Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22 and the Psychiatric Intensive Care Unit, 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 Royal Glamorgan Hospital, Cwm Taf Morgannwg University Health Board on 20,21 and 22 November 2023. The following hospital wards were reviewed during this inspection:

- Admission Ward - Adult Mental Health
- Ward 21 - Adult Mental Health
- Ward 22 - Adult Mental Health
- Psychiatric Intensive Care Unit - Adult Mental Health.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of nine questionnaires were completed by patients or carers. Feedback and some of the comments we received appear throughout the report.

We also spoke to staff working at the service during our inspection. Feedback and some of the comments we received appear throughout the report.

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

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

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found a dedicated staff team that were committed to providing a high standard of care to patients. We saw staff at all levels interacting with patients respectfully throughout the inspection.

Robust arrangements were in place to tailor care and treatment plans to patients' individual needs and preferences. This included good evidence of multidisciplinary involvement, to ensure patients' care plans are comprehensive.

As highlighted in our previous inspections some wards still had a mix of single and two-bedded rooms. These shared rooms can impact on the privacy and dignity of patients. Also, patients told us that improvements were required regarding menu choices for patients with specific dietary requirements.

Patients told us that staff at the hospital looked after them well.

This is what we recommend the service can improve:

- More varied menu choices for patients with specific dietary requirements
- More robust application of the health boards no smoking policy.

This is what the service did well:

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

Delivery of Safe and Effective Care

Overall summary:
We found an excellent standard of care planning which reflected the domains of the Welsh Measure. Care plans were well detailed, individualised, and reflected a wide range of MDT involvement. There was also clear and documented evidence of patient involvement.

There were good processes and audits in place to manage risk, health and safety and infection control. This enabled staff to continue to provide safe and clinically effective care. However, some improvements are required in relation to reliability of current personal alarm systems.

We identified the discharge planning process as a key strength, as we found significant improvements from previous HIW assurance work. This included good communication between inpatient and community services.

Unresolved plumbing and drainage issues continue to impact upon the availability of toilet, shower, and bath facilities across the mental health wards.

This is what we recommend the service can improve:

- Redecoration of ward and communal areas
- Review of staff personal alarms
- Resolve plumbing and drainage issues on all wards.

This is what the service did well:

- Patient care plans were regularly being monitored and assessed
- Safe and effective medication management
- Robust strategies were in place to help manage challenging behaviour, to promote the safety and wellbeing of patients
- Comprehensive and detailed discharge planning process.

Quality of Management and Leadership

Overall summary:
We found significant improvements had been made to address the findings from our last inspection in 2019, and the HIW local review in 2022. This related to care planning, audit activity and discharge planning processes. In addition, it was positive to see that the health board had learnt from previous inspection findings.

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

We found well established governance arrangements in place to provide oversight of clinical and operational issues. Staff told us that they felt supported in their roles and satisfied with their organisational management.

Processes were in place to ensure staffing levels met the hospital's staffing templates. However, it was clear that the service required a high use of agency staff to fill vacant shifts, which placed additional pressure on staff.

At the time of our inspection, we noted a high number of permanent staffing vacancies, and some staff told us they felt there were not enough staff to meet increased patient demand on the wards.

Immediate assurances:
HIW highlighted the following training deficiencies for mandatory training courses which required immediate action by the health board. Please note this list is not exhaustive and full details are contained in Appendix B:

- Improve mandatory training compliance in respect of Immediate Life Support, Basic Life Support, Physical Intervention and Safety and Moving and Handling Training
- Promote patient safety in the interim.

This is what we recommend the service can improve:

- Ensure mandatory training courses are accessible and available and staff have opportunities to attend training
- The health board must review the hospital's current staffing template to consider whether it continues to support effective patient care and staff welfare requirements
- The health board must continue to actively focus on the recruitment of staff to outstanding permanent vacancies.

This is what the service did well:

- Significant Improvements had been made to the discharge planning process
- Robust and effective governance systems in place
- Good collaborative work between ward staff and community-based teams.

3. What we found

Quality of Patient Experience

Patient Feedback

We handed out HIW questionnaires during the inspection to obtain views on the service provided at the hospital. We received nine questionnaires; this low number needs to be borne in mind when considering these responses. We also reviewed internal patient feedback, complaints, and survey logs to help us form a view on the overall patient experience.

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

“Staff are very good”.

“Food very good, staff helpful”

Person centred

Health Promotion
Royal Glamorgan hospital had a range of facilities to support the provision of therapies and activities. This included regular access to the community for patients that were authorised to leave the hospital.

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

Health promotion and healthy eating was clearly evident within individual patient care plans.

Daily patient meetings take place to provide patients with information on any external appointments, and activities that were scheduled for the day.

We observed patients and staff participating in a range of activities throughout the inspection. The occupational therapy staff offered a variety of activities for patients, and it was clear to see that the OT department were providing some beneficial therapeutic activities for the patient group.

Dignified and Respectful Care
We found that all employees engaged with patients appropriately, and treated patients with dignity and respect. This included ward staff, senior management, and administration staff.

The staff we spoke with were enthusiastic about their roles and how they supported and cared for the patients. We saw most staff taking time to speak with patients and address any needs or concerns the patients raised. This showed that staff had responsive and caring attitudes towards the patients.

It was noted that the ward entrances were locked and an intercom system to the ward prevented any unauthorised access.

Some rooms had en-suite bedrooms for patients and provided a good standard of privacy and dignity. Patients could lock their rooms, but staff could override the locks if needed. We saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering.

All rooms have closable observation panels that can be open or closed by the patient from inside their room, and staff use a key to open from the outside. All staff have keys.

The ward provided mixed gender care which can potentially present challenges around aspects of dignified care. It was therefore positive to find that staff were knowledgeable and had effective safeguards and processes in place to manage these challenges to ensure that dignified care was maintained. However, as highlighted during previous inspections; Ward 21, Ward 22 and Admission Ward still had a mix of single bedrooms and two-bedded rooms. This does not reflect modern mental health care provision because shared bedrooms can impact on the privacy and dignity of patients. One patient comment included:

“Don’t wish to share a room would like my own room”.

The health board should review the shared bedrooms and consider updating the rooms to allow patients the privacy of their own room.

In addition, some staff we spoke to told us that the male to female ratio of staff could be improved as there were limited numbers of males working the wards.

The health board should consider the gender balance of staff and ensure that there are enough male staff present on each shift.

Patients were able to personalise their rooms and store their own possessions. Personal items were risk assessed on an individual basis for the safety of each patient. This included the use of personal mobile phones. A telephone was available at the hospital for patients to use to contact friends and family if

needed, and digital devices were available for patients to use with support from staff when required.

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

Patient information

Written information was displayed on the ward for patients and their families. We saw that posters displayed information about advocacy services, and how patients could provide feedback on the care they received on the wards. The information was up-to-date and relevant to the patient group. This included information on health promotion, health eating and drug and alcohol support.

We saw that there was clear signage within the wards in both Welsh and English.

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

During the inspection we noted cigarette ends in the grounds of the hospital and some patients were not adhering to the health boards smoking policy when using the outside areas of the hospital. In addition, prior to the inspection anonymous referrals had been made to HIW relating to both staff and patients not adhering to the health boards no smoking policy.

The health board must ensure a more robust application of the health boards no smoking policy and the framework supporting it.

Individualised care

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

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

Patients were fully involved in monthly multidisciplinary reviews. We saw evidence that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals. Our findings showed clear evidence of

multidisciplinary involvement in the care plans, this helped support the hospital in being able to deliver comprehensive care to the patients.

Timely

Timely Care

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

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

During these meetings it was positive to see staff from other areas in the mental health teams offering to support staff with resources and patient appointments.

Equitable

Communication and language

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

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

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

There were a number of meetings involving patients and staff. These meetings included formal individual care planning meetings.

During the inspection we observed patients and staff speaking Welsh and noted that not all staff were wearing appropriate lanyards and badges which helped to identify them as Welsh speakers.

The health board must ensure that Welsh speaking staff wear the appropriate lanyards and badges to help identify them as Welsh speakers.

Rights and Equality

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

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

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

Feedback forms were also located in the reception area for visitors to access.

Delivery of Safe and Effective Care

Safe

Risk management
Access to the wards was secure to prevent unauthorised access. Staff could enter the ward with swipe cards and visitors rang the buzzer at the ward entrance.

Staff wore personal alarms which they could use to call for help if needed. Personal alarm checks formed part of the morning meeting agenda, however during the inspection visit there appeared to be two types of personal alarms given to staff and visitors, due to some uncertainty around the reliability of the alarms.

The health board must ensure that a full review is undertaken on the appropriateness and reliability of the current personal alarm systems used.

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

The appointment of a deputy support services manager appears to be a valuable addition to the wards management team. The role is highly thought of by staff on the wards, and they feel that it provides a communication route with estates and facilities that has not been present previously. Staff stated that some aspects of the ward areas were improving because of the workforce champions who were working collaboratively with the deputy support service manager to improve aspects of the environment.

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

- Damaged chair in interview room on Ward 22
- Missing ceiling tiles in PICU corridor exposing piping
- Water damaged ceiling tiles in Ward 22
- Review of dining chairs on wards to establish if suitable for patient group
- Missing privacy curtain in shared room on Ward 21 needs replacing
- Drainage in toilets and shower areas in PICU.

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

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

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

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

Cleaning equipment was not always stored and organised appropriately. COSHH materials such as laundry detergents were not stored in a locked cupboard in the PICU area. There were suitable arrangements in place for the disposal of clinical waste.

The health board must ensure that COSHH equipment is stored correctly.

Staff told us of ongoing drainage and sewage issues on the wards. These cause regular problems with toilet, shower, and bath facilities across the mental health wards, particularly in the ECA and PICU area. This often results in these facilities being out of order to patients and affects staffing toilets, therefore limiting their availability for use. This issue must be addressed and rectified as this was also a finding in our 2019 inspection.

The health board must ensure that drainage and sewage issues are resolved.

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

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

The patient information handbook also provided details to patients on how to report a safeguarding issue.

Medicines management
We found that there were suitable arrangements for the safe and secure storage and administration of controlled drugs. We saw evidence of regular temperature checks of the medication fridge to monitor that medication was stored at the advised temperature of the manufacturer.

Overall, the clinical areas were clean, tidy, and well organised.

All wards are given good support from the pharmacy department who carry out regular audit of stock and individual medication. However, we did find an out-of-date bottle of morphine in the controlled drugs cabinet.

The health board must ensure that out of date medication is disposed of appropriately.

The Medication Administration Records we viewed were fully completed. However, in some records the legal status was not completed fully, with some missing information around the legal status and dates of section.

The health board must ensure that MAR charts are fully completed.

Staff were knowledgeable and confident when administering medication. However, we did note that the medication trolley on ward 22 was not securely fixed to the wall.

The health board must ensure that staff comply with the health board policies and guidance on safe and secure storage of medication trolleys and how they are stored on the wards and in clinical rooms.

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

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

Challenging behaviour

Strategies were described for managing challenging behaviour to promote the safety and wellbeing of patients. We were told that preventative techniques were used and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the safe physical restraint of patients was used, but this was rare and only used as a last resort. Any use of restraint was documented. Information produced to the inspection team confirmed that restraint data was low.

The inspection team witnessed positive redirection and de-escalation of difficult behaviours during the course of the inspection, all of which were done respectfully and in a very supportive manner.

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

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

Patients notes from PICU included very detailed assessments that indicated risks and triggers for patients. The notes included historical analysis to establish what had worked well, and what hadn't worked well to manage patients' behaviours.

During our review of some observation records we noted that they were signed for. However, the records only documented the location of the patient and should include information on the patients behaviour or mental state.

The health board must ensure that observation records include details on patients behaviours.

Effective

Effective care

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

Patient records
Patient records were being kept electronically. The electronic system was password protected to prevent unauthorised access and breaches in confidentiality. We used the system throughout the inspection and found patient records to be comprehensive and well organised.

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

Nutrition and hydration
The hospital provided patients with meals on the ward, making their choices from the hospital menu. Patients are also helped to order in takeaway meals when required.

We were told that specific dietary requirements were accommodated, however patients told us that there were not many options or variety for those who have specific dietary requirements.

The health board must ensure that there are more variety of choices for patients with specific dietary requirements.

Mental Health Act Monitoring
We reviewed the statutory detention documents for five patients.

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

During examination of records, we found that the use of Section 17 leave wasn't always recorded.

The health board must ensure that use of Section 17 leave and the outcome is recorded.

We found Approved Mental Health Professional (AMHP) reports were provided soon after admission and were of a high standard.

The Mental Health Act administrator ran an efficient and effective system to support the implementation monitoring and review of the legal requirements of the Mental Health Act.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed nine care files and found that they were kept to a good standard.

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

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

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

Clinical records were well kept and gave a comprehensive picture of the patient and their current presentation. They are reviewed regularly and changed when necessary.

The clinical records clearly showed patient involvement in care discussions, which were patient focussed and signed by the patient. Records also included evidence of the patients' voice to reflect their views on what works and what doesn't work for them, and all of these were very individualised.

Discharge planning is part of the regular review process and there is a high level of attention given to ensuring this aspect is robust, and in the best interest of the patients reviewed.

There was good communication between inpatient and community services for both admission to and discharge from the inpatient service. Discharge appears to be facilitated by a pre discharge planning meeting, a pre discharge meeting involving the patient, family, and community team and then a review on the day of discharge. An email is sent to the GP within 48 hours outlining the discharge plan.

The discharge planning process was identified as an area of good practice as significant improvements had been made to the discharge planning process since HIW last inspection and the local review.

Quality of Management and Leadership

Leadership

Governance and leadership

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

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

During interviews with staff, they were fully aware of the on-call systems in place at the hospital. However, during the evening inspection visit there did not appear to be any out of hours co-ordinator to oversee the mental health wards and to provide support and leadership to ward staff. This resulted in the inspection team waiting in the reception area for some time before any staff were identified to meet with us.

In addition, as there is no night manager on site and only one qualified nurse per ward, should an individual require controlled drugs to be administered, a qualified nurse must leave their ward to assist. This leaves the ward vulnerable and there is a potential risk to patient safety. The same would apply if there was a physical emergency on one of the wards.

It was positive to see that senior staff attended when notified of the inspection teams' arrival and were on hand to provide additional support to staff.

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

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

Staff described ward managers and deputies as always being approachable and accessible and there appears to be a strong and supportive leadership culture on both wards. This was supported by staff who described the ward managers as supportive, visible, and accessible at all times. However, most staff stated that

they would like more visibility, support, and engagement, with the senior management team.

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

Workforce

Skilled and enabled workforce

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

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

We were provided with a range of policies, the majority of which were updated however, the Equality and Diversity policy was out of date and due for review in October 2021.

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

The inspection team reviewed the staff training compliance on all wards. Training figures provided to us on the inspection indicated that compliance was extremely low. We could not be assured that staff are appropriately trained to maintain professional standards and compliance in the workplace which could impact on the safety of patients.

These issues were also dealt with under our immediate assurance process, further details can be found in Appendix B.

We noted a number of staffing vacancies in the hospital which the health board was attempting to recruit into. Gaps in staffing were covered by bank staff or agency staff who were usually familiar with the patient group. Staffing issues were discussed in the daily morning safety meetings. During staff interviews we were told that there had been some changes in staffing, due to promotions or staff moving onto other roles in the health board. This had originally caused some staff to feel unsettled, however we were told things had now started to improve.

Staff also told us that that the health board needs to undertake a review on staffing levels, as this had not been done for some time. Also, the environment staff were working in was becoming more challenging and complex.

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

Wellbeing services were available for staff who had access to psychologist group supervision and the consultant psychologist was implementing a reflective practice service for staff.

Culture

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

We saw that information was available on Duty of Candour, however some staff were unclear and indicated that they had not received training.

The health board must ensure that staff are reminder of the requirements of Duty of Candour and that all staff receive appropriate training.

Staff told us that they would feel secure raising concerns about patient care or other issues at the hospital and felt confident that the health board would address their concerns.

Staff provided examples of recent whistleblowing concerns and we were told that senior staff within the health board had acted appropriately and spoke with staff and investigations were ongoing to resolve the issues raised. The staff we spoke with were satisfied with the health boards response. This demonstrated that the health board senior managers engaged with staff and reacted and dealt with whistleblowing concerns. This also demonstrated that staff on the wards felt confident in following the guidance provided by the health boards whistleblowing policy.

In addition, staff raised concerns to the inspection team around inappropriate use of the Extra Care Area in PICU, staff indicated that this area would sometimes be used as an extra bedroom for patients.

The health board must ensure that the ECA suite is not used as a bedroom area and should only be used for its intended purpose.

During staff discussions it was raised that there were some inconsistent processes taking place. This related to some patients being inappropriately placed and

moved onto different wards without appropriate assessments, consultation with staff or staffing numbers being considered. It is important that the health board engage with staff and have open discussions around changes to systems and processes. This will ensure that staff can be part of the decision-making process and contribute their views to any proposed changes.

The health board must make sure that staff feel consulted, involved, and understand decision making processes by senior staff that affect them, and that staff feel confident in sharing ideas and contributing to change.

During our discussions with staff, staff raised some concerns around the organisational change process which was ongoing at the time of the inspection. This had caused some anxiety amongst staff. However, we were told that ongoing communication had occurred between staff and senior management to alleviate some concerns.

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

Information

Information governance and digital technology

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

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

Through examination of training records, we confirmed that staff had received training on information governance. The training statistics varied across the wards and improvements in the completion of mandatory training is included in the appendix B.

Learning, improvement and research

Quality improvement activities

It was clear from our discussions with senior staff that the health board was reviewing the provision of the service on the wards. We saw many positive

examples of improvements, which had been undertaken since our previous inspection. We were also informed that ongoing efforts were being made to complete the HIW local review improvement plan.

The Deputy Clinical Services Manager had identified ward champions for IPC, estates, and fire safety issues. The nominated ward champions also provided opportunities for staff development. Plans were also in place for culture champions to be identified to help support and improve values and behaviours throughout the wards.

As previously highlighted, during the inspection the health board were coming to the end of an organisational change process, with the potential of a new leadership team being put in place. It is important that the new leadership team continue to drive forward with the changes that have been implemented since the last inspection and review process, and actively engage and consult with staff to ensure staff feel supported, valued, and listened to.

Whole system approach

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

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

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B - Immediate improvement plan

Service: Royal Glamorgan Hospital

Wards: Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit.

Date of inspection: 20 – 23 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.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Quality of management and leadership				
Finding - Safe Care - Managing Risk and Promoting Health and Safety; Staff and Resources - Workforce The inspection team considered staff training compliance for Physical Intervention training, Basic Life Support, Immediate Life Support, Moving and Handling and Information Governance on all mental health wards at Royal Glamorgan Hospital. We were provided with the following		A training needs analysis will be undertaken on each ward and a plan devised with trajectory to ensure that 85% of applicable staff groups will be fully compliant in Immediate Life Support, Basic Life Support, Manual Handling and Prevention and Management of Violence & Aggression mandatory training.	Cath Granelli, Senior Nurse, Inpatients	30 November 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
compliance rates: **PICU** – Immediate Life Support 33 %, Basic Life Support 0%, Manual Handling 0% and Physical Intervention training 69% **Ward 21** - Immediate Life Support 20%, Basic Life Support 0%, Manual Handling 0% **Ward 22 -** Immediate Life Support 67%, Basic Life Support 17%, Manual Handling 0%, Physical Intervention training 60% **Admissions** – Immediate Life Support 38% Basic Life Support 0%, Manual Handling 0% HIW is not assured that enough staff working in the department have the required up to date skills to perform effective resuscitation, restraint techniques and to use safe moving and handling techniques when assisting patients. This poses a potential risk to the safety and wellbeing of patients in the event of a patient emergency (collapse), use of physical intervention on patients and to		Progress towards this target and future training compliance rates will be managed using the agreed MH&LD Inpatient training matrix and monitored through line management arrangements.	Cath Granelli Senior Nurse, Inpatients	31 December 2023
		Progress against the immediate assurance plan will be monitored and reported on through the Care Group Quality Safety Risk and Patient Experience (QSRE) group	Brahms Robinson, Lead Nurse for MH, RTE	31 December 2023
		Mandatory training compliance will be included as a standing agenda item during line management sessions between senior nurse and Ward managers. Deviation from the proposed improvement trajectory and failure to maintain the target levels of compliance will be escalated at the	Cath Granelli, Senior Nurse, Inpatients	31 December 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
patients who are unable to move independently.		Mental Health Adult Directorate Performance Review meetings		
The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken: • To improve mandatory staff training		In the interim the Mental Health unit leadership team will ensure that adequate measures are in place on a shift by shift basis to ensure that patient safety is maintained until mandatory training compliance improves. Senior Nurse and ward managers will monitor staffing rosters in order to ensure that there are adequate numbers of trained staff across the unit to ensure safe patient care. These arrangements will be formulated each day in the daily unit 'huddle' (Safe to Start Meeting) and shared with the clinical areas.	Cath Granelli, Senior Nurse, Inpatients	28 February 2024

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
compliance in respect of ILS, BLS, physical intervention and safe moving and handling training To promote patient safety in the interim.		**<u>Update ILS</u>** **Planned training sessions:** 4 planned sessions in Nov to-Feb 2024 A process is in place for the allocation of responders to medical/respiratory emergencies for each shift. The allocation is recorded as part of the daily unit 'huddle' (Safe to Start Meeting) and shared with the clinical areas.	Brahms Robinson, Lead Nurse for MH, RTE Janet Gilbertson, Head of Clinical Education	January 2024
		<u>Update BLS</u> **Planned training sessions:** 4 planned sessions in Dec and 2 in Jan '24 A process is in place for the allocation of responders to medical/respiratory emergencies for each shift. The allocation is recorded as part of the daily unit 'huddle' (Safe to Start	Brahms Robinson, Lead Nurse for MH, RTE Janet Gilbertson, Head of	January 2024

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Meeting) and shared with the clinical areas.	Clinical Education	
		Update PMVA **Planned training sessions:** 1 planned session in January '24 A process is in place to monitor the number of trained staff on duty each shift and to ensure a response team is identified for each shift with this information being made available across the clinical areas. This will be formulated and recorded during the daily 'huddle' (Safe to Start Meeting).	Brahms Robinson, Lead Nurse for MH, RTE Emyr Jones, Personal Safety Advisor, Health, Safety & Fire.	28 February 2024

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Update Manual Handling Following a training needs analysis undertaken with the manual handling Subject Matter Expert (SME) and Workstream lead of safe and skilled workforce it has been clarified that the nursing workforce on the adult acute inpatient units will require training at manual handling level 1 B, this is covered for all newly qualified staff as part of the All Wales manual handling passport with an annual workplace assessment required. All staff who have fallen out of compliance will require an additional 1-day training to refresh skills. this will be delivered by the health Board manual handling team. Any requirement for additional manual handling skills will be identified on a patient by patient basis with the support of the manual handling lead in Older person's inpatient services and the manual handling SME. An action	Brahms Robinson, Lead Nurse for MH, RTE. Chris Beadle, Assistant Director, Health Safety & Fire.	28 February 2024

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		plan will be formulated within the patient care plan, and the nursing team will have access to manual handling equipment and additional training as required.		

Service representative:

Name (print): Ana Llewellyn

Job role: Care Group Director of Nursing-Primary Care, Community & Mental Health

Date: 5/12/2023

Appendix C - Improvement plan

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.

Service: Royal Glamorgan Hospital

Wards: Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit.

Date of inspection: 20 - 23 November 2023

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
Ward 21, Ward 22, and Admission Ward still have a mix of single bedrooms and two-bedded rooms. This does not reflect modern mental health care provision because shared bedrooms can impact on the privacy and dignity of patients.	The health board should review the shared bedrooms and consider updating the rooms to allow patients the privacy of their own room.	The Health Board has reviewed the current ward environment. With consideration of the ward footprint, clinical need and bed capacity within the Adult Mental Health Directorate it is not possible at present to provide a fully single bedroom inpatient provision. To mitigate potential impact of the present arrangements	Directorate Manager, Adult Mental Health Services	Completed

		the nursing teams ensure that all shared rooms are single sex, with identified curtained private space for each person. The specific need for single rooms is identified at point of admission/assessment, with consideration of individual need i.e., gender, sexual orientation, or physical need/risk, and care plan developed as required. The nursing team identify patients who wish to have shared rooms e.g. for company. If requested, an individual room will be provided when available and if there is no other pressing clinical need.		
Some staff we spoke to told us that the male to female ratio of staff could be improved as there were limited numbers of males working the wards.	The health board should consider the gender balance of staff and ensure that there are enough male staff present on each shift.	The Health Board undertakes a fair and equitable recruitment process, in order to ensure that all staff are employed based on the qualities, values, skills and	Inpatient Lead Nurse, Adult Mental Health Services	Completed

		the experience they demonstrate during recruitment. It is, of course, not lawful to discriminate or make such decisions based on gender. The Royal Glamorgan Hospital (RGH) Senior Nursing team work across adult and older persons wards and will support each ward to ensure that there is an optimal skill, and when possible, gender mix. All shift requirements are monitored at the daily staffing "huddle" to identify particular issues and ensure that safety needs are adequately met i.e. that there are adequate Prevention and Management of Violence and Aggression (PMVA) trained staff on shift. There is opportunity to alter staff skill and when necessary, gender mix to address needs	

		of an individual e.g. If patient is sexually disinhibited or targeting staff due to gender. In extremis the Senior Nursing team can call on staff from across the care group i.e. Princess of Wales and CAMHS Mental Health wards, and there have been examples of recent good practice.		
During the inspection we noted cigarette ends in the grounds of the hospital and some patients were not adhering to the health boards smoking policy when using the outside areas of the hospital. In addition, prior to the inspection anonymous referrals had been made to HIW relating to both staff and patients not adhering to the health boards no smoking policy.	The health board must ensure a more robust application of the health boards no smoking policy and the framework supporting it.	It is a priority of the Health Board to support the communities we work with to make positive decisions about their health, and we maintain a commitment to support all patients and staff to give up smoking. Since the "Smoke-free Premises and Vehicles (Wales) Regulations 2020" came into force in the Mental Health Unit (MHU) in September 2022, smoking on there has been prohibited. Following implementation, the significant challenges this presented to individuals who found smoking cessation	Inpatient Lead Nurse, Adult Mental Health Services	Completed

		measures to be ineffective or unwelcome were noted, and after discussion with staff and patients the Mental Health Smoking Cessation group agreed that in the RGH MH unit we would create small designated outside smoking areas for restricted use. This seemed to be well received by the patient group, but following an anonymous concern being raised with the Health Inspectorate Wales in summer 2023, this arrangement was halted while the measures were reviewed. Following presentation of a mitigating paper to the Health Board Executive Leadership Group, a "Derogation in compliance" was agreed for a period of six months while the Mental Health Care Group develop options for a permanent solution across all Mental Health sites. It is recognised by the Health Board that this temporarily contravenes the Smoke-free Premises and Vehicles (Wales)		

		Regulations 2020. Practically, on the RGH MHU, this means that there is an availability of managed smoking sessions at designated times in a space within the footprint of the MHU on the patios/terraces directly off the ward corridor. This is an arrangement that is clearly documented within the care plan of all patients who identify this as being their wish following smoking cessation assessment. The conditions and restrictions of the designated smoking area are made clear to all patients and signposted across the wards. Ash trays are being purchased for designated smoking area, there is a bin currently in place as an alternative. There is routine discussion within the patient community groups around smoking arrangements and support by		

		the patient groups of self-regulation of cleanliness of such areas by smokers. This is checked by ward staff regularly and extraordinary cleaning requested of facilities if required.		
During the inspection we observed patients and staff speaking Welsh and noted that not all staff were wearing appropriate lanyards and badges which helped to identify them as Welsh speakers.	The health board must ensure that Welsh speaking staff wear the appropriate lanyards and badges to help identify them as Welsh speakers.	The Health Board is committed to making the "Active Offer" around services in the Welsh language, as defined in the Welsh Language Measure 2011. A review is underway to identify all Welsh speakers across the MHU. Competence at all levels will be noted and improvement encouraged through Personal Development (PADR). As the routine use of lanyards by Nursing staff in clinical areas is prohibited due to Infection Prevention and Control measures, the Health Board supplies all staff who have a competence in Welsh	Inpatient Lead Nurse, Adult	28 February 2024

		language with insigniad uniforms that identify them to those who wish to communicate in Welsh. For ease of recognition, this identifying uniform will be displayed to patients and visitors on Information Boards in each of the clinical areas.		
There appeared to be two types of personal alarms given to staff and visitors, due to some uncertainty around the reliability of the alarms.	The health board must ensure that a full review is undertaken on the appropriateness and reliability of the current personal alarm systems used.	At time of the HIW inspection (November 2023) there was an Standard Operating Procedure (SOP) in place that directed that a dual personal alarm system was in place on the RGH MHU for all clinical staff. This was due to a recent increase in the frequency of incidents whereby the panic alarm failed to activate when tested. A full diagnostic review of the “all call” system was undertaken in November 2023, with the system noted to be returned to a serviceable and operational	Directorate Manager, Adult Mental Health Services	30 June 2024

		state. This issue however remains on the Directorate Risk Register for the immediate future and incidents of alarm failure will be reviewed and reported via the Datix system. The SOP also remains in place on the MHU. A review of any activation failures will be undertaken by the MHU Inpatient Senior Nurse and Assistant Directorate Manager for inpatient services for discussion at Directorate Quality Safety Risk and Experience meeting (QSRE) in June 2024. Subsequently a decision will be made by the Adult Mental Health Senior Leadership Team as to whether the Safe System of working for a dual alarm system can be stepped down or will remain in place		

		with the risk remaining on Directorate Risk Register.		
HIW identified several decorative and environmental issues that required attention: • Damaged chair in interview room on Ward 22 • Missing ceiling tiles in PICU corridor exposing piping • Water damaged ceiling tiles in Ward 22 • Review of dining chairs on wards to establish if suitable for patient group • Missing privacy curtain in shared room on Ward 21 needs replacing	The health board must address the environmental issues and resolve them in a prompt and timely manner.	The ward 22 damaged chair, with exposed foam filling which is not compliant with the relevant legislation has been condemned and removed with a temporary replacement now in place. A specialist furniture manufacturer has provided a quotation for new seating within the Interview room and a Statement of Need submitted. Psychiatric Intensive Care Unit (PICU) missing ceiling tiles have now been replaced Water damaged ceiling tiles in the Ward 22 office have all been replaced. There remain 6 water damaged tiles between the lounge & dining room awaiting replacement which have been logged with	Directorate Manager, Adult Mental Health Services	Completed

• Drainage in toilets and shower areas in PICU.		Estates Department. These have been prioritised by Estates as non-urgent, as they are considered decorative rather than safety sensitive, and the progress on replacement is monitored weekly by the Inpatient Deputy Directorate manager. After consultation with a specialist furniture manufacturer the Inpatient Senior Nurse confirmed the suitability of the dining chairs currently in place in Ward 22. The dining room chairs are multipurpose and need to be moved between dining room and lounge for group discussions/activities and therefore need to be of a manageable weight. The Adult Mental Health Senior Leadership Team acknowledged that the weight of the current chair would allow them to be picked up	

and potentially brandished as a weapon, however this risk would not be completely eradicated unless the chairs were of a weight that would disadvantage patients with mobility restrictions and potentially increase risk of injury to staff when moving for cleaning purposes. The nursing team mitigate risk of furniture being used in this way through individual risk assessment and maintaining observation of these areas when in use.

Ward 21 bedroom rails and privacy curtains have been replaced.

There are long standing difficulties with inadequacy of wastewater/ sewage capacity within the RGH MHU site. As a result, the PICU Extra Care Area (ECA) utilises a Sani-flo macerator system to move waste from ECA to the main sewage system. This can

		result in issues when foreign objects are placed in toilet in ECA. Groundwork investigations report that a permanent solution to connect ECA to main sewage system would require extensive excavation works with significant capital spend and long-term closure of the PICU. The Adult Mental Health Senior Leadership are of the opinion that this is not viable at present due to disruption of service. The development of a new Mental Health Inpatient facility remains on the Health Board Risk Register Reporting and monitoring of all environmental concerns is governed through a Standard Operational Procedure for Maintenance of the MHU and progress on reported concerns is actively monitored weekly by the Inpatient Deputy Directorate manager.	

COSHH materials such as laundry detergents were not stored in a locked cupboard in the PICU area.	The health board must ensure that COSHH equipment is stored correctly.	All wards on the MHU have flammable lockers where all laundry detergents are stored. It is the responsibility of all Health Board staff to be aware of and undertake their responsibilities when using COSHH materials. The Inpatient Senior Nurse has emailed a reminder to all staff including HCSW about COSSH and requirement re storage. Checks on the environment are undertaken by ward managers as part of weekly environmental checks (Ward Managers Assurance Audit) and matters of concern addressed with staff at the time or escalated in line with Mental Health SOP.	Inpatient Senior Nurse, Adult Mental Health Services	Completed

Out-of-date bottle of morphine in the controlled drugs cabinet.	The health board must ensure that out of date medication is disposed of appropriately.	Following the HIW Review in November 2023, all medication cabinets across the MHU were inspected and no further out of date medications were found. Review of all medication dates and returns to pharmacy is monitored through the "Ward Managers Assurance Audit" which is undertaken weekly and monitored by the Inpatient Senior Nurse. The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE) through monthly exceptions report and action taken as	Inpatient Senior Nurse, Adult Mental Health Services	Completed

		required.		
Legal Status and dates of sections were not recorded on some MAR charts	The health board must ensure that MAR charts are fully completed.	Inpatient Senior Nurse and Mental Health pharmacist will revisit the role of pharmacist technician to ensure that review of MARS charts will be included in their routine checks. An email has been sent by the Clinical Director to all medical team to reaffirm the documentation standards required on clerking and reviewing medication. A sample of MARS charts are reviewed through the "Ward Managers Assurance Audit" which is undertaken weekly and monitored by the Inpatient Senior Nurse. The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The		

		Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE) through monthly exceptions report and action taken as required.		
Medication trolley on ward 22 was not securely fixed to the wall.	The health board must ensure that staff comply with the health board policies and guidance on safe and secure storage of medication trolleys and how they are stored on the wards and in clinical rooms.	Reminder email from Senior Nurse reminding staff of agreed standard. Security arrangements of medication trolley are reviewed through the "Ward Managers Assurance Audit" which is undertaken monthly and monitored by the Inpatient Senior Nurse. The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE)	Inpatient Senior Nurse, Adult Mental Health Services	Completed

		through monthly exceptions report and action taken as required.		
During our review of some observation records we noted that they were signed for, however the records only documented the location of the patient and did not include descriptive details of the patients behaviour or mental state.	The health board must ensure that observation records include details on patients behaviours.	The present Health Board Observation Policy was scheduled for review in March 2022 and while awaiting approval as part of the ongoing review of Clinical Policies, is still in place as a live clinical document. Within the Policy there is clear direction on the nature of case recording to be undertaken. The Inpatient Senior Nurse has emailed all nursing staff to remind them of the agreed standards within the policy. Following reiterating of the standards a “spot” audit of no less than 10 Observation records across a 2-week period will be undertaken by the Inpatient Senior Nurse and reported to Adult Mental	Inpatient Senior Nurse, Adult Mental Health Services	30 April 2024

		Health Directorate QSRE in March 2024.		
Patients told us that there were not many options or variety for those who have specific dietary requirements.	The health board must ensure that there are more variety of choices for patients with specific dietary requirements.	All Health Boards in Wales follow a menu which is based on The All-Wales Catering & Nutrition Standards. The Health Board Catering Service works with clinical teams to adapt the patient menus to patient specific requirements. The present patient menu changed in September 2023 to a two-week rolling menu which replaced an `a la carte' style menu. The new menu was reviewed by the All-Wales dieticians and assessed for compliance with the Catering and Nutrition Standards. The Inpatient Nursing teams seek feedback from patients via the Inpatient Community Group and "Have Your Say" suggestion boxes (which are regularly monitored). This feedback informs discussions with the wider service i.e.	Directorate manager, Adult Mental Health Services	Completed

		Catering and outstanding issues can be escalated to the Adult Mental Health Senior Leadership Team. The Catering Team recognise the need to increase the frequency of the menu review and change and are currently working on the new version for 2024.		
During examination of records, we found that the use of Section 17 leave wasn't always recorded.	The health board must ensure that use of Section 17 leave is recorded.	The Section 17 Leave policy is awaiting revision as part of the ongoing review of Clinical Policies. The inpatient expert group will undertake this review with a documentation standard devised and included. This will be communicated to all staff by Senior Nurse informing staff of agreed standard. In the interim the Senior Leadership team have agreed	Lead Nurse, Adult Mental Health Services	June 2024

		that as a minimum there will be a clear record in the patient notes of each departure from and return to the ward for all patients including those under Section s17 leave. A “spot” audit of the interim standards no less than 10 patient records across a 2 week period will be undertaken by the Inpatient Senior Nurse and reported to Adult Mental Health Directorate QSRE in March 2024. Following development and dissemination of the Policy standards a “Spot” audit undertaken will be undertaken and reported Adult Mental Health Directorate QSRE in June 2024.		
Equality and Diversity policy was out of date and due for	The health board must ensure that policies are reviewed and kept up to	The Health Board Equality and Diversity policy has been	Head of Organisational Development &	31 March 2024

review in October 2021.	date.	reviewed and will be being superseded by a Strategic Equality Plan (SEP). The SEP is in final draft and will be approved by Executive Board in March 2024.	Inclusion, CTMUHB	
Staff told us that staffing levels had not been reviewed for some time and the environment, they were working in was becoming more challenging and complex.	The health board must review staffing levels to ensure they meet the demands of the patient group.	The Mental Health Head of Nursing has recently concluded a thorough nursing establishment review that has considered levels of acuity and demand across the Mental Health Inpatient units. This review acknowledged the changing picture of inpatient work and environments since the last Mental Health inpatient staffing review in 2017 and recognised the challenges of maintaining a motivated and engaged workforce when pressures within these clinical settings are increasing. Using principles drawn from	Head of Nursing, Mental Health Services	Completed

All Wales Mental Health Workstream on the implementation of the Nurse Staffing Levels Act, the report makes recommendations about amendments to skill mix and enhancement of Nursing leadership roles the better to improve opportunities for recruitment and particularly staff retention.

The Staffing review report will be presented to the Mental Health Nursing Workforce meeting on 25 January 2024, for consideration by Director of Nursing on subsequent actions.

Considerations of staffing levels day to day are a core role of the Ward Managers and Senior Nurse, with all shift requirements monitored initially at the daily staffing “huddle” to identify particular issues and ensure that safety

needs are adequately met i.e. that there are adequate staff on shift.

Review of clinical need is a dynamic process that involves all members of the Nursing team, and staffing levels are increased in response to increased levels of acuity e.g. 1:1 patient observations to maintain safety or a need for intensive personal care.

At this time, there is an organisational acknowledgement of the particular challenges to recruitment of unregistered nurses into Mental Health posts and as a result the Health Board embargo on the use of agency Health Care Support Workers, has been temporarily relaxed for the Mental Health Directorate.

While there is a high degree of scrutiny around the use of

staff in addition to substantive staff, with appropriate evidence and rationale in place, a request for additional bank or agency staff will always be supported by the Senior Nursing Leadership.

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		intensive personal care. At this time, there is an organisational acknowledgement of the particular challenges to recruitment of unregistered nurses into Mental Health posts and as a result the Health Board embargo on the use of agency Health Care Support Workers, has been temporarily relaxed for the Mental Health Directorate. While there is a high degree of scrutiny around the use of staff in addition to substantive staff, with appropriate evidence and rationale in place, a request for additional bank or agency staff will always be supported by the Senior Nursing Leadership.		
We noted a number of staffing vacancies in the hospital which the health board was	The health board must ensure that staff vacancies are filled, and future initiatives are explored to encourage	Recruitment of band 5 registered nurses remains a challenge and the HB is taking steps to ensure that all		

attempting to recruit into	recruitment into the hospital.	vacancies are being filled. The recently completed nursing establishment review has been considered by the Care Group Senior Leadership Team who are currently exploring the financial implications and opportunities of the recommendations. The Head of Nursing is leading on the development of a recruitment and retention plan, which includes actions such as working closely with the local universities to maximise SSP opportunities for recruitment.		
Some staff were unclear and indicated that they had not received Duty of Candour training.	The health board must ensure that staff are reminder of the requirements of Duty of Candour and that all staff receive appropriate training.	Service user information about Duty of Candour is available across the units. A Duty of Candour E-training module is provided for all staff on the Health Board Electronic Staff Record (ESR)	Inpatient Lead Nurse, Adult Mental Health Services	31 March 2024

		All nursing staff across the MHU will undertake this training, with a target of 85 % compliance for Adult Mental Health units by March 2024. The Inpatient Senior Nurse will report on compliance at Adult Mental Health Integrated performance meeting in April 2024.		
Staff raised concerns around inappropriate use of the Extra Care Area in PICU, staff indicated that this area would sometimes be used as an extra bedroom for patients.	The health board must ensure that the ECA suite is not used as a bedroom area and should only be used for its intended purpose.	The operational guidance around the use of the ECA is clear that it is to be used as a planned or urgent intervention within the low stimulus environment. This is a resource for individuals who are presently inpatients and as such have a bed within the unit. It will not be used to provide additional bed capacity. This has been agreed by the RGH senior leadership team and circulated to all staff. Any instances of breach of this	Inpatient Lead Nurse, Adult Mental Health Services	31 January 2024

		standard will be reported through the Datix system and escalated by the Inpatient Senior Nurse to the Adult Mental Health Directorate QSRE Present guidance on the use of ECA will be revised and formalised by the Senior Nurse by 31 January 2024.		
Staff indicated that Inconsistent processes take place relating to some patients being inappropriately placed and moved onto different wards without appropriate assessments, consultation with staff or staffing numbers being considered	The health board must make sure that staff feel consulted, involved, and understand decision making processes by senior staff that affect them, and that staff feel confident in sharing ideas and contributing to change.	All patient transfers that take place in working hours are informed by consultation between the ward managers/ Nurse in Charge of both the transferring and receiving ward. This core information is shared with clinical staff through the twice daily handover. In order to ensure that there is clarity of communication, the Nursing team will develop a Ward Transfer proforma for	Inpatient Lead Nurse, Adult Mental Health Services	28 February 2024

		communication of essential clinical information on transfer. The Adult Mental Health Directorate recognises that staff experience, engagement and feedback is an essential part of a compassionate leadership approach to service improvement and as part of the Mental Health Care Group is implementing the learning from the Ty Llidiard and Maternity Services improvement work on staff engagement. The Directorate will use Sharing Information/learning arrangements within the services e.g. QSRE, team meetings, 7 minute briefings to maintain staff awareness of decision making around clinical and operational matters. The Inpatient Senior Nurse will lead on development of the Ward Transfer proforma in	

		collaboration with a working group of qualified and Health Care Support Workers in order to ensure that all key communications are considered, and the process addresses the concerns about miscommunication of decision.		

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): Brahms Robinson

Job role: Lead Nurse Mental Health

Date: 09 January 2024