Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Angelton Clinic, Glanrhyd Hospital, Cwm Taf Morgannwg 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 Angelton Clinic, Glanrhyd Hospital, Cwm Taf Morgannwg University Health Board on the evening of 13 November 2023 and the following days of 14 and 15 November 2023. Angelton Clinic provides a service for older people with serious and enduring mental health diagnoses and dementia. We reviewed the following wards during the inspection:

- Ward 1, a 12 bedded, mixed-sex ward which was providing care for six patients at the time of our inspection
- Ward 2, a 20 bedded, mixed-sex ward which was providing care for seventeen patients at the time of our inspection.

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.

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

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

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We observed staff treating patients with respect and supporting patients in a dignified and sensitive way. All patients had their own bedroom and bathroom which maintained their privacy and dignity. Patients had access to a mental health advocate who provided information and support with any issues they may have regarding their care.

We saw evidence that patients were provided with a varied programme of therapeutic activities which were tailored to their individual needs. However, there were no physical exercise facilities available to patients and the hospital's communal gardens required weeding and general maintenance to make them a more pleasant therapeutic environment.

We found suitable visiting arrangements provided for family and carers within the off-ward atrium of Angelton Clinic. However, staff told us that patients would benefit from having access to additional rooms or areas where they could be visited on the wards.

This is what we recommend the service can improve:

- The hospital communal gardens areas must be tidied and maintained to provide a more pleasant and appealing environment for patients
- The health board should ensure the provision of gym and exercise equipment to support patient health promotion and improvement
- The health board must implement measures to ensure the active offer of Welsh is appropriately delivered in the hospital
- The health board should ensure the provision of suitable areas where patients can be visited on the wards.

This is what the service did well:

- Staff demonstrated a caring and understanding attitude to patients, and communicated using appropriate and effective language
- Appropriate arrangements were in place to protect patients' privacy and dignity
- We found plentiful patient information provided in the hospital including a comprehensive patient information booklet which had been developed in collaboration with family and carers

- We saw examples of personalised approaches to patient care, which supported their independence.

Delivery of Safe and Effective Care

Overall summary:
Overall, we were assured that the hospital had robust processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors. However, we identified several potential risks to patient safety which were appropriately resolved during the inspection. Some examples included staff not using personal safety alarms, and emergency resuscitation equipment not being readily accessible to staff. We also found that one patient's Care and Treatment Plan (CTP) had been accidentally deleted from the hospital's electronic health record system and required immediate replacement to ensure the safe care of the patient concerned.

We reviewed a sample of patient records to ensure compliance with the Mental Health Act (MHA) and found that the statutory documentation verified that patients were legally detained and reliably informed of their rights under the Act. We examined patient care plans and Medication Administration Records (MAR charts) and found they were being maintained to a good standard. Effective infection prevention and control (IPC) arrangements were evident but we saw low compliance figures with Ward 2 IPC environmental audits. We also found improvements were required to ensure the hospitals audit processes were routinely completed to support patient safety. Some examples included fridge and clinic room temperature checks, magnetic door checks, patient adverse reactions assessments and venous thrombosis assessments.

The hospital had an electronic process in place to log estates and maintenance issues. However, we found a number of outstanding maintenance issues and were not assured there was an effective process in place which ensured that maintenance issues were being identified, addressed and signed off as complete to support patient safety.

This is what we recommend the service can improve:

- The health board must ensure that the hospital's established audit processes are fully completed within set timescales to ensure the safety of patients, staff and visitors
- The health board must ensure instances when clinic room temperatures fall outside of recommended guidelines are appropriately recorded and promptly escalated to support patient safety

- The health board must ensure the hospital's maintenance issues are promptly and effectively recorded, addressed and signed off
- The health board must undertake robust measures to improve IPC environmental audit compliance on Ward 2
- The health must ensure patient foods are regularly checked, appropriately labelled and suitably stored.

This is what the service did well:

- The hospital had an appointed Mental Health Act Manager who demonstrated very good understanding of the health board's MHA processes and responsibilities.

Quality of Management and Leadership

Overall summary:
We found a strong ethos of continuous service improvement in the hospital, and the staff were very enthusiastic and motivated. It was positive to find many improvements had been undertaken since our previous inspection in November 2022. It was clear from our discussions with senior staff that the health board was continuously reviewing the provision of the service on the wards to support safe and effective patient care. Established governance arrangements were in place to provide oversight of clinical and operational issues. However, we noted that several health board policies were undated or outdated, resulting in a lack of clear guidance for staff. We further noted that improvements were required in respect of overall staff compliance with several mandatory training courses.

There were processes in place to ensure key issues were being effectively investigated, escalated, supervised and scrutinised to prevent reoccurrence. The hospital's governance systems and arrangements largely supported quality improvement and shared learning. However, we identified that some improvements were required to ensure recurrent staff errors and points of learning were appropriately escalated and addressed. We also found improvements were required to ensure hospital records could be filtered to retrieve ward-specific data to support effective governance oversight and monitoring.

At the time of our inspection the hospital's staffing levels met health board templates. However, it was concerning to note that there was a high number of permanent staffing vacancies including 1.7 Registered Nurses on Ward 1 and 6 Registered Nurses on Ward 2. We were told the hospital required a high use of agency staff to fill vacant shifts, which placed additional pressure on ward staff. Some staff we spoke with during the inspection felt there were not enough staff to meet staffing requirements and increased patient demand on the wards.

This is what we recommend the service can improve:

- The health board must review any outdated or undated policies to provide clear guidance to staff and support them in their roles
- The health board must implement measures to ensure all outstanding mandatory staff training is completed, regularly monitored and that staff are supported to attend the training
- The health board must ensure that staff and family/carer meetings take place within set timescales to ensure their feedback is regularly captured and addressed as appropriate.

This is what the service did well:

- Staff were receptive and responsive to our findings and recommendations
- We observed strong, supportive team working on the wards throughout our Inspection.

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. We received a total of three family/carer questionnaires, and there were 23 patients being cared for in the hospital at the time of our inspection. The sample size is therefore too small to draw robust conclusions and identify themes or trends. We also spoke with patients on the wards when appropriate to do so, however, many patients lacked capacity to participate in our questionnaire process.

As noted above, we only received three completed questionnaires from family and carers. However, the feedback was overall very positive. All respondents rated the care and service provided at the hospital as very good. All agreed that they could visit as much as they would like, and that they felt welcomed and safe in the hospital. All agreed that staff treated patients with kindness and respect, and told us they felt encouraged to be involved in the care and treatment of patients.

The comments provided by family and carers in the questionnaires included:

> *"So relieved that my husband is here, being definitely the appropriate setting for him for the foreseeable future"*
>
> *"Staff Ward 1 kind and caring"*

Person centred

Health Promotion

We reviewed a sample of patient records and saw evidence that patients received appropriate physical assessments upon their admission. Patients had physical health care plans which documented any required ongoing health promotion and preventative interventions, such as dietician support and Speech and Language Therapy (SALT). Patient healthcare requirements were regularly reviewed during weekly multidisciplinary Team (MDT) meetings and by ongoing dynamic assessment. We saw evidence that longstanding patient health conditions were appropriately monitored.

The wards were clean and tidy and provided a comfortable environment of care. Patients had access to their own bedrooms, communal areas and outside garden

areas. We observed that patients and relatives were encouraged to use the communal garden areas. However, the gardens required weeding and general maintenance to make them a more pleasant therapeutic environment for patients.

The hospital communal gardens areas must be tidied and maintained to provide a more pleasant and appealing environment for patients.

There were lounge areas on the wards which offered self-directed activities such as a TV, board games and books. In addition to the communal lounges, patients could spend time away from the wards and meet with visitors in the hospital's large 'atrium' reception area.

We saw evidence that patients were provided with a varied programme of therapeutic activities that were tailored to their individual needs. Both wards were supported by a dedicated activities coordinator who arranged recurring and bespoke activities for patients. We were told that the hospital's psychologist provided a weekly patient reminiscence activity and wellbeing group.

However, during the inspection we were told there were no physical exercise facilities available to patients within the hospital. Staff told us they felt that the patients would greatly benefit from the provision of gym and exercise equipment to engage them in physical fitness activities and maintain their health and wellbeing.

The health board should ensure the provision of gym and exercise equipment to support patient health promotion and improvement.

Dignified and Respectful Care
Throughout the inspection we observed all staff treating patients with dignity and respect. Staff demonstrated a caring and understanding attitude to patients, and communicated using appropriate and effective language. The staff we spoke with were passionate about their roles, and enthusiastic about how they supported and cared for the patients. We observed staff taking time to speak with patients and address any needs or concerns they raised. This demonstrated that good professional relationships had been developed to support patients' health and wellbeing.

We found appropriate arrangements were in place to protect the privacy and dignity of the patients on both wards. On Ward 1, male and female patients were mixed, with appropriate monitoring and risk assessments in place. On Ward 2, male and female patients were segregated into two separate, ten bedded ward areas. There were suitable communal areas where patients could congregate and socialise as required. On both wards, each patient had their own en-suite bedroom

which provided a good standard of privacy. Patient belongings were suitably labelled and they were able to store possessions and personalise their rooms as desired. We witnessed staff knocking before entering patient bedrooms, which evidenced their respect for patient privacy.

All bedroom doors had observation panels, which allowed staff to undertake patient observations without opening the door. This minimised the risk of disturbing the patient and helped to maintain their privacy and dignity. We witnessed staff closing the observation panels when attending to patient personal care, and allowing patients privacy to attend to their own personal care needs as appropriate.

We were told that the hospital provided end of life care for patients. Some staff we spoke with during the inspection felt that patients receiving end of life care should be cared for separately from other patients to ensure their comfort, privacy and dignity during this time. The health board may to wish to conduct further discussions with staff in respect of this matter.

Patient information

We found plentiful patient and visitor information displayed and provided within the communal and reception areas of the hospital, which was appropriate to the patient group. This included a 'Carers' Corner' notice board which invited family and carer feedback via a QR code.

Since our previous inspection of the hospital in November 2022, staff had developed a comprehensive seventeen-page patient information booklet in collaboration with family and carers. The booklet contained detailed and practical information to support patient and family/carer understanding of relevant aspects of their care, which we identified as an example of good practice.

We found helpful 'Meet the Team' and pictorial staff uniform information within the patient information booklet, which supported the identification of staff members. Additionally, each ward had a notice board that outlined which staff members were on duty for patient and visitor awareness.

Individualised care

We reviewed the Care and Treatment Plans (CTPs) of four patients across the two wards. 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 saw strong evidence of individualised care being provided to patients which reflected their personal choices on how they wished to be supported. Patients had individual care plans which outlined areas where they could be involved in making decisions, such as food and clothing choices. All patients had a documented 'about me' profile which detailed their likes, dislikes and care requirements to support staff awareness and engagement. We saw examples of personalised approaches to patient care, which included family pets being permitted onto the wards to visit them.

We observed patients being supported to carry out everyday tasks to promote their independence. The hospital's dedicated Occupational Therapist (OT) and activities coordinators supported patients to engage in meaningful activities and we witnessed care being provided to patients to suit their individual needs. For example, natural waking was actively promoted and encouraged for patients and their treatment was adapted in accordance with their sleeping patterns.

Patients had access to aids which promoted their independence and quality of life as appropriate. We saw evidence of discharge planning in place for patients and were informed that staff conducted follow-up home visits for patients who were subject to phased discharge arrangements. Staff we spoke with during the inspection showed respect and understanding of the particular needs and requirements of the patient group.

Timely

Timely Care

We found strong evidence that patients were regularly monitored and received timely care in accordance with individual and clinical need. There were various meetings and processes that supported the timely and effective care of patients.

The wards held daily safety huddle meetings to establish bed occupancy levels, discuss individual patient cases and prioritise patient care. We attended a staff meeting during the inspection, and noted good discussions being had around patient observation levels and staffing requirements. Staff also attended weekly multidisciplinary (MDT) meetings to share information and discuss individual patient cases.

However, during our discussions with staff they expressed concern that the isolated geographical location of the clinic presented challenges for them to facilitate transport for patients requiring treatment at another hospital site. We were told that patients were frequently made to wait for ambulances when urgent or outpatient care was required. Staff advised that the clinic previously had a

dedicated wheelchair accessible vehicle that was regularly used and considered a great asset, but it had since been removed and was not replaced.

The health board should consider reinstating the hospital's dedicated wheelchair accessible vehicle to promote timely patient care.

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 had dedicated Speech and Language Therapy (SALT) provision that supported individual patient communication needs.

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 personal mobile phones, subject to individual risk assessment. We were told that digital technology was available for patients to keep in contact with family and carers if required.

During the inspection, we were informed that the health board had established a Welsh Speaking Steering Group to drive and monitor compliance with the Welsh Language Standards. We noted that ward staff completed mandatory Welsh Language Awareness training but found that Ward 2 staff compliance was low at 65 per cent. We saw some examples of patient information being displayed or provided in Welsh, which included some hospital signage and the patient information booklet. Staff confirmed that translation services were available and that patient information could be provided in Welsh if required.

However, we saw little evidence that the active offer was being delivered in the hospital nor recorded prominently within patient records. We further found it was difficult to identify Welsh speaking staff as they were not provided with uniforms or badges which identified them as such. We identified that this could cause confusion for patients, staff and visitors who wished to converse in Welsh and we highlighted this issue to staff. Following the inspection, we received evidence that information posters, staff lanyards and branded uniforms had been ordered for the hospital.

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

The health board must implement measures to ensure the active offer of Welsh is appropriately delivered in the hospital.

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). Further information on our findings on the legal documentation is detailed in the Mental Health Act Monitoring section of this report.

We found satisfactory arrangements in place to promote and protect patient rights. Reasonable adjustments were in place so that everyone could access and use the hospital's services on an equal basis. Overall staff compliance with mandatory Equality, Diversity and Human Rights training was high at 82 per cent on Ward 1 and 90 per cent on Ward 2. Policies were in place to help ensure that everyone had access to the same opportunities and to the same fair treatment.

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.

There were suitable visiting rooms in the communal atrium area where patients could meet with visitors in private. However, we were informed that visitors were discouraged from visiting patients on the wards or within their own bedrooms, and were instead required to wait in the atrium for the patient to be brought out to them. Staff told us that the wards would benefit from additional rooms or areas where patients could be visited on the wards rather than in the atrium.

The health board should ensure the provision of suitable areas where patients can be visited on the wards in addition to the Angelton atrium area.

Delivery of Safe and Effective Care

Safe

Risk management
It was positive to find that since our previous inspection in November 2022, many improvements had been made to support the safe care of patients. Overall, we were assured that the service had processes in place to maintain the health and safety of patients, staff and visitors. The ward entrances were accessible to everyone and were secured at all times throughout the inspection to prevent unauthorised access. There were nurse call points around the wards and within patient bedrooms so that patients could summon assistance if required. We were informed that all patient beds were suitably alarmed to alert staff when patients got out of bed. Each ward provided a clean and comfortable environment for patients and was equipped with suitable furniture, fixtures and fittings for the patient group.

There were established policies, processes and audits in place to manage risk and health and safety, which enabled staff to continue to provide safe and clinically effective care. The hospital had a list of restricted items that was clearly documented within the patient information book for general awareness. Ligature cutters were appropriately stored for use in the event of a self-harm emergency. We found comprehensive and up-to-date ligature point risk assessments in place on both wards.

During our previous inspection of the setting in 2022 we noted that staff did not have access to personal safety alarms and made recommendations in respect of this. During this inspection we again found staff were not using personal safety alarms and there were insufficient alarms available to staff, with just two alarms provided on Ward 1 and three alarms on Ward 2. We further noted that the health board's Standard Operating Procedure (SOP) for the use of personal safety alarms 'encouraged', but did not mandate the use of the alarms. We identified this posed a safety risk to staff, patients and visitors and raised this issue with senior staff. We were advised that new personal safety alarms had been on order and had since arrived at the hospital, but had not yet been issued to staff. This matter was resolved during the inspection as the alarms were issued to staff, and the personal alarm SOP was amended to ensure mandatory staff compliance with personal safety alarm use.

We found an established electronic system in place for recording, reviewing and monitoring incidents via DATIX. There was a hierarchy of incident sign-off which ensured that incident reports were reviewed and finalised in a timely manner.

Incident reports were produced and reviewed at senior management level so that appropriate lessons could be taken which encouraged shared learning. We reviewed a sample of incidents recorded on Datix and found that they were appropriately recorded, reviewed and monitored to assist in the provision of safe care.

The hospital had established processes and audits in place to support patient care and safety. We found that additional audit processes had been introduced since the last inspection, to address the key areas for improvement. Some examples of this included Senior Nurse Monthly Spot Checks and thrice daily entrance magnetic door checks, to ensure the hospital's magnetic doors were in full working order. However, we found that some of the hospital's audit processes were not being consistently completed by staff as follows:

- Whilst we found the wards were appropriately secure throughout the inspection, we noted there were numerous gaps in the Ward 2 entrance magnetic door daily checklists between August and November 2023
- We saw a number of gaps in the Ward 2 daily kitchen fridge temperature checklists between September and November 2023
- The Ward 2 weekly legionella flushes checklist was not completed on a weekly basis. The documentation we reviewed evidenced that the flushes were last conducted on 8 October and 4 August 2023. We were informed that domestic staff performed this task as part of their daily routine. However, this was not documented within the hospital cleaning schedules to support robust governance oversight and monitoring. Following the inspection, we received evidence that the cleaning schedules had been amended to include the flushing process.

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

The hospital had an electronic process in place to log estates and maintenance issues. However, we viewed the estates logs for both wards and found it was impossible to identify whether the recorded issues had been rectified or repaired as the logbook did not display any record of completion or sign off. We discussed this matter with senior staff members who were unable to confirm whether the issues had been rectified, and could not provide clarity regarding governance oversight of these matters. We were further told that staff kept an additional, informal hand-written logbook of outstanding estates issues which appeared duplicative and confusing. Therefore, we were not assured there was an effective

process in place which ensured that outstanding estates issues were being identified, addressed and signed off as complete for the awareness of all staff.

The health board must implement a programme of governance oversight which ensures that the hospital's maintenance issues are promptly and effectively recorded, addressed and signed off.

During the inspection we noted several maintenance issues which required repair within the hospital:

- We saw areas across the wards which required general decorative repair due to scuffed paint work and flooring
- The Ward 2 male kitchen hot water dispenser was out of order
- The Ward 2 male and female kitchen macerators both displayed 'out of order' signs. Staff advised that they would not be replaced but they had not been removed and disposed as appropriate
- There were two large holes within patient bedroom walls on Ward 2
- We saw a plug socket within one Ward 2 patient bedroom which appeared to be in poor state of repair and required replacement
- Staff voiced concerns that the hospital's anti-ligature door handles consistently fell off and required regular repair. We were told of a previous occasion when a patient was temporarily locked in a room when the door handle fell off, and the door could not be opened.

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

The health board must undertake a full environmental audit of Angelton clinic to identify, record and address any additional outstanding maintenance issues.

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. The training statistics provided evidenced a high level of staff compliance with their infection control training at 83 per cent on Ward 1 and 93 per cent on Ward 2. The environment of care on both wards and the wider hospital was clean and uncluttered. Hospital equipment was appropriately stored. The majority of furniture and fittings appeared to be in a good state of repair to enable suitable decontamination.

Cleaning schedules were in place and suitably completed to promote regular and effective cleaning of the wards. Staff had sufficient access to Personal Protective

Equipment (PPE) to support individual patient care. Shared equipment and reusable medical devices were appropriately decontaminated and suitably labelled to indicate they had been cleaned and were safe to use. The staff we spoke with seemed clear about their individual responsibilities in relation to infection control measures at the hospital.

Audit processes were in place to check the cleanliness of the environment and monitor compliance with hospital procedures. We were told that the hospital had recently introduced a new electronic Audit Management and Tracking (AMaT) system which will improve working practices for staff. We viewed the hospital's monthly hand hygiene audits on the AMaT system and noted high compliance on both wards. Ward 1 staff compliance with IPC environmental audits was high, at 94 and 97 percent during September and October 2023 respectively. However, we saw lower compliance figures on Ward 2 at 75 and 67 per cent over the same period. We noted that some of the issues included in the Ward 2 audit related to general clutter and environmental repair requirements, which had reduced the overall score.

The health board must undertake robust measures to improve IPC environmental audit compliance on Ward 2.

During the inspection we examined the hospital kitchen areas and found the male kitchen on Ward 2 was in an untidy state. We noted several issues which posed a risk to patient safety:

- We found unsealed, expired and unlabelled communal patient foods in the cupboards and fridge so the date of opening could not be ascertained
- We saw unsealed food items left out on worktops including milk and undiluted squash cartons, which posed a risk of contamination
- There were unlabelled non-prescription medications on the top of the kitchen cupboard and staff could not account for them.

We highlighted these issues to staff and noted that the kitchen was suitably tidied during the inspection.

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

Patient foods must be appropriately sealed and stored to prevent spoiling and contamination.

Medications must not be stored in the ward kitchen areas.

Safeguarding children and adults
Both wards provided care to adults only and we found suitable measures in place to safeguard vulnerable adults. There were established processes in place and referrals were being directed to external agencies as and when required.

Ward staff had access to the health board safeguarding procedures via the intranet. During our discussions with staff, they demonstrated good knowledge of the health board's safeguarding procedures and reporting arrangements. We were told that safeguarding incidents and concerns were regularly reviewed to help identify any themes and lessons learned. We noted that staff compliance with Safeguarding Adults level 2 training was high on Ward 2 at 90 per cent, but lower on Ward 1 at 78 per cent.

The health board must undertake measures to improve Ward 1 staff compliance with mandatory safeguarding training.

Medicines management
Relevant policies, such as medicines management and rapid tranquillisation, were available to staff electronically on computers. However, we noted that the health board's Policy for the Management of Severely Disturbed Patients, or of Violent Behaviour by Adult Inpatients was in draft format. We further noted that the health board's Medicines Management policy had expired in 2014. The expired policy contained a reference to 'Appendix A' which should provide guidance to staff regarding the health board's medication storage requirements. However, this entire section was found to be missing from the policy and could not be located by staff during the inspection. We highlighted our concerns to staff that the absence of this information resulted in a lack of clear guidance for staff and therefore, posed a risk to patient safety.

The health board must review the outdated Medicines Management policy and provide guidance for staff on the storage of medications to support staff in their roles and ensure patient safety.

We reviewed the hospital's clinic arrangements and generally found robust procedures in place for the safe management of medicines on the wards. Medication was being stored securely in cupboards at all times and the medication fridges were locked when not in use. The clinic rooms were clean, tidy and well organised. Appropriate arrangements were in place for the storage and safe use of controlled drugs and drugs liable to misuse.

There were systems in place to ensure that daily checks of the clinic room equipment were being completed. Regular audits were being conducted on emergency equipment and patient medications. However, during our evening tour

of the hospital, we observed that the key for the Ward 1 oxygen cylinder was being stored in a nearby drawer within the clinic room. We also found that the giving set was not attached to the cylinder ready for use. This posed a risk to patient safety by preventing staff from quickly accessing and assembling the cylinder in the event of an emergency. We highlighted this issue to staff and the matter was immediately resolved during the inspection.

On both wards we saw evidence of regular temperature checks of the medication fridges, to monitor that medication was being stored at the manufacturer's advised temperature. However, we found numerous gaps in the Ward 2 daily clinic room ambient temperature checklist between July and November 2023, which posed a potential risk to patient safety due to medication damage. Additionally, we saw three recorded instances when the Ward 2 clinic room temperature had exceeded recommended guidelines during September 2023. During our discussions with staff, they confirmed that the temperature spikes had not been appropriately escalated. Also, some staff did not know the correct procedure to follow when temperatures were found to be outside acceptable ranges. We found there was limited guidance for staff regarding the process of escalation in respect of this matter.

The health board must:

- **Strengthen quality governance and leadership and provide clear guidance to staff to ensure the hospitals clinical audit processes are consistently completed**
- **Ensure that instances when temperatures fall outside recommended guidelines are appropriately recorded and promptly escalated to support patient safety.**

We viewed a sample of Medication Administration Records (MAR charts) and found they were being maintained to a good standard. The MAR charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. Patients had individualised medication management plans and we saw evidence of regular medication reviews completed during weekly ward rounds. Most patients lacked capacity to understand their medications but we saw good evidence of family/carer involvement in their care. The hospital was supported by pharmacy staff who attended the hospital on a daily basis. We observed safe, sensitive and appropriate prescribing of medications in accordance with patient needs.

However, during the inspection we noted that patient adverse reactions and venous thrombosis assessments were not being appropriately completed on Ward 2. We saw evidence that this issue had previously been identified by pharmacy staff, who had inserted recommendations within the records to ensure these

actions were completed. Despite this, the issue had not been rectified at the time of our inspection and we found that the assessments were still absent from patient records on Ward 2.

The health board must:

- **Ensure patient venous thrombosis and adverse reactions assessments are consistently completed to support patient safety**
- **Implement additional training, governance oversight and action planning for staff to ensure this process is consistently completed.**

At the time of our inspection there were four patients being detained under the Mental Health Act (MHA) on Ward 2. During our examination of patient records, we found that the current MHA legal status for patients was not recorded within any of the MAR charts we viewed. We also found consent to treatment certificates were not being stored with the corresponding medication records. The absence of this information meant that staff could not refer to the certificate when administering medication to ensure that medication was prescribed under the consent to treatment provisions within the Act. We engaged with staff in respect of this matter, and the MAR charts were appropriately rectified during the inspection.

Challenging behaviour
The hospital had policies in place to help protect the safety and wellbeing of patients and staff, including a policy for the Recognition, Prevention and Therapeutic Management of Violence and Behaviours that Challenge. Incidents of restrictive practices were reported through the Datix system which had an established governance structure in place and incorporated a hierarchy of investigation process and incident sign-off.

During our discussions with staff, they showed understanding of the restrictive practices available to them. This included appropriate preventative measures that can reduce the need for restrictive responses to challenging behaviour. Staff compliance with mandatory Prevention and Management of Violence and Aggression (PMVA) training was high at 82 per cent on Ward 1 and 97 per cent on Ward 2. We were told that there had been only one recorded incident of restraint recorded in the hospital within the last six months prior to our inspection. This demonstrated that restrictive practices were used as a last resort, after other methods of de-escalation had proved unsuccessful.

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. Patient observation requirements were discussed on a daily basis and we were told that staff would observe patients more frequently if their behaviour required closer monitoring. We saw staff undertaking safe and supportive therapeutic patient observations, and found they were being conducted and contemporaneously recorded in line with hospital policy. However, we noted that the health board's therapeutic observation forms provided very limited space for staff to record full details of patient behaviours and mental state. As a result, we saw some examples where only the location of the patient was recorded within the observation records.

The health board must review patient observation records documentation to ensure it provides enough space for staff to record sufficient detail.

During the inspection we noted that staff did not receive training on how to undertake effective and safe observations. The health board may wish to consider arranging this for their staff to further improve patient therapeutic observation processes.

Effective

Effective care

Each ward had a manager and deputies who were supported by a committed ward and multidisciplinary teams. The hospital had good dedicated medical support arrangements in place, with two consultants and four junior doctors covering both wards. 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.

However, some staff we spoke with during the inspection told us they felt that the current staffing template was not sufficient to support safe and effective care. We were told that the staffing pressures and patient acuity often resulted in ward managers and their deputies being required to work alongside ward staff to support patient care. Staff told us that this impacted on their supervisory duties and responsibilities. We were further told that Ward 2 staff provided care to a wide range of patients including new admissions, patients displaying challenging behaviours and patients requiring end of life care. Given that this ward was split into two separate areas, the staff team was effectively divided across both sides of the ward, with just one qualified nurse working on each side. Staff told us that when a clinical incident occurred on one side of Ward 2, the qualified nurse from the other side attended to assist. This left one side of the ward unsupervised, which posed a potential risk to patient safety. Staff advised that they felt that the recruitment of an additional qualified nurse to work on each shift on Ward 2 would provide adequate support for staff, and mitigate any potential risk to patient safety.

The health board should conduct further discussions with staff to review the hospital's current staffing templates and ensure staffing levels support safe and effective patient care.

We found established systems in place for recording, reviewing and monitoring incidents. The 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.

Patient records

Patient records were being maintained electronically and via paper files. Paper files were securely stored on site and the electronic system was password protected to prevent unauthorised access and breaches in confidentiality. We found well-organised paper and electronic records completed in the hospital, which were easy to navigate through clearly marked sections. Information was being captured regularly and comprehensively, which provided a detailed overview of the patients and their care.

Further information on our findings is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Nutrition and hydration

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.

During the inspection we observed that staff were supportive of individual patient food choices. Individual patient dietary requirements were displayed in the nursing offices and ward kitchens for staff awareness. There were set times for meals throughout the day, and we were told that patients could access additional drinks and snacks as needed. We found patients were supported to make their own food choices and were provided with a nutritionally balanced diet. However, some staff told us that the hospital menu did not rotate on a regular basis, and the quality of the food provided to patients was poor. We observed food being served to patients during the inspection and found it appeared to be unappetising and unappealing.

The health board must undertake a review of the quality and variety of patient food provided at the hospital to ensure that it meets patient satisfaction and dietary requirements.

Mental Health Act Monitoring

We reviewed four patient records to ensure compliance with the Mental Health Act (MHA), including three patients who were detained under the MHA and one patient subject to a Deprivation of Liberty Safeguards (DOLS) authorisation. We found that legal documentation to detain patients under the Act was compliant with the legislation. Patients were legally detained and reliably informed of their rights under the Act. The hospital had an appointed Mental Health Act Manager who demonstrated very good understanding of the health board's MHA processes and responsibilities.

Information was being recorded within the hospital's electronic Care Partner system and within paper-based folders held at ward level. The Care Partner system was functional, accessible and contained detailed and relevant information. The hospitals paper Mental Health Act files were well organised, easy to navigate and clearly sectioned, but we found the volume and number of paper MHA files was very large. The health board may wish to consider implementing a fully electronic MHA record system in future, which would further improve the efficiency and organisation of MHA processes.

Mental Capacity assessments were being completed in accordance with the Mental Capacity Act, which clearly demonstrated that the assessment of patient capacity was a regular and dynamic process. We saw strong evidence that capacity assessment findings were used to inform patient risk assessments, and care and treatment planning as appropriate.

Patients were supported by South Wales Mental Health Advocacy (SWMHA) services who visited the clinic at least twice or three times per week. We were informed that patients could also request advocacy support on an ad hoc basis as required.

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 four patient Care and Treatment Plans (CTPs) across both wards and found a good standard of clinical record keeping which reflected the needs and risks of the patients in the hospital. The CTPs were aligned to the domains of the Wales Mental Health measure and provided a comprehensive account of the patient presentation and interventions being offered. The records were regularly reviewed, well organised and easy to navigate. Patient care plans were person-centred and contained strong evidence of patient and/or family involvement wherever possible.

To support patient care plans, there was an extensive range of assessments to identify and monitor the provision of patient care, along with risk assessments

which set out the identified risks and how to mitigate and manage them. Some examples included Wales Applied Risk Research Network (WARRN) risk assessments, Malnutrition Universal Screening Tool (MUST) assessments and further assessments appropriate to the patient group such as SALT, falls and Waterlow assessments.

MDT participation was evident across both wards and included the involvement of family/carers and external agencies where required. Discharge planning and preparation processes were in place for any patients well enough to be discharged from the hospital. The hospital held Discharge Priorities meetings involving ward staff, community professionals and other resources appropriate to the patient.

However, during the inspection we attempted to review the CTP of a Ward 2 patient and found that it had been deleted from the hospital's electronic health record system, so the patient had no care plan in place. We were therefore unable to review any aspect of the patients care and treatment and highlighted this to staff as a serious risk to the safety of the patient concerned. We were provided with assurances that this was an isolated incident caused by human error when a staff member had incorrectly utilised an existing care plan to generate a new one, rather than initiating a blank CTP proforma.

To address this matter, we requested that a CTP must be immediately completed for the patient concerned and a full audit must be conducted of all patient records to ensure there had been no repetition of this error. We further required senior staff to provide assurances on what actions would be taken to prevent reoccurrence of this error in future.

This matter was appropriately rectified during our inspection, in that a new care plan was created for the patient and an audit was completed to ensure all patient care plans were present and correct. To prevent reoccurrence of this error, a Standard Operating Procedure (SOP) was created to advise staff on the correct procedure for generating a blank CTP proforma when initiating a care plan. We were further informed that relevant learning would be shared with staff at all levels and during the health board's Quality Safety, Risk and Experience (QSRE) group meetings to prevent reoccurrence and drive quality improvement.

Quality of Management and Leadership

Leadership

Governance and leadership
It was positive that throughout the inspection staff were very receptive and responsive to our views, findings and recommendations. We observed strong team working on the wards and found staff were dedicated to delivering a high standard of patient care. Staff were respectful of each other and there was a positive approach to team working with clear lines of responsibility for certain tasks. The staff members we interviewed during the inspection spoke passionately about their roles and the care they provided to patients.

We found an effective governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care. We saw evidence of good collaborative working across the health board to support improvements and disseminate quick learning from incidents and serious untoward events. However, as outlined in this report, we did find that some improvements were required to ensure the health board's audit processes were effectively completed and supervised, and that any issues of note were appropriately escalated and addressed.

The majority of staff members we spoke with during the inspection told us that they felt supported in their roles, and described the leadership team as being visible and approachable. However, at the time of our inspection we were told that the health board was in the process of restructuring how its mental health services will be delivered, and there were impending organisational changes being made across the Mental Health and Learning Disabilities Care Group. Whilst the proposed changes mainly affected senior staff members above ward level, the organisational structure and identity of senior staff members was unclear and unpredictable for all staff. Additionally, we witnessed that the interim status of some staff senior members created feelings of uncertainty amongst staff. The health board may wish to conduct further discussions with staff to provide clarity and stability during its period of organisational transition.

During the inspection we noted that several health board policies were out of date or in draft format, with no apparent review dates. Policies that were outdated or displayed no apparent review date included:

- Observation - expired March 2022
- Recruitment and Selection – expired December 2020

- Safe and Supportive Engagement and Observation Procedure in Mental Health Wards - expired March 2022
- Medicines Management – expired October 2014
- Local Procedure for the use of Seclusion – no date
- Consent to Treatment Procedure – no date
- Policy for the Recognition, Prevention and Therapeutic Management of Violence and Behaviours that Challenge - no date
- Policy for the Management of Severely Disturbed Patients or of Violent Behaviour by Adult Inpatients with Cwm Taff Morgannwg – no date.

The health board must review any outdated or undated policies to provide clear guidance to staff and support them in their roles.

Workforce

Skilled and enabled workforce

We were informed that measures were in place to ensure the hospital's staffing levels met health board templates. However, at the time of our inspection it was concerning to find that there was a high number of staffing vacancies within the hospital, including vacancies for 1.7 Registered Nurses on Ward 1 and six Registered Nurses on Ward 2. Staff told us the service is reliant on a high use of bank and agency staff to fill 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 staffing requirements and increased patient demand on the wards.

We noted that many of the improvements we identified during the inspection related to Ward 2, which was providing care for a higher number of patients whilst also carrying a significantly high number of staffing vacancies. We were further told that recent instances of long-term staff sickness on Ward 2 had placed additional strain on staff.

During our discussions with senior staff, they advised that there were ongoing recruitment processes to fill the hospital's vacant posts. However, they felt many potential applicants were reluctant to apply, as the hospital did not offer a desirable twelve-hour shift pattern. At the time of our inspection, we noted there was a petition ongoing amongst staff in respect of this matter. The health board may wish to conduct further discussions with staff to resolve this issue and recruit staff to vacant posts in the hospital.

We found suitable processes were in place for senior staff to monitor compliance with mandatory training. We were provided with evidence which indicated that overall training compliance statistics were 83 per cent on Ward 1 and 70 per cent on Ward 2. We were informed that the recent employment of five

new staff members on Ward 2 had reduced the overall compliance statistics on this ward.

Whilst there had been notable improvements with staff mandatory training compliance since our last inspection, we found that improvements were still required in relation to the courses listed below. It was concerning to find a low rate of compliance across both wards with Management of Safeguarding People training.

Ward 1:

- Safeguarding Adults Level 2 – 78 per cent
- Management of Safeguarding People - 55 per cent
- Violence Against Women Domestic Abuse and Sexual Violence - 70 per cent
- Information Governance - 78 per cent.

Ward 2:

- Fire Safety – 77 per cent
- Welsh Language Awareness - 65 per cent
- Manual Handling Level 1 – 71 per cent
- Manual Handling Level 2 – 69 per cent
- Management of Safeguarding People - 62 per cent
- Violence Against Women Domestic Abuse and Sexual Violence - 77 per cent.

The health board must implement measures to ensure all outstanding mandatory staff training is completed, regularly monitored and that staff are supported to attend the training.

At the time of the inspection, we were told that 95 per cent of Ward 1 staff and 75 per cent of Ward 2 staff had received their Performance Appraisal and Development Review (PADR) and Performance Development Review (PDR). Staff reiterated that this lower percentage was due to the recent employment of new staff members on Ward 2.

Culture

People engagement, feedback and learning
The health board had an established process in place where patients could escalate concerns via the health board's Putting Things Right complaints procedure. Senior staff confirmed that formal complaints were recorded on the Datix system and were supervised by senior managers throughout the investigation. Staff told us that wherever possible they would try to resolve complaints

immediately, and share learning from incidents appropriately. We were told that information and training had been provided to staff on the Duty of Candour requirements.

We found strong evidence that feedback could be provided to the hospital in a number of ways. The hospital provided family and carers with a suggestion box and both paper and electronic processes which invited their feedback. The hospital also had a dedicated bimonthly family and carers meeting process, to capture views and feedback on the care being provided within the hospital. Meeting minutes we reviewed strongly evidenced that staff collaborated with family and carers, to discuss patient care and drive quality improvement. However, we noted that the previous family and carers meetings prior to our inspection were held in February and June 2023.

The health board must ensure that family and carer meetings take place within set timescales to ensure their feedback is regularly captured and addressed as appropriate.

We found there was no dedicated patient meeting process within the hospital and were told that this was due to the cognitive ability of the patient group. Staff confirmed that patients could raise any concerns at any time, and that they were also clearly signposted to the health board's complaints process via the hospital's notice boards, patient information booklet and easy read leaflets. We noted that the February 2023 family and carers meeting minutes indicated that the staff team were looking at implementing patient experience meetings, to formally capture patient feedback. However, this action had not been completed at the time of our inspection.

The health board should consider ways to formally and routinely capture patient feedback within the hospital, in order to drive quality improvement.

The ward had a dedicated monthly staff meeting process to share concerns and feedback and strengthen staff working relationships. We were informed that when meetings were held, the minutes were collated and circulated for staff awareness. However, we found that the staff meetings did not take place on a regular basis and there had been no staff meetings between May and October 2023 on both wards. Senior staff told us that this was due to long term supervisory staff sickness within the hospital over this period. Following the inspection, we received assurances that the issue would be discussed as a standing agenda item during monthly ward manager meetings, to ensure ongoing governance oversight of staff meeting processes.

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

A whistleblowing policy was in place to provide guidance on how staff can raise concerns in the hospital. We were told there were various support systems available to staff going through the complaints process, including union, HR and psychology support, wellbeing services, and Occupational Health.

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. All information recorded on the hospital's electronic health record system was password protected. Information was accessible to all relevant staff and there were established processes to share information with partner agencies in safe and secure way. At the time of our inspection, staff compliance with mandatory information governance training was 78 per cent on Ward 1 and 90 per cent on Ward 2.

Learning, improvement and research

Quality improvement activities

We found a strong ethos of continuous service improvement on the wards, and the staff were very enthusiastic and motivated. We saw many improvements had been undertaken since our previous inspection in November 2022. We were informed that the improvement plan from the previous inspection had been fully completed. Senior nursing staff conducted monthly spot checks to review the ward environment and identify areas of improvement. We were told that that hospital staff were working on a 'Falls Initiative', which involved ongoing collaboration with Innovative Health Initiative and Improvement Cymru to reduce the number of patient falls within Cwm Taf Morgannwg.

There were systems and processes in place to ensure key issues were being effectively investigated, escalated, supervised and scrutinised to prevent reoccurrence. The hospital governance systems and arrangements supported continuous improvements and shared learning from incidents and serious untoward events. Hospital staff attended held weekly clinical governance meetings to discuss patient care and share learning across the Mental Health Services Group. The Quality, Safety Risk and Experience (QSRE) board held bimonthly meetings to discuss issues, points of learning, themes and trends across the health board. We saw evidence that relevant issues were escalated for awareness and discussion

during QSRE meetings. We were told that key issues and points of learning were cascaded to all staff electronically and verbally.

However, during the inspection we noted that staff had difficulty in interrogating and filtering hospital records and data to extract and separate information which specifically related to Angelton Clinic, rather than the wider Adult Mental Health Services. For example, when reviewing clinical governance tracker documentation and incidents recorded on Datix, it was difficult for staff to filter data to produce ward-specific data. Whilst this information was eventually produced during our inspection, we noted it was a time consuming and laborious process for staff. We identified this posed difficulty for supervisory staff to monitor and supervise incidents and to identify themes, trends and opportunities for shared learning.

The health board must ensure that hospital systems and processes can be suitably filtered to extract ward-specific data to support effective supervision, governance oversight and shared learning.

The hospital's various audit processes generally supported quality improvement but we found some improvements were required to ensure that points of learning were escalated and cascaded to staff. In addition to some of the audit and escalation process issues already outlined in this report, we saw that the Senior Nurse Monthly Spot Checks process had identified some recurring issues between June and October 2023. Some examples included ward doors being found wedged open and gaps in ward-based audit checklists. The documentation evidenced that the issues were identified and highlighted to supervisory ward staff for discussion during staff meetings. However, senior staff could not describe any additional governance oversight nor processes implemented to further encourage shared learning and prevent reoccurrence of this error.

The health board must ensure ongoing senior management scrutiny of the hospital's systems and audit processes to ensure key and recurrent issues are being effectively escalated and appropriately action planned, to prevent reoccurrence.

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. We were told that regularly engaged with local authorities, General Practitioners, Community Mental Health Services and third sector organisations to ensure a whole system approach to patient care.

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 summarises 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
Staff were not using personal safety alarms and there were insufficient personal alarms for staff, with just two alarms available on Ward 1 and three alarms on Ward 2. We further noted that the health board's Standard Operating Procedure (SOP) for the use of personal safety alarms 'encouraged' but did not mandate the use of the alarms.	This posed a safety risk to staff, patients and visitors.	We highlighted this issue to senior staff.	We were advised that new personal safety alarms had been on order and had since arrived at the hospital but had not yet been issued to staff. We received assurances that the alarms were issued to staff during the inspection and the personal alarm SOP was amended to ensure mandatory staff compliance with personal alarm use.
During our evening tour of the hospital, we observed that the key for the oxygen cylinder and giving set within the Ward 1 clinic room was being stored in a nearby drawer and the giving set was not attached to the cylinder ready for use.	This posed a risk to patient safety by preventing staff from quickly accessing and assembling the cylinder in the event of an emergency.	We highlighted this issue to staff.	The matter was immediately resolved during the inspection in that the key was suitably stored and the giving set appropriately connected.

The current MHA legal status for patients was not recorded within any of the MAR charts we viewed. We also found consent to treatment certificates were not being stored with the corresponding medication records.	The absence of this information meant that staff could not refer to the certificate when administering medication to ensure that medication was prescribed under the consent to treatment provisions within the Act. This posed a risk to staff and patients.	We engaged with staff in respect of this matter.	The MAR charts were appropriately rectified during the inspection.
We found the CTP of a Ward 2 patient and had been deleted from the hospital's electronic health record system so the patient had no care plan in place.	Staff were therefore unable to review any aspect of the patients care and treatment which posed a serious potential risk to the safety of the patient concerned.	We highlighted this issue to senior staff and requested the following actions: • a CTP must be immediately completed for the patient concerned • A full audit must be conducted of all patient records to ensure no	This matter was appropriately rectified during our inspection: • A new care plan was created for the patient • An audit was completed to ensure all patient care plans were present and correct. • To prevent recurrence of this error, a Standard Operating Procedure (SOP) was created to advise staff on the correct procedure for generating a blank CTP proforma when initiating a care plan. • Senior staff advised that relevant learning would be shared with staff

		repetition of this error. • Senior staff must provide assurances on what actions would be taken to prevent recurrence of this error	at all levels and during the health board's Quality Safety, Risk and Experience (QSRE) group meetings to prevent reoccurrence and drive quality improvement.

Appendix B – Immediate improvement plan

Service: Angelton Clinic, Glanrhyd Hospital

Date of inspection: 13-15 November 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 Assurance issues were identified during this inspection.				

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: Angelton Clinic, Glanrhyd Hospital
Date of inspection: 13 - 15 November 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. The communal gardens required weeding and general maintenance to make them a more pleasant therapeutic environment for patients.	The hospital communal gardens areas must be tidied and maintained to provide a more pleasant and appealing environment for patients.	The Facilities department have a schedule for garden maintenance works within Angelton Clinic. This will be carried out in the Spring where plants and bulbs will be planted. The Angelton team have also been working closely with the third sector organisation Mental Health Matters who have and will continue to support the maintenance and gardening. This will also provide an opportunity for the patients to be involved as a therapeutic activity.	Ward Manager Senior Nurse	In Progress Estimated Completion Date April 2024
2. There were no physical exercise facilities available to patients within the hospital.	The health board should ensure the provision of gym and exercise equipment to support patient health promotion and improvement.	Angelton Clinic has a dedicated Physiotherapist. We have identified an area within Angelton Clinic to be used to support physical exercise, patient health and promotion.	Ward Manager Senior Nurse	Completed 28/12/2023

		Appropriate equipment has been identified and is in place.		
3. We were told that the clinic's dedicated wheelchair accessible vehicle had been removed and was not replaced.	The health board should consider reinstating the hospital's dedicated wheelchair accessible vehicle to promote timely patient care.	Angelton Clinic has always had access to a wheelchair accessible vehicle however unfortunately it was involved in an accident and wasn't repairable, a replacement is on order.	Senior Nurse	Completed 28/1/2023
4. Ward 2 staff compliance with Welsh Language Awareness training was low at 65 per cent.	The health board must undertake measures to improve mandatory Welsh language training compliance.	Welsh Language Awareness training levels to reach a minimum of 85% whilst working toward 100% Ward 1 is currently 100% Ward 2 is currently 78.5%	Ward Manager Senior Nurse	In Progress Estimated date for completion January 2024
5. We saw little evidence that the active offer was being delivered in the hospital nor recorded prominently within patient records.	The health board must implement measures to ensure the active offer of Welsh is appropriately delivered in the hospital.	Admission paperwork has been updated to ensure that the patient or relative is asked what their preferred language is on admission and this is clearly documented. A section has been added to the Inpatient Management Plan to identify patients' preferred language.		Completed 28/12/2023

		Welsh speaking staff now have the appropriate uniform and/or lanyard displaying that the staff member is a Welsh speaker.		
6. We were informed that visitors were discouraged from visiting patients on the wards or within their own bedrooms and were instead required to wait in the atrium for the patient to be brought out to them.	The health board should ensure the provision of suitable areas where patients can be visited on the wards in addition to the Angelton atrium area.	There is a private visiting area/room along the corridor in Angelton Clinic for visitors that wish to have privacy when visiting their loved ones. If visitors wish to visit their family member on the designated Ward they are welcome to do so within their loved one's personal bedroom. This has been raised and discussed within the carers/families recent meeting.	Ward Manager Senior Nurse	Completed 28/12/2023
7. We found some of the hospital's audit processes were not being consistently completed by staff as follows: • There were numerous gaps in the Ward 2 entrance magnetic door daily checklists between	The health board must implement a robust programme of governance oversight which ensures that the hospital's established audit processes and checklists are fully completed within set timescales to ensure the safety of patients, staff and visitors.	All Checks have since been revised. On the advice of the reviewing team the magnetic door checks are now once a day as opposed to three times a day which was leading to gaps The kitchen fridge temperature check form was showing an expectation of 3x daily checks however the expectation is 2x daily	Ward Manager Senior Nurse	Completed 28/12/2023

August and November 2023 • We saw a number of gaps in the Ward 2 daily kitchen fridge temperature checklists between September and November 2023 • The Ward 2 weekly legionella flushes checklist was not completed on a weekly basis.		checks which led to gaps. This has now been corrected and the results uploaded to AMAT. Legionella Flushes are being carried out on a weekly basis by the Ward Domestic Team All checks form part of the Ward Manager weekly check list and Senior Nurse monthly checklist. Senior Nurse will escalate any concerns immediately and address at the monthly Ward Managers meetings. Ward Managers will then share the information discussed and address these issues within the wider nursing team staff meetings. Ward managers have put Audits/compliance as a fixed agenda item on ward staff meetings.		
8. We were not assured there was an efficient process in place which ensured that	The health board must implement a programme of governance oversight which ensures that the hospital's	A new process has been put in place which is managed by the Directorate Support Manager.	Directorate Support Manager	Completed 28/12/2023

outstanding estates issues were being identified, addressed and signed off as complete for the awareness of all staff.	maintenance issues are promptly and effectively recorded, addressed and signed off.	We now have one central estates log for all areas within Angelton Clinic which can be accessed via the discharge drive. The Directorate Support Manager inputs the issue reported into the estates log and will escalate any issues to estates. Directorate Support Manager will monitor outstanding jobs and ask estates for updates regularly to ensure all jobs are signed off appropriately. Any outstanding estates issues will be put on the Health and Safety Highlight report and updated at the Health and Safety Meeting.		
9. During the inspection we noted several maintenance issues which required repair within the hospital.	The hospital's outstanding maintenance and environmental issues must be reviewed and	A new estates monitoring process is currently in place to ensure any outstanding issues are reviewed and rectified to ensure the comfort and safety of patient's staff and visitors.	Directorate Support Manager	Completed 28/12/2023

	rectified to ensure the comfort and safety of patients, staff and visitors. The health board must undertake a full environmental audit of the Angelton clinic to identify and address any additional maintenance issues.	A full environmental audit within Angelton Clinic will be completed to address and identify any further additional maintenance issues	Directorate Support Manager	In Progress Estimated date for completion Jan 2024
10. We saw low compliance figures with Ward 2 IPC environmental audits during September and October 2023 at 75 and 67 per cent.	The health board must implement robust measures to improve IPC environmental audit compliance on Ward 2.	Environmental audit completed within Ward 2 Angelton Clinic. Audit completed on AMAT, current compliance 85.3%	Ward Manager	Completed 28/12/2023
11. The male kitchen on Ward 2 was in an untidy state. We noted several issues which posed a risk to patient safety including: • Unsealed, unlabelled, expired communal patient foods • Unlabelled non-prescription medications on the top of the kitchen cupboard.	The health board must implement robust measures to ensure patient foods are regularly checked, suitably stored and appropriately labelled so that the opening and expiry date can be viewed. Medications must not be stored in the ward kitchen areas.	Following inspection an email has been sent to ALL staff on both wards highlighting the need to ensure that there is no: Unsealed, unlabelled, expired communal patient foods Unlabelled non-prescription medications on the top of the kitchen cupboard. Ward Manager weekly check put in place to ensure ward kitchens are kept to a high standard.	Ward Manager	Completed 28/12/2023

		Senior Nurse monthly spot checks now incorporate kitchen/fridge checks. Any issues identified to be brought to Ward Managers attention for dissemination to ward staff.		
12. Staff compliance with Safeguarding Adults level 2 training was low on Ward 1 at 78 per cent.	The health board must undertake measures to improve Ward 1 staff compliance with mandatory safeguarding training.	Ward 1 and Ward 2 Safeguarding Adults Level 2 Training has been addressed to increase compliance. Currently Ward 1 at 95% Ward 2 85.71% The HB compliance standard is 85% but both wards will aim for 100% compliance.	Ward Manager	Completed 28/12/2023
13. The health board's Medicines Management policy had expired in 2014. The expired policy contained a reference to 'Appendix A' which should provide guidance to staff regarding medication storage requirements. However, this entire section was found to be missing from the policy.	The health board must review the outdated Medicines Management policy and provide guidance for staff on the storage of medications to support staff in their roles and ensure patient safety.	The health board has updated the policy which was published 15/11/2023.	Chief Pharmacist	Completed 28/12/2023

14. We found numerous gaps in the Ward 2 daily clinic room ambient temperature checklist between July and November 2023 and saw three recorded instances when the Ward 2 clinic room temperature had exceeded recommended guidelines during September 2023. We found there was limited guidance for staff regarding the process of escalation in respect of this matter.	The health board must: • Strengthen quality governance and leadership and provide clear guidance to staff to ensure the hospitals clinical audit processes are consistently completed • Ensure that instances when temperatures fall outside recommended guidelines are appropriately recorded and promptly escalated to support patient safety.	Ward audit is completed on a weekly basis by Ward Manager any issues identified are then addressed within the Ward Managers Staff Meeting. All staff have been informed of the escalation process if the room temperature spikes above 25 degrees, new Daily Clinical Room and Fridge Temperature list in place.	Ward Manager	Completed 28/12/2023
15. Patient adverse reactions and venous thrombosis assessments were not being appropriately completed on Ward 2.	The health board must: • Ensure patient venous thrombosis and adverse reactions assessments are consistently completed to support patient safety • Implement additional training, governance oversight and action planning for staff to ensure this process is consistently completed.	All prescribing staff have been reminded of the importance of completing the assessments. Angelton Clinic is supported by a designated pharmacist. The MH lead pharmacist has reminded all pharmacy staff who attend the ward to highlight any missed sections e.g. Allergy, VTE and report these to the medical team for review.	Lead Pharmacist	Completed 28/12/2023

		Completing the assessments will now be included in the induction of new medical staff. The charts and compliance with the recommendations will now be checked during every ward round.		
16. The health board's therapeutic observation forms provided very limited space for staff to record full details of patient behaviours and mental state.	The health board must review patient observation records documentation to ensure it provides enough space for staff to record sufficient detail.	Therapeutic observation forms have been amended to ensure sufficient space is available for staff to provide sufficient information.	Senior Nurse	Completed 28/12/2023
17. Some staff we spoke with during the inspection told us they felt that the current staffing template was not sufficient to support safe and effective care.	The health board should conduct further discussions with staff to review the hospital's current staffing templates and ensure staffing levels support safe and effective patient care.	The Head of Nursing has recently completed a review of all CTM MHLD inpatient wards. This review has considered changes to shift patterns and recommends that 12-hour shifts are trialled and evaluated. A pilot proposal is being developed.	Head of Nursing	Completed 28/12/2023
18. We were told that the hospital menu did not rotate on a regular basis and the quality of the food provided to patients	The health board must undertake a review of the quality and variety of patient food provided at the hospital to ensure that it meets patient	The current menu for Angelton Clinic has been put in place by the catering Lead to meet the nutritional	Catering Lead	Completed 28/12/2023

was poor. We observed food being served to patients during the inspection and found it appeared to be unappetising and unappealing.	satisfaction and dietary requirements.	standards and offer a variety of food for Angelton Patients.		
19. During the inspection we noted that several health board policies were out of date or in draft format, with no apparent review dates.	The health board must review any outdated or undated policies to provide clear guidance to staff and support them in their roles.	As part of another HIW improvement plan the MHLD Care group has a Policy Review group which has an operational scope to: • Review & RAG of all existing MH Policies to establish priorities rating • Develop a policies plan with trajectories for addressing the backlog • To progress for sign off at Care Group level • Maintenance of a register of policies for review Terms of Reference have been agreed for the policies group with the process for ratifying policies and procedures reflecting the recently revised organisational process for ratification.	Chair of Policies Group	Completed 28/12/2023

		The HB has revised its process for the ratification of policies, policies now need a 6-week consultation pan CTM, endorsement via Operational Management Board and then final ratification at QSC. This process will lead to more timely and efficient ratification of the MHLD policies		
20. We found improvements were required to improve staff compliance with several mandatory training courses.	The health board must implement measures to ensure all outstanding mandatory staff training is completed, regularly monitored and that staff are supported to attend the training.	Mandatory Training has been part of our improvement plan in 2023. Mandatory Training is a fixed agenda item on the monthly Ward Managers meeting. The Senior Nurse checks all mandatory training levels monthly and reports back to Ward Managers this is fed back to the ESR Ward Champion who will then support and encourage staff members to access the mandatory course required and complete. All staff are given time to complete ESR Mandatory Training	Ward Manager Senior Nurse	Completed 28/12/2023

		ESR is updated automatically and Ward Managers ensure the mandatory training database is also updated.		
21. The hospital had a dedicated bimonthly family and carers meeting process but we noted that the previous family and carers meetings prior to our inspection were held in February and June 2023.	The health board must ensure that family/carer meetings take place within set timescales to ensure their feedback is regularly captured and addressed as appropriate.	Family/Carer meetings were 3 monthly, this has now been increased to every 2 months to ensure discussions are taking place and feedback is captured.	Ward Managers Senior Nurse	Completed 28/12/2023
22. There was no dedicated patient meeting process within the hospital to formally capture patient feedback.	The health board should consider ways to formally and routinely capture patient feedback in order to drive quality improvement.	Angelton Clinic have recommenced the Patient feedback form in conjunction with Therapy colleagues to encourage completion wherever appropriate. This will be carried out weekly during protected patient time. Feedback will be passed on to the Senior Nurse through the Ward Managers and will be included in the Senior Nurses QSRE report.	Ward Manager Senior Nurse Ward Staff	Completed 28/12/2023
23. The monthly staff meetings did not take place on a regular basis and there had been no staff meetings between May	The health board must ensure staff meetings are conducted on a regular basis to engage staff, discuss issues and encourage staff feedback.	Ward meetings are held monthly, unfortunately there was an increase in sickness within Angelton Clinic including the Ward Manager and	Ward Manager Senior Nurse	Completed 28/12/2023

and October 2023 on both wards.		Clinical Lead therefore this led to cancellation of staff meetings. If this situation occurred again the Senior Nurse would now hold the meetings. Ward managers to set dates for monthly staff meetings, dates to be shared with staff well in advance. Timetable to be put in place.		
24. Staff had difficulty in interrogating and filtering hospital records to extract and separate ward specific data. This posed difficulty for supervisory staff to monitor and supervise incidents and to identify themes, trends and opportunities for shared learning.	The health board must ensure that hospital systems and processes can be suitably filtered to extract ward specific data to support effective supervision, governance oversight and shared learning.	The incident management system Datix Cloud IQ can be filtered down to show specific data relating to areas, incident type and severity. The Head of Nursing is working with the Patient Care and Safety Business Intelligence officer to ensure all Lead Nurse, Senior Nurse and ward Managers have access to and training on datix dashboards.	Head of Nursing Care and Safety Business Intelligence officer	In Progress Due for completion end of Jan 2024
25. The Senior Nurse Monthly Spot Checks identified recurrent issues which had not been resolved. Senior staff could not describe any additional governance oversight nor processes implemented to	The health board must ensure ongoing senior management scrutiny of the hospital's systems and audit processes to ensure key and current issues are being effectively escalated, and appropriately action planned to prevent reoccurrence.	On the Senior Nurse spot check list a column has been added to clearly show actions/escalations carried out. This information is shared within the Ward Managers meetings and	Ward Manager Senior Nurse	Completed 28/12/2023

further encourage shared learning and prevent reoccurrence of this error.		discussed, the action going forward this is then shared with the wider nursing team through Staff meetings and handovers. The Senior Nurse will share any persistent issues through their QSRE report to the locality QSRE which will then be further escalated if necessary through the Lead Nurses QSRE to the directorate. The Cascade and Escalate Standard Operating Procedure document describes the process.		

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): **Clare Yates**
Job role: **Lead Nurse**
Date: **03/01/2024**