Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Tenby, Newton & Penarth Wards, Caswell Clinic, Swansea University Health Board

Inspection date: 11, 12 and 13 September 2023

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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 Caswell Clinic, Swansea Bay University Health Board on 11, 12 and 13 September 2023. The following hospital wards were reviewed during this inspection:

- Tenby Ward – 14 bed male assessment and treatment ward
- Newton Ward – Eleven bed female admission, rehabilitation and recovery ward
- Penarth Ward - Eight bed male Psychiatric Intensive Care Unit (PICU).

Our team for the inspection comprised of two HIW Healthcare Inspectors, two 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. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of four questionnaires were completed by patients. Feedback and some of the comments we received appear throughout the report.

There were insufficient questionnaires completed by staff to report on, however, we 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:
We found a dedicated staff team that were committed to providing a high standard of care to patients. We saw staff interacting with patients respectfully throughout the inspection.

Patients told us that improvements were required regarding menu choices.

This is what we recommend the service can improve:

- Improvements to menu choices
- Improved access to electronic devices.

This is what the service did well:

- Good team working and motivated staff
- Patients spoke highly of staff and told us that they were treated well.

Delivery of Safe and Effective Care

Overall summary:
There were established processes and audits in place to manage risk, infection control, and health and safety. This enabled staff to continue to provide safe and clinically effective care. However, some improvements are required in relation to making the outdoor areas safe.

Staff appeared committed to providing safe and effective care. We noted a good standard of care planning which reflected the domains of the Welsh Measure. The care plans were well detailed, individualised, reflected a wide range of MDT involvement, and there was clear and documented evidence of patient involvement.

This is what we recommend the service can improve:

- Redecoration of ward and communal areas
- Review of staff personal alarms and location of current alarm points
- Estates response to environmental issues requires improvement
- Tumble dryers should be fixed and available for patient use.

This is what the service did well:

- Safe and effective medicine management

- Good standard of care planning
- De-escalation skills of staff when managing patient behaviours.

Quality of Management and Leadership

Overall summary:
We found a friendly, professional, and kind staff team who demonstrated a commitment to providing high quality care to patients.

We found an effective governance structure in place in terms of meetings to discuss incidents, complaints and issues related to patient care.

Staff told us that they would feel secure raising concerns about patient care or other issues at the hospital and felt confident that the health board would address their concerns. A whistleblowing policy was in place to provide guidance on how staff can raise concerns and staff had access to the Guardianship Service. Some improvements are required in relation to updating policies and compliance with mandatory training.

This is what we recommend the service can improve:

- Review and update of policies
- Compliance with mandatory training
- Staff and patient meetings should be minuted.

This is what the service did well:

- Motivated and patient focussed team
- Staff team were cohesive and positive about the support and leadership they received from ward managers.

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

3. What we found

Quality of Patient Experience

Patient Feedback

We handed out HIW questionnaires during the inspection to obtain views on the service provided at the hospital. We received four responses to the questionnaires; this low number needs to be borne in mind when considering these responses.

We also reviewed internal patient feedback surveys to help us form a view on the overall patient experience. Patients we spoke to told us that staff treated them well and were kind towards them.

Some of the comments provided by patients on the questionnaires included:

> *"Best hospital I've been in."*
> *"Staff are great".*

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

> *"Food is boring and menu needs changing".*
> *"Not enough to do".*

Person centred

Health Promotion
Caswell Clinic had a range of facilities to support the provision of therapies and activities along with regular access to the community for patients that were authorised to leave the hospital.

Patients were able to access GP, dental services and other physical health professionals as required. Patient records evidenced detailed and appropriate physical assessments and monitoring.

Dignified and Respectful Care
We noted that all employees; ward staff, senior management, and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect.

The staff we spoke with were enthusiastic about their roles and how they supported and cared for the patients. We saw most staff taking time to speak with patients and address any needs or concerns the patients raised, displaying a responsive and caring attitude towards the patients.

During the inspection, the inspection team were approached by several patients all of whom spoke about how good the staff were and how well they were looked after in the hospital. The inspection team also observed staff using good de-escalation skills with patients and this was highlighted as an area of good practice during the inspection.

Patients had en-suite bedrooms that provided a good standard of privacy and dignity. Patients could lock their rooms, but staff could override the locks if needed. We saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering. Patients were able to personalise their rooms and store their own possessions. Personal items were risk assessed on an individual basis for the safety of each patient. This included the use of personal mobile phones. A telephone was available at the hospital for patients to use to contact friends and family if needed, and digital devices were available for patients to use with support from staff when required. However, patients told us that the electronic devices had been removed from the wards to be fixed and had not been returned for months.

The Health Board must ensure that the electronic devices are promptly fixed and returned to the wards for patient use.

Each bedroom door had a vision panel which enabled staff to undertake observations from the corridor without opening the door to minimise any potential disruption to patients sleeping. During our tour of the hospital, we positively noted that the vision panels were closed by default to protect the privacy of patients as people passed the rooms.

We checked if patients had access to outdoor spaces for therapeutic time. The garden area was overgrown and had a notable number of weeds, with old and worn looking furniture. In addition, the courtyard on Penarth Ward was uneven and the paving stones were loose, which could pose a risk to staff and patient safety. Overgrown trees and shrubbery also posed a risk to patient safety.

We were told by staff and during the inspection that there were several blind spots in the garden areas surrounding Caswell Clinic which compromised staff and patient safety.

The health board must ensure that work is undertaken to improve the appearance and safety of the garden for patients to use.

The health board must undertake a full review of the hospital grounds surrounding the wards to identify blind spots and areas where patient and staff safety will be compromised. The estates department must respond to the issues raised in a timely manner.

Patient information
Written information was displayed on the ward for patients and their families. We saw that posters displayed information about advocacy services and how patients could provide feedback on the care they received on the wards.

Patient status at a glance board were in the nursing offices. The boards were out of sight of patients which helped protect patient confidentiality.

There was no information available on either ward on the role of HIW and how patients can contact the organisation. This is required by the Mental Health Act 1983 Code of Practice for Wales.

The health board must ensure that information and contact details of HIW are displayed on the ward.

We were told that patient ward meetings take place however during the inspection we noted they were not minuted.

The health board must ensure that patient meetings are minuted.

Individualised care
There was a clear focus on rehabilitation with individualised patient care that was supported by least restrictive practices, both in care planning and hospital practices.

Patients had their own individual weekly activity planner, which included individual and group sessions based within the hospital and the community (when required authorisation was in place).

Patients were fully involved in monthly multidisciplinary reviews. We saw evidence that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals. Our findings showed clear evidence of multidisciplinary involvement in the care plans, this helped support the hospital in being able to deliver comprehensive care to the patients.

Timely

Timely Care

Overall, we found evidence that patients were provided with timely care during their time on the ward. Patient needs were promptly assessed upon admission, and we observed staff assisting patients in a timely manner when requested.

The ward held daily safety huddle meetings which adequately established the bed occupancy levels, observations, staffing levels and any emerging patient issues.

Equitable

Communication and language
During the inspection we observed staff engaging and communicating in a positive way with patients.

We saw that staff engaged with patients in a sensitive way and took time to help them understand their care using appropriate language. There was clear mutual respect and strong relational security between staff and patients.

For individual meetings, patients could have help from external bodies to provide support and guidance, such as solicitors or advocacy. With patients' agreement, wherever possible, their families and carers were included in meetings.

Rights and Equality
We found that arrangements were in place to promote and protect patient rights.

There were facilities for patients to see their families in private. Rooms were also available for patients to spend time away from other patients according to their needs and wishes. Arrangements were in place for patients to make telephone calls in private.

We looked at the records for patients who were detained under the Mental Health Act (the Act) and saw that documentation required by legislation was in place within the sample of patient records we saw. This showed that patient rights had been promoted and protected as required by the Act.

All patients had access to advocacy services, and we were told that advocates visit the hospital. Staff told us that patients are invited to be part of their MDT meetings and that the involvement of family members or advocates was encouraged where possible.

Delivery of Safe and Effective Care

Safe

Risk management
We were told that staff did not wear personal alarms and relied on the alarm call points located on the walls of the hospital. There was no policy in place to indicate why staff were not using personal alarms.

Although wall alarm call bells are available, the location and appropriateness of these for a medium secure setting need to reviewed, as the current positions could present a risk to staff and patient safety.

The health board must ensure that a full review is undertaken on the appropriateness of the current alarm system and ensure that the alarm policy is updated.

We saw evidence of various risk assessments that had been conducted including ligature point risk assessments and fire risk assessments. We were told of the environmental checks that are completed and saw evidence of ward manager checks on all wards.

The inspection team considered the hospital environment during a tour of the hospital on the first night of the inspection and the remaining days of the inspection. Overall, the ward appeared clean and tidy, however we identified several decorative and environmental issues that required attention:

- Missing tiles in communal bathrooms on Newton and Penarth Ward
- Broken toilet in communal bathroom on Tenby Ward
- Mould and flaking paint in all communal and patient areas
- Leak in communal area on Penarth Ward
- Poor flooring in communal areas of Tenby ward
- Fire door on Tenby Ward
- Poor drainage in patient showers
- PAT testing needs to be reviewed on all three wards.

In addition, staff told us that the estates department did not respond in a prompt and timely manner when environmental issues were raised.

The health board must address the above environmental issues and resolve them in a prompt and timely manner.

The ambient temperature on the three wards we inspected was uncomfortably hot throughout our visit and staff indicated this is an ongoing issue.

We recommend that the health board review and consider systems which would make the temperature in wards areas more comfortable for staff and patients.

Infection, prevention, control and decontamination
We found suitable IPC arrangements in place at the hospital. A range of up-to-date policies were available that detailed the various infection control procedures to keep staff and patients safe. Regular audits had been completed to check the cleanliness of the environment and check compliance with hospital procedures.

Cleaning equipment was stored and organised appropriately. There were suitable arrangements in place for the disposal of clinical waste.

We saw evidence to confirm that the health board conducted necessary risk assessments and updated relevant policies and procedures. Staff we spoke to were aware of infection control obligations.

We also saw that staff had access to, and were using, personal protective equipment (PPE) where appropriate. Staff we spoke to confirmed that PPE was always readily available. Sufficient hand washing and drying facilities were available.

There were hospital laundry facilities available so that patients could undertake their own laundry with appropriate level of support from staff based on individual needs. We were told that the tumble dryers frequently break down and are unavailable for patients to use. During the inspection the tumble dryers were not working properly.

The health board must ensure that the tumble dryers are fixed or replaced for patients to use.

Safeguarding children and adults
There were established health board policies and processes in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Ward staff had access to the health board safeguarding procedures via its intranet. Senior ward staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff, they were able to show knowledge of the process of making a safeguarding referral.

Medicines management
Medicines management was safe and effective. Medication was stored securely with cupboards and medication fridges locked. There was evidence of regular

temperature checks of the medication fridge to monitor that medication was stored at the manufacturer's advised temperature.

There was regular pharmacy input and audit undertaken that helped the management, prescribing and administration of medication on the ward.

There were arrangements in place on the ward for the storage and use of Controlled Drugs and Drugs Liable to Misuse. Records we viewed evidenced that twice-daily checks were conducted with nursing signatures confirming that the checks had been conducted.

The Medication Administration Records reviewed were fully completed by staff. We saw several medication rounds, and saw that staff undertook these appropriately and professionally, interacting with patients respectfully and considerately.

We saw evidence of regular auditing of resuscitation equipment. Staff had documented when these had occurred to ensure that the equipment was present and in date.

Challenging behaviour
Strategies were described for managing challenging behaviour to promote the safety and wellbeing of patients. We were told that preventative techniques were used and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the safe physical restraint of patients was used, but this was rare and only used as a last resort. Any use of restraint was documented. Information produced to the inspection team confirmed that restraint data was low. Throughout the inspection we observed staff using effective de-escalation skills with patients and it was evident that staff were very skilled in this area.

There was an established electronic system in place for recording, reviewing, and monitoring incidents. Incidents were entered on to the health board's incident reporting system (DATIX).

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed so that the occurrence of incidents could be reviewed and analysed. Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation.

During staff discussions, it was evident that staff were aware of the locations of ligature cutters in case of an emergency.

Effective

Effective care
Overall, we found that systems and governance arrangements were in place, which helped ensure that staff provided safe and clinically effective care for patients. Staff confirmed that de-briefs take place following incidents. Meetings we attended and evidence obtained during the inspection confirmed that incidents and use of physical interventions are checked and supervised.

Patient records
Patient records were mainly paper files that were stored and maintained within the locked nursing office, with some electronic documentation, which was password protected.

During staff discussions we were told that staff would prefer to transfer across to electronic files.

Further information on our findings in relation to patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010 Care planning and provision section of this report.

Nutrition and hydration
The hospital provided patients with meals on the ward, making their choices from the hospital menu. We were told that specific dietary requirements were accommodated. The dining rooms were clean and tidy and provided a suitable environment for patients to eat their meals.

Most patients indicated that they were not happy with the menu choices available at Caswell Clinic and patients indicated that they would prefer a more varied menu choice.

The health board should provide a more varied menu choice for patients.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
We reviewed the statutory detention documents for five patients at the hospital.

All patient detentions were found to be legal according to the legislation and well documented. Overall, the records we viewed were well organised, easy to navigate and contained detailed and relevant information.

Several patients had Section 17 leave marked as cancelled, rather than no longer valid. The codes of practice stipulate that that the record should be stamped as no longer valid. In addition, the date of interview between Registered Consultant and patient was wrong in one renewal document we viewed.

The health board must ensure that Section 17 leave is stamped correctly and renewal documents are checked and correct.

The list of tribunal solicitors on Newton and Penarth Wards was out of date. In addition, there were no Codes of Practice available on Tenby and Penarth Wards for patients to access.

The health board must ensure that list of tribunal solicitors is updated and that all wards have a copy of the codes of practice.

We reviewed the care plans of five patients and found that they were kept to a good standard.

Entries were comprehensive and recognised assessment tools were used to monitor mental and physical health.

We saw evidence that care plans were detailed, comprehensive and person centred with support provided in a structured way to enable patients to achieve individual goals. Our findings showed clear evidence of multidisciplinary involvement in the care plans; this helped support the hospital in being able to deliver comprehensive care to the patients.

Management of patients' behaviours were reflected in their care plans and risk management profile, along with staff training to use skills to manage and defuse difficult situations.

The inspection team witnessed positive redirection and deescalation of difficult behaviours, all of which were done respectfully and in a very supportive manner.

We saw care files clearly showed patient involvement in care discussions, which were patient focussed and signed by the patient. Records also included evidence of the patients' voice to reflect their views, the Inspection team highlighted the care planning documentation as an area of good practice.

Quality of Management and Leadership

Leadership

Governance and leadership
There was a clear organisational structure for the hospital, which provided clear lines of management and accountability. They defined these arrangements during the day, with senior management and on-call systems in place for the night shift.

During interviews with staff, they were fully aware of the on-call systems in place at the hospital.

The operation of the hospital was supported by the health board's governance arrangements, policies, and procedures.

We found a friendly, professional staff team who showed a commitment to providing high quality care to patients. Staff were able to describe their roles and appeared knowledgeable about the care needs of patients they were responsible for.

Throughout our inspection, all staff made themselves available to speak to the HIW inspection team and engaged very positively with the process.

During our feedback meeting at the end of the inspection, senior ward staff and hospital managers were receptive to our comments. They demonstrated a commitment to learn from the inspection.

Workforce

Skilled and enabled workforce
Staff we interviewed spoke passionately about their roles. Throughout the inspection we observed strong team working.

Staff were able to access most documentation requested by the inspection team in a prompt and timely manner, demonstrating that there are good governance systems in place at the hospital.

We were provided with a range of policies, the majority of which were updated however, the following policies were found to be out of date:

- Alarm policy review date Aug 2022

- Seclusion policy review date July 2023
- Consent policy review date July 2023
- Operational procedure and role and function ward review date Oct 2022.

The health board must ensure that policies are reviewed and kept up to date.

We noted a number of staffing vacancies in the hospital which the health board was attempting to recruit into. Gaps in staffing were covered by bank staff or agency staff who were usually familiar with the patient group. We were told that the health board had recruited some oversees nurses and a cohort of students were due to start soon. Staffing issues and resourcing are discussed in the daily safety huddles.

The health board must ensure that staff vacancies are filled, and future initiatives are explored to encourage recruitment into the hospital.

We were told that ward staffing meetings take place, however we were not provided with minutes of the meetings to view whilst on the inspection.

The health board must ensure that staffing meetings are minuted.

Culture

People engagement, feedback and learning
Arrangements were in place to quickly share information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the service provided.

The inspection team considered staff training compliance and provided with a list of staff mandatory training compliance. Training figures provided to us on the inspection indicated that overall compliance figures were over 90 per cent.

A new training strategy for restraints was due to be implemented and was due to be rolled out to staff. This had affected some training statistics. We were reassured by the head of nursing that there was robust scrutiny on rotas to ensure that there were sufficiently trained staff on the wards. In addition, restraint data was low and continually being monitored.

We saw that information had been provided to staff on the new Duty of Candour requirements. Staff also told us that they would feel secure raising concerns about patient care or other issues at the hospital and felt confident that the health board

would address their concerns. A whistleblowing policy was in place to provide guidance on how staff can raise concerns and staff had access to the Guardianship Service.

Information

Information governance and digital technology

The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and the General Data Protection Regulations 2018 within the wards.

We were told that all staff had their own computer access login to help ensure information governance was maintained. All staff spoken to understand their roles and responsibilities in respect of accurate record keeping and maintenance of confidentiality.

Through examination of training records, we confirmed that staff had received training on information governance. The training statistics showed a high level of staff compliance with information governance training at 86 per cent.

Learning, improvement and research

Quality improvement activities

It was pleasing to see the amount of ongoing research projects and quality improvements taking place in Caswell Clinic. There were many examples of collaboration with other local health boards on improvement projects such as The Forensic Transformation Programme.

We saw documentation evidencing that the nurse director undertook unannounced inspection reviews which linked into the health boards Quality Assurance Action Plan. This helped to identify where areas of improvements were required. Documentation we reviewed confirmed that findings would be discussed in meetings and actioned appropriately.

We were also told that question and answer sessions had been arranged between ward staff and senior management, however these sessions had not been taking place as frequently as planned. We were told that senior management were hoping to reintroduce these sessions as staff found them beneficial.

Whole system approach

Partnership working and development

Staff were able to describe how the service engaged with partners to provide patient care and implement developments. They told us they engaged with outside partner agencies including local authorities, General Practitioners, housing, community health services to ensure a whole systems approach to patient care.

We were told that senior staff attended regular joint agency meetings to discuss issues and build strong working relationships.

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
No Immediate Improvements were identified during this inspection.			

Appendix B - Immediate improvement plan

Service: Caswell Clinic

Date of inspection: 11 - 13 September 2023

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
No Immediate Assurances				

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):

Job role:

Date:

Appendix C – Improvement plan

Service: Caswell Clinic

Date of inspection: 11 – 13 September 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
1. Electronic devices not being available for patients.	The Health Board must ensure that the electronic devices are promptly fixed and returned to the wards for patient use.	Secure electronic devices from Digital Services and disseminate to wards for patient use.	Directorate Manager	November 23 Complete
2. Garden areas were overgrown and pose a risk to patient safety.	The Health Board must ensure that work is undertaken to improve the appearance and safety of the garden for patients to use.	Revisit service risk assessment of outdoor space and liaise with facilities and estates departments to target priority areas.	Directorate Manager in liaison with the Technical Services Manager, Facilities CTUHB	December 23
3. Staff indicated that there are numerous blind spots in the garden areas that compromise staff and patient safety.	The Health Board must undertake a full review of the hospital grounds surrounding the wards to identify blind spots and areas where patient and staff safety will be compromised.	As above, revisit risk assessment and liaise with facilities department to resolve any blind spots that may compromise staff or patient safety.	Directorate Manager in liaison with the Technical Services Manager, Facilities CTUHB	December 23
4. No information within the clinic on the role of HIW.	The Health Board must ensure that information and contact details of	Posters containing information on role and	Lead Nurse/Ward Managers	November 23

	HIW are displayed on the ward.	purpose of HIW to be put up on the information boards within all ward environments.		
5. The inspection team were told that patient meetings take place, but no copies of minutes were produced to the team.	The Health Board must ensure that patient meetings are minuted.	Nominate note takers so that patient meetings are minuted.	Lead Nurse/Ward Managers	To commence November 23
6. Staff were not wearing personal alarm the current positions of the wall alarms could present a risk to staff and patient safety.	The Health Board must ensure that a full review is undertaken on the appropriateness of the current alarm system and ensure that the alarm policy is updated.	Revisit Personal Alarm investment case to expand on clinical governance risks of the existing system and update risk assessment. Policy Group to update Personal Alarm Policy and escalate this to the Service Group Policy Review Group.	Risk Co-ordinator	January 24
7. We identified several decorative and environmental issues that required attention: • Missing tiles in communal bathrooms on	The Health Board must address the environmental issues and resolve them in a prompt and timely manner.	Directorate Manager to ensure that the estates department prioritise completion of the noted environmental defects as a matter of urgency.	Directorate Manager in liaison with the Estates Officer, CTUHB	January 24

Newton and Penarth Ward need replacing • Toilet in communal bathroom on Tenby Ward needs to be fixed • Communal and patient areas on all wards require redecoration as mold and flaking paint was present • The leak in communal area on Penarth Ward needs to be fixed • Flooring in communal areas of Tenby ward require replacing • Fire door on Tenby Ward needs to be fixed • Poor drainage in patient showers needs to be reviewed				

• PAT testing needs to be reviewed on all three wards. We were also told that there are delays with estates resolving the environmental issues.				
8. The ambient temperature on the three wards we inspected was uncomfortably hot throughout our visit and staff indicated this is an ongoing issue.	We recommend that the Health Board review and consider systems which would make the temperature in wards areas more comfortable for staff and patients.	Directorate Manager to ensure that the estate Dept reviews the ward temperatures and establish and appropriate management system.	Directorate Manager in liaison with the Estates Officer, CTUHB	November 23
9. Tumble dryers were broken and not available for patients to use.	The Health Board must ensure that the tumble dryers are fixed or replaced for patients to use.	Review status of tumble dryers and liaise with provider to arrange necessary repairs.	Head of Admin/Housekeeping	December 23
10. Most patients indicated that they were not happy with the menu choices available at Caswell Clinic and patients indicated that they would prefer a more varied menu	The Health Board should provide a more varied menu choice for patients.	Revisit the work commenced around a review of the meal choices for patients and make adjustments accordingly.	Directorate Manager	January 24

choice.				
11. A review of one patient Section 17 leave record had been stamped as cancelled.	The Health Board must ensure that Section 17 leave is stamped correctly.	Replacement stamps containing the appropriate terminology "No Longer Valid" have been ordered and a communication circulated across the clinic.	HoN in liaison with HoN for Quality and Governance	November 23
12. The date of interview between Registered Consultant and patient was wrong in one renewal document we viewed.	Renewal documents are checked and correct.	Communication to be sent by the Clinical Director to all Responsible Clinicians to remind them to ensure that all entries are recorded accurately.	Clinical Director/Responsible Clinicians	November 23
13. The list of tribunal solicitors on Newton and Penarth Wards was out of date.	The Health Board must ensure that list of tribunal solicitors is updated	Replace the information regarding tribunal solicitors on each ward.	Ward Managers	November 23
14. No Codes of Practice available on Tenby and Penarth Wards for patients to access.	The Health Board must ensure that copies of the Codes of Practice are available on all wards.	MHA Code of Practice leaflets to be placed in all wards to ensure that they are available to all patients.	HoN/Ward Managers	November 23
15. The following policies were found to be out of date: • Alarm policy review date Aug 2022 • Seclusion policy review	The Health Board must ensure that policies are reviewed and kept up to date.	All outdated/under review divisional policies are to be updated via the divisional Policy Review Group and escalated for ratification	Directorate Manager and Safety and Risk Co-ordinator	December 23

date July 2023 • Consent policy review date July 2023 • Operational procedure and role and function ward review date Oct 2022.		against the Service Group PRG.		

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): Janet Williams

Job role: Service Director: Mental Health and Learning Disabilities Service Group

Date: 02/11/2023