	Ward Manager	Complete 10/08/2023
21. We found multiple missing signatures within the medication charts we viewed. We further		46) Implementation of daily checks of medication charts by the incoming RMN in handover.	Ward Manager	Complete 10/08/2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
reviewed the hospitals weekly medication chart audit completed since 2020 and saw instances when it had not been completed within the set timescales. This audit documented numerous missed signatures with accompanying comments that the staff concerned had been informed or emailed. The monthly Controlled Drugs audit also identified missing staff signatures. During our discussions with staff they were not able to describe any additional governance oversight nor processes implemented to encourage shared learning and prevent reoccurrence of this error. We notified staff of this issue but still found an additional six missing signatures within the medication records over the course of the inspection. Staff did not address the seriousness of the issues present and the remedial actions required. Therefore, we were not assured that		47) Deputy Ward Manager Medication Management Audit to be completed weekly and escalated to Ward Manager/Senior Nurse when signatures are missed for further action.	Ward Manager	Complete 10/08/2023
		48) Ward Manager to continue to audit the above on a monthly basis, escalating findings to Senior Nurse, Directorate & Division.	Ward Manager	This is established procedure
		49) All staff to complete Medication Management Training on ESR.	Ward Manager	28/08/2023
		50) Medicines Management to be added to supervision agenda for all registered nursing staff.	Ward Manager	Complete 14/08/2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
patients are being fully protected from harm on the ward.				
22. The patient legal status section of the medication record was not completed within three of the records we viewed		51) Consultant Psychiatrist to ensure all medical staff are aware.	Consultant Psychiatrist	Complete 14/08/2023
		52) Ward MHA Champion to complete a monthly audit.	Deputy Ward Manager	Complete 14/08/2023
23. Some staff we spoke with during the inspection were not aware of the legal requirement for C02 Certificate of Consent to Treatment and C03 Certificate of Second Opinion forms when administering medication, which posed a risk to patient safety.		53) Learning document to be shared by MHA Office for staff training.	MHA Team	21/08/2023
		54) All Ward MHA Champions to complete a monthly spot check to ensure forms C02 & C03 are appropriately filed	Deputy Ward Manager	Complete 14/08/2023
		55) The MHA Admin team will continue to audit all MH & LD wards every 6 months and share findings with ward managers, Senior Nurses Directorate & Divisional Teams	MHA Admin Team Manager	Rolling audit
		56) MHA Admin Manager to deliver specific training re: forms C02 & 3 to the ward.	MHA Admin Manager	To commence 19 September 2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		57) MHA training is offered on a rolling basis. MHA trainer to book update sessions with each ward across the Division.	MHA Trainer	September-October 2023
		58) Legal requirement re: forms C02 & C03 included in the Newly Qualified Nurse Journey of Excellence (JOE) training.	MHA Trainer	Complete Current cycle of JOE training commenced August 2023
The health board must: **24.** Implement a robust system of governance oversight which ensures that the hospital's medications management processes support patient safety		59) Robust audit tool to be developed for Medicines Management and implemented across the MH & LD Division.	Divisional Nurse	04/09/2023
25. Provide additional training to staff to ensure that staff understand their roles and responsibilities when completing the charts and administering medication.		60) Additional to medicines management online training, classroom training to be sought for all staff who require further support or have been identified to have not followed correct medicines management processes.	Ward Manager	This is established practice
Quality of management and leadership				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
During the inspection we identified a lack of governance oversight and communication between senior staff and ward staff in relation to ward-based systems, audit processes and opportunities for shared learning. Therefore, we were not assured that key issues were being effectively investigated, escalated, supervised and scrutinised to prevent reoccurrence and drive quality improvement.				
The health board must: **26.** Undertake robust measures to ensure patient safety and strengthen the leadership and management systems within the hospital.		61) Senior Nurse to continue to facilitate unit management meetings on a monthly basis. This will take the form of a multi-professional approach to include, Ward Manager, OT Lead, Psychology Lead, Medical colleagues, Community Team Leads. A standing agenda item will be the sharing of minutes from all directorate QPS/DPM meetings. These are rolling monthly meetings with minutes disseminated to staff unable to attend & include operational updates, open space, themes & learning from complaints, incidents, compliments & audits.	Senior Nurse	Next meeting is 13.09.23, these will be a permanent feature
		62) Senior Nurse & Ward Manager have daily 'check in' meetings to ensure swift escalation, review and management of any issues, findings of weekly/ monthly audits and ensure effective and timely sharing of information, learning & quality issues. Issues requiring immediate escalation will be discussed at daily	Senior Nurse	From 10/08/23

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		scheduled Directorate/ Divisional huddles.		
27. Provide ongoing senior management scrutiny of the hospital's systems and audit processes to ensure they are completed in a timely and effective manner and drive quality improvement.		63) Senior Nurse to increase monthly supervision with Ward Manager to fortnightly, with a robust agenda to include review of clinical & quality assurance processes. This will be monitored by the Lead Nurse in 1:1 supervision with Senior Nurse.	Senior Nurse	Fortnightly reviews commenced 4/8/23. Review after 3 months (November 2023)
		64) Audit results to be shared to evidence and provide focus on quality improvement and learning at the following meetings: Ward staff meetings; Ward Manager's meeting; Inpatient workstream meeting; Directorate and Divisional QPS & Assurance Meetings; Divisional QPS and Assurance meetings with Executive colleagues and wider Health Board forums. Directorate reporting templates to be updated & used at existing, established meetings.	Lead Nurses and Professional Leads	Complete (These are established meetings across the Division. Updated templates will be used from September meetings).
		65) Cross-ward Quality Assurance inpatient audits have been developed to measure	Directorate Management	August 2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		against a broad range of standards encompassing the Health & Care Quality Standards. Existing tools have been piloted to ensure one tool captures all that is required. These include RCPsych Quality Network for OAMH services standards, 15 steps challenge IPaC & Medicines Management.	Team with Divisional Lead Nurse oversight and steer	(commenced 24/08/2023)
28. Identify any additional staff training and development needs and implement training accordingly.		66) Senior Nurse & Ward Manager to identify & implement additional training needs of nursing staff as per Directorate training matrix & identify requirements. Training requirements will be escalated to Directorate/ Division as appropriate.	Senior Nurse	Training requirements reviewed at fortnightly meeting with Senior Nurse & Ward Manager as of 4/8/2023
		67) 'Positive Approaches to Care' training has been delivered to ward nursing staff. (13 x RNMH & 22 x HCSW).	Senior Nurse	Rolling programme of delivery between 2-26/7/2023. Next cycle to commence October 2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
				to capture newly qualified nurses
		68) A training matrix for Directorate inpatient nursing staff has been developed, setting the expected requirement across OAMH inpatient wards	Senior Nurse	Complete August 2023
29. Strengthen quality governance and leadership to ensure effective communication between senior management and ward staff.		69) All Ward Managers to be invited to Directorate QPS meetings going forward.	Lead Nurse	Complete 14/08/2023
		70) All Directorates will continue to provide an update on Quality Improvement and Learning at Divisional QPS Meeting & Divisional Learning Group.	Lead Nurses/ Divisional Nurse	New templates in use at Divisional QPS meeting from 27/8/23
		71) Dashboards to be developed at ward & Directorate level to include complaints, compliments, serious incidents, Datix incidents, safeguarding & 'Civica' patient experience/Improvement Cymru PREMs feedback to be discussed at Directorate & Divisional level, to monitor for themes &	Directorate Management Team/ Ward Managers with Divisional QPS oversight	September 2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		trends & to enable sharing of good practice.		
		72) Older Adult Directorate team members (including Lead Nurse) continue to visit the ward on a minimum six weekly basis.	Directorate Management Team	Complete (These are established visits).
		73) Senior nurse will be physically based on the ward at least twice per week.	Senior nurse	Commenced 4/8/23
		74) Divisional Senior Management team members (including Divisional Nurse/ Deputy) continue to visit the ward on an announced & unannounced basis.	Divisional Management Team	Complete (these are established visits)

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): **Michelle Forkings**

Job role: **Divisional Nurse for MH/LD**

Date: 16/08/2023 (updated version 06/09/2023)

Appendix C - Improvement plan

Service: **Ysbyty'r Tri Chwm**
Date of inspection: **07-09 August 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
We identified that some areas would benefit from being tidied and de-cluttered, including the staff office, the day room, the clinic room and 'Singing Kettle' room.	The ward must be tidied and de-cluttered to ensure staff and patient safety.	Ward has been de-cluttered and tidied. Night staff complete a nightly cleaning audit to ensure areas are tidy and clear, but that items promoting activity can still be accessed easily by patients. Deputy Ward Managers audit the nightly audits weekly. Ward Manager meets with Senior Nurse on a fortnightly basis to discuss results and concerns. The results including any issues/themes are then escalated for assurance to the Directorate team, and where appropriate Divisional team.	Ward Manager	Complete

We noted that each patient had their own bedroom which supported their privacy but there were no designated toilets and washing facilities for male and female patients.	The health board must ensure the provision of separate toilets and washing facilities for male and female patients.	Costings have been requested for 'unisex/accessible' signs in accordance with Equality, Diversity & Inclusion guidance.	Service Improvement Manager	Costings requested 26.09.23
		'Dementia Friendly Environment' audit recently completed which has identified that toilet doors need to be painted a consistent, contrast colour. Costing has been submitted to paint all toilet doors orange.	Service Improvement Manager / Ward Manager	Costing requested 27.09.23
There was only one ensuite bedroom on the ward. The ward provided two communal baths and one shower for all fourteen patients and the toilets were located separately from the bathrooms.	The health board must review the ward bathroom and toilet arrangements with a view to providing additional and more appropriate washing facilities.	Costings have been requested to: • Convert unused bathroom into wet room with accessible shower. • Convert bath in ensuite to shower. • Consideration to be given to contrasting colours to suit dementia friendly environment.	Service Improvement Manager / Facilities	Costing requested 27.09.23

The covered bedroom vision panels arrangement prevented staff from conducting patient therapeutic observations without opening the door and potentially disturbing patients.	The health board must implement measures to ensure all patient bedroom vision panels and windows support their privacy and dignity.	Ward personnel met with facilities to explore options available. Costings to replace all doors to be requested. Paper to be developed to outline options and financial costs for the Health Board to consider.	Facilities Manager/ Ward Manager/ Service Improvement Manager	Costing requested 27.09.23
		To be added to Directorate risk register.	Service Improvement Manager	Complete 29.09.23
One patient bedroom had a clear glass window fitted with partially damaged blinds which had been left open. The window overlooked the nursing station of the ward and allowed light into the bedroom even with the blinds closed. This compromised patient privacy and dignity and posed a risk of potentially disturbing the patient.	A full assessment must be conducted of the ward environment to ensure the bedroom fixtures and fittings allow patients to rest and sleep in comfort.	Window to be fitted with mirror film. Costing has been requested.	Facilities/ Service Improvement Manager	Costing requested 27.09.23
		In the interim, vertical blinds have been sourced as remedial resolution.	Ward Manager	Complete 29.09.23

During the inspection we witnessed two patients receiving personal care in their bedrooms with their bedroom doors left open, which compromised their privacy and dignity.	The health board must ensure that patient privacy and dignity is maintained and respected when administering personal care.	Ward manager has reminded the staff of the importance of closing bedroom doors when personal care is being delivered (unless there is a clinical rationale in the care plan).	Ward Manager	Complete
Patients could not freely access their own bedrooms during the day. We identified that this arrangement compromised patient privacy and dignity.	Patients must be provided with free-flow access to their own bedrooms to support their privacy and dignity, subject to individual risk assessment.	The door fob controlling access to the bedroom corridor has been deactivated.	Ward Manager	Complete
		To review current arrangements on all OAMH wards to improve security of belongings (NB valuable items are stored in the safe or family asked to keep safe). This will be assessed on an individual basis and included in the patient's risk assessment and care plan where applicable.	Ward manager	October 2023
The Cedar Parc reception area leaflet display was very untidy and some of	The reception area leaflet display must be tidied and kept up to date.	New, up to date leaflets, are now in use on the ward	Ward Clerk	Complete

the information provided was out of date.		Ward clerk will monitor and maintain this area and keep up to date information.	Ward Clerk	Complete
The following patient information boards displayed outdated or incomplete information: • Meet the team boards • Patient menu boards • Patient activity boards	Patient information boards must be fully completed and kept up to date	Cedar Parc team board is now up to date.	Ward Manager	Complete
		Patient Menu Boards are up to date. HCSWs update these daily (text and pictures).	Nurse in Charge	Complete
		Activity Board is up to date.	Occupational Therapy team	Complete
We found that overall compliance with Welsh Language and Welsh writing training was low at 64 per cent.	The health board must undertake measures to improve mandatory Welsh language training compliance.	Clinical Lead Nurse has taken responsibility for monitoring and maintaining training compliance.	Clinical lead nurse	Complete
		Directorate representative to attend Health Board quarterly Welsh Language meetings.	Directorate Lead Administrator	From 11.10.23
		Ward compliance will have increased to 80% by the end of October.	Ward Manager & Clinical Lead Nurse	October 2023

Some non-Welsh speaking staff had been provided with uniform which identified them as a Welsh speaker due to a uniform shortage. This could cause confusion for patients, staff and visitors who wished to converse in Welsh.	The health board must ensure that only Welsh speaking staff are issued with uniforms which identify them as a Welsh speaker.	Ward Manager to ensure appropriate uniform is worn by all staff.	Ward Manager	Complete
The hospital ligature cutters were being kept in a locked drawer within the medication trolley in the clinic room, which prevented staff from quickly accessing them in the event of an emergency.	The health board must ensure that ligature cutters are easily accessible for staff to ensure patient safety.	Cutters are now stored in the correct place as per guidance.	Ward Manager	Complete
		Storage and any usage are monitored via the weekly audit with any issues escalated to Ward Manager/ Senior Nurse.	Deputy Ward Managers	
We examined the Works and Estates Handyman Log Book and found that many of the recorded descriptions of faults were insufficient and did not indicate the full	The health board must implement robust programme of governance oversight to ensure the hospital's maintenance issues are recorded appropriately and resolved promptly and effectively.	Log book has been removed. Any issues are reported via helpdesk in a timely way, with any delays escalated to the Directorate team (and Divisional team as required).	Ward Clerk/ Ward Manager	Complete

nature of the fault nor the risk it posed. We further found that the 'reference number' and 'date completed' sections contained numerous gaps so it was not always possible to identify whether the work had been completed by Works and Estates.		Ward Clerk maintains a folder with all requests and updates, which are accessible to all. All staff are aware of this file and where to find it. Ward manager discusses daily with the Ward Clerk, who formally updates weekly.		
We requested that a full audit must be conducted of the log book at which time it was established that there were three actions outstanding which had not been addressed.	The hospital's outstanding maintenance and environmental issues must be addressed to ensure the comfort and safety of patients, staff and visitors.	All works are now reported via helpdesk (see above).	Ward Clerk/ Ward Manager	Complete
The light above the staff kitchen had no cover and posed a safety risk.	The light above the staff kitchen must be repaired or replaced.	This has been escalated via helpdesk for repair.	Ward Clerk	October 2023
The venepuncture chair in the clinic room was damaged, in that the	The venepuncture chair in the clinic room must be repaired or replaced.	New chair has been ordered.	Ward Manager	Delivery due on 03/10/23

arm had come loose from the chair.				
We found various IPC audits that were incomplete or contained gaps: • The Ysbyty'r Tri Chwm (YTC) Ward Cleaning Schedule outlined the daily cleaning requirements of the ward but was completed and signed on a weekly basis rather than a daily basis.	The health board must implement a robust programme of governance oversight which ensures that the hospital's established processes and audits are fully completed within set timescales to ensure the safety of patients, staff and visitors.	Night staff complete a nightly cleaning audit to ensure items are cleaned regularly. Deputy Ward Managers audit these weekly and these are discussed in Ward Manager supervision with the Senior Nurse on a fortnightly basis. These are then escalated for assurance to the Directorate team.		Complete
		Historically, the ward was not part of the monthly environmental cleanliness audit. Facilities Division has now included the ward within the next audit in October 2023.	Facilities Division	October 2023
• The ward's Daily Personal Protective Equipment checks had not been completed since 06 February 2023.		The Clinical Lead Nurse is responsible for completing these checks weekly and requesting any stock is ordered via the ward clerk. Ward Manager reviews this weekly, escalating any concerns via Senior Nurse/ Directorate	Clinical Lead Nurse/ Ward Manager	Ongoing from September 2023

		team/ Divisional team as required.		
• The monthly ward hand hygiene audits were not completed between September and December 2022 and had not been completed since 09 March 2023.		As above. The Ward manager will review the audit weekly and action as appropriate.	Clinical Lead Nurse (B6)/ Ward Manager	Complete Ongoing from September 2023
During our tour of the ward, we observed that the washing machine was leaking and there were towels on the floor of the utility room to capture the leaking water.	The washing machine must be repaired or replaced to support effective IPC and ensure the safety of patients and staff.	Ward to order a new washing machine. Costings have been requested to progress.	Service Improvement Manager/Ward clerk	Costings requested 25/09/23
We observed multiple stains and watermarks on the ward communal bath	The bathing facilities must be cleaned after each use.	This bath is not used as it is not safely accessible by patients. Costings requested to convert this bath to a shower room	Service Improvement Manager /Facilities	Costings requested 25/09/23

We found no decontamination stickers on any of the communal patient facilities and equipment to indicate they were clean and safe for use.	The health board must ensure the use of decontamination stickers to indicate whether communal equipment has been cleaned and is safe for use.	Stickers now in place	Ward Manager	Complete
		Ward stickers ordered and received to confirm record of cleaning.	Ward Manager	Complete
We found communal patient foods and cereals which were open but unlabelled so the expiry date and date of opening could not be ascertained. We also found open and unsealed foods in the fridge which displayed no date of opening.	The health board must ensure that patient foods are regularly checked and appropriately labelled so that the opening and expiry date can be viewed.	Labels now provided and local arrangement agreed with facilities catering staff to checking these.	Facilities	Complete
		Monitored by ward manager via random spot checks.	Ward Manager	Complete Ongoing from September 2023
We examined the staff kitchen and found it to be in an untidy and generally unclean state.	The staff kitchen must be tidied and maintained to ensure staff safety.	The staff kitchen has been added to the ward nightly cleaning rota.	Ward Manager	Complete Ongoing from September 2023
We viewed the staff fridge and found that the freezer compartment had completely frosted	The staff fridge must be reviewed and repaired or replaced as appropriate.	Fridge removed. A new fridge has been received.	Ward Manager	Complete

over and could not be opened.				
We identified a general lack of communication between senior management and hospital staff in relation to safeguarding issues. Additionally, some ward staff told us they did not receive feedback and opportunities for shared learning from incidents after safeguarding referrals had been made.	The health board must review its communication processes between senior management and hospital staff regarding the dissemination of information, feedback and learning to all staff following patient safety incidents.	Communication processes have been strengthened. Directorate senior staff meeting and template agenda has been developed to include a number of standing agenda items regards quality and patient safety. Issues are then cascaded by Senior Nurse and Ward Manager. The ward process reflects the Directorate process and there is now a standardised ward meeting template which includes quality and patient safety issues. Issues are also raised and escalated where required in Ward Manager supervision with Senior Nurse on a fortnightly basis. These are then reflected by Senior Nurse to Directorate team (and to the Divisional team, where indicated). This will be reviewed and monitored through assurance meetings and Divisional staff forums and surveys.	Ward Manager/ Senior Nurse/ Directorate Management team (including Directorate Lead Nurse)/ Divisional Management team (including Divisional Nurse)	Complete Ongoing from August 2023

		All staff are encouraged to speak up		
		There is a Divisional improvement plan in place which is reported and monitored by Executives of the Health Board on a fortnightly basis.	Divisional Management Team	Ongoing from July 2023
We saw four examples of patient information boards which had not been completed and were left blank.	Individual patient information boards must be fully completed to ensure the provision of appropriate and individualised patient care.	This has been identified as the role of the named nurse and HCSW team on admission. This is updated with information from the 'All about me' document facilitated by the OT team on and during admission and information transferred should the patient move rooms.	Ward Manager/ Named Nurse/ OT team	Complete
		Nurse in Charge/Ward Manager to review daily.	Ward Manager	Complete

We found that the hospital's paper records were poorly organised, mixed together and not filed in chronological order. The documents were loosely stored within the folders where they could easily become lost or mislaid.	The health board must review the hospitals record keeping arrangements to ensure patient records are well-organised, securely stored and easy to navigate.	Alternative files have been ordered to replace all current files across the Division, to ensure secure filing of documents.	Service Improvement Manager / General Manager	October 2023
The ward's weekly food supplements audit had not been completed since 26 June 2023 and there were multiple occasions when the checks were not completed on a weekly basis, with gaps of up to two months between checks.	The health board must ensure the weekly food supplements audit is fully completed within set timescales.	This is now part of the weekly Deputy Ward Managers' audit and discussed weekly with Ward Manager. Issues are discussed by Ward Manager in supervision with Senior Nurse. Any issues/themes are then escalated for assurance to the Directorate team, and to the Divisional team, where indicated.	Deputy Ward Managers/ Ward Manager	Complete Ongoing from August 2023

During the inspection we found the MHA records were poorly organised and difficult to navigate both electronically and in paper format. We saw conflicting information regarding the process of uploading relevant MHA documents to WCCIS which could cause confusion for staff. Some relevant MHA documentation including Section 132 patient rights, Section 17 Leave forms and Consent to Treatment forms were either missing or not easily accessible within the paper folders and WCCIS.	The health board must review the hospital's MHA document completion and filing processes to ensure that information is appropriately and securely stored and accessible for all staff.	Enquiries have been made with the WCCIS team to review where core uploaded documents (including statutory documentation) are stored on the system.	Head of Quality & Improvement	In progress from September 2023
		Core documents, including copies of statutory MHA documentation should also be stored in the hard file. The new files (please see 48) have dividers to ensure that documentation is consistently stored and can be easily located.	Service Improvement Manager	October 2023
	The WCCIS system must be reviewed to ensure that it supports consistent and accessible filing of MHA documentation.	As above.	Head of Quality & Improvement	In progress from September 2023

	Staff must be provided with additional WCCIS training and support to ensure understanding and consistency in MHA administration processes.	The MHA training will include where and how to upload information and where/how to store hard copies.	MHA Trainer/ MHA Administration Team Lead	From October 2023 (linking with ward time out day on 06.10.23)
We noted an instance when there had been a delay in staff completing Consent to Treatment forms for a detained patient and a further delay in staff requesting a Second Opinion Appointed Doctor (SOAD) to address this issue. This had later resulted in the requirement for an urgent treatment authorisation under Section 62 of the Act. We identified that additional training and instruction was required to prevent	The health board must implement additional MHA training for staff which encompasses the legal requirements for C02 Certificate of Consent to Treatment and C03 Certificate of Second Opinion forms when administering medication.	This has now been explicitly added to the standard MHA training. This has now been added to the Journey of Excellence (JOE) programme of training for newly qualified nursing staff.	MHA Trainer/ MHA Administration Team Lead	From October 2023 (linking with ward time out day on 06.10.23)

reoccurrence of this error in future.				
We found that Section 17 leave arrangements were not in place for all patients to authorise unexpected or emergency leave from the hospital.	The health board should consider the completion of S17 leave forms for all patients as a matter of good practice.	The Health Board will review this arrangement with the MHA Department	Head of Quality & Improvement	October 23
		To be discussed at the Divisional Quality & Patient Safety meeting and with Responsible Clinicians in the Senior Psychiatrists' meeting	Head of Quality & Improvement	November 2023

We did not find evidence that patient rights were re-presented on a regular basis and there was no indication that copies of the documentation had been provided to relevant parties as required.	The health board must ensure that patients are reliably informed of their rights on an ongoing and regular basis and that relevant documentation is fully completed and shared as appropriate.	Reading and re-presentation of rights is included in MHA training programme. This will include 'best interest' process if a patient is too distressed or lacks capacity.	MHA Trainer Ward Manager	Complete Complete
We found navigation of the patient CTPs to be both difficult and time consuming due to the disorganisation of the paper folders and multiple recording formats. We identified that this issue could pose	The health board must improve the hospital's care planning filing processes to ensure patient safety and ease of access for all staff.	Enquiries have been made with the WCCIS team to review where core uploaded documents (including statutory documentation) are stored on the system.	Head of Quality & Improvement	In progress from September 2023

a risk to patient safety as any new or unfamiliar staff would not have prompt access to patient records.		Core documents, including copies of statutory MHA documentation should also be stored in the hard file. The new files have dividers to ensure that documentation is consistently stored and can be easily located.	Service Improvement Managers.	October 2023
		There is a Standard Operating Policy in place to guide authorising access to WCCIS for temporary staff such as bank nurses. This has been shared with Directorates/ wards again.	Directorate Lead Nurse	Complete
We were informed that 79 per cent of staff had received their annual Performance Appraisal and Development Review.	The health board must continue to improve Performance Appraisal and Development Review completion.	The Health Board and Division is committed to staff Performance Appraisal and Development Reviews. All ward staff reviews have been arranged or completed for staff currently in work.	Ward Manager	Complete

		The Clinical Lead Nurse has taken responsibility for monitoring PADR compliance across the nursing team to ensure PADRs are arranged in a timely way.	Clinical Lead Nurse	Complete
Some staff told us they had not received an induction to the ward.	The health board must ensure all staff receive a full induction to the ward.	In addition to the Health Board corporate induction, there is a MH and LD induction programme and each ward has a local induction. Additionally, new staff to the ward are supernumerary for a minimum of two weeks as part of that induction. A brief induction is provided to agency/bank staff who are unfamiliar with the ward at the start of each shift.	Ward Manager	Complete
We noted that overall staff compliance with the following mandatory training courses was low	The health board must conduct a review of staff mandatory training compliance to ensure that all mandatory training is fully completed, regularly	The ward's overall compliance with mandatory training is over 80% as per Health Board requirements. This will be maintained.	Ward manager/ Clinical Lead Nurse	Complete

and required improvement: • Moving and handling level 2 • Violence Against Women, Domestic Abuse and Sexual Violence. We also noted that staff compliance with other relevant non-mandatory training, such as Mental Capacity Act (58 per cent), Catheter Care (50 per cent) and SALT (73 per cent) was low.	monitored and that staff are supported to attend the training.	The Clinical Lead Nurse (B6) has taken responsibility for monitoring compliance with this, ensuring staff are aware and have the opportunity to attend in a timely way.	Clinical Lead Nurse/ Ward manager	Complete
		Mental Capacity Act, Catheter Care and SLT training is essential training. The clinical lead nurse will ensure staff are compliant with this training	Clinical Lead Nurse/ Ward manager	Complete
		Any issues with compliance and/or difficulty sourcing training will be escalated by Ward manager to Senior Nurse/ Directorate team/ Divisional team as appropriate.	Clinical Lead Nurse/ Ward manager	Complete

We were told that feedback was captured on an informal basis and there was no dedicated process in place to routinely capture patient and family/carer feedback on the provision of care on the ward.	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 ward has a 'You said, we did board' which is regularly completed and updated, incorporating patient and carer/family feedback. This will continue to be captured.	Ward Manager	Established process which is ongoing
		The ward has patient/ carer feedback forms available and will include these in the patient/carer information notice board. Ward manager will prompt nursing staff to request feedback from patients/family during their stay and upon discharge. Feedback will be reviewed and monitored through the Ward manager and Senior Nurse meeting. This will feed into and governed through the Directorate QPS and Divisional QPS meeting for identified themes and good practice.	Ward Manager/ nursing team	October 2023 (will be discussed at team away day 05.10.2023) October 23

		The Health Board has recently launched 'Civica'- a patient experience feedback system where patients can raise observations/ suggestions & feedback about their experience. This is currently being introduced in the MH/ LD Division.	Divisional Nurse	November 2023
We noted that the ward had a dedicated bimonthly staff meeting process but found that the meetings did not take place on a regular basis and there had only been one staff meeting since December 2022.	The health board must ensure staff meetings are conducted on a regular basis to engage staff, discuss issues and encourage staff feedback.	Ward meetings have been re-instated for all staff which will be led by the Ward Manager. Minutes are taken and available to all staff. Staff are encouraged to raise items for the agenda on a white board for discussion and the meeting.	Ward manager	Complete Ongoing from mid-September 2023
		Agenda and outcome discussed by Ward Manager with Senior Nurse at fortnightly supervision.	Ward Manager Senior Nurse	Complete Ongoing from mid-September 2023

		Directorate teams also hold bimonthly QPS meetings. Membership has now been extended to all colleagues at Band 7 level or equivalent from all professional groups. Minutes are shared and issues cascaded via team and ward meetings/ via professional structures. One meeting was cancelled during the summer due to increased leave and the priority being to cover clinical duties.	Directorate Lead Nurse	Established practice which is ongoing
	All relevant members of staff must be invited to attend meetings to support effective communication, shared learning and quality improvement.	Minutes of the Directorate meeting are circulated for further cascade and information/learning to all departments.	Directorate Lead Nurse	Ongoing from August 2023

We found that several health board policies were out of date during our inspection.	The health board must review any outdated policies to support staff in their roles.	The Health Board has an improvement plan in place to improve policy compliance, working with the relevant executive directors and policy authors.		November 2023 In progress from August 2023
During our discussions with senior staff they advised that many of the issues we had identified during the inspection had already been recognised by the health board. We were advised that the health board was in the process of developing a divisional improvement plan to address and improve these matters across the Division of Mental Health and Learning Disabilities, which includes the Older Adult Mental Health directorate.	We have recommended a number of improvements as a result of our inspection and the health board must ensure that these are incorporated into the divisional improvement plan upon completion.	Themes from the HIW inspection have been cross-referenced with the Division's 30/60/90 day Quality, Safety and Governance Improvement Plan. Actions will be monitored by the Health Board and NHS Wales Executive team in line with the Divisional fortnightly Improvement Plan reviews.		In progress from July 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): Michelle Forkings

Job role: Divisional Nurse

Date: 28/09/2023