Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Cardiff and Vale University Health Board

Unannounced visit to Iorwerth Jones Centre

Date of Inspection: 7–9 May 2013

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Contents

Chapter Number		Page
1.	Introduction	1
2.	Findings:	
	The Environment	3
	Patient Activities	8
	Food and Nutrition	9
	Clinical Practices	10
	Staff Training and Development	13
	Mental Health Act	13
	Service Development	16
3.	Recommendations	18
4.	Next steps	23
Annex A	Roles and Responsibilities of Healthcare Inspectorate Wales	24
Annex B	Mental Health Act Monitoring	26
Annex C	Action Plan	28

1. Introduction

1.1 Over the three day period from 7 to 9 May 2013, Healthcare Inspectorate Wales (HIW) undertook an unannounced Mental Health Act Service Review to Iorwerth Jones Centre (the Centre) part of Cardiff and Vale University Health Board following concerns that had been brought to our attention through discussions with the Health Board.

Background to the Mental Health Act

1.2 The Mental Health Act (the Act) gives organisations the legal power to detain people under certain circumstances or place conditions on them whilst they are in the community. Since April 2009, HIW[1] has undertaken the monitoring of the Act on behalf of Welsh Ministers. Further information is provided at Annex B of this report.

Methodology of the Inspection

1.3 HIW recruits a number of Mental Health Act Reviewers who carry out both announced and unannounced visits to settings in Wales. They monitor that the correct legal processes are being adhered to; patients understand their rights and receive the care and treatment that is appropriate to their needs.

1.4 We visit and talk to individuals who are subject to restrictions made under the powers of the Act in hospitals, registered establishments and the community. These discussions are mainly held in private and only take place when the individual consents. We explore the individual's views on their care and treatment and will ensure that they understand their rights and the reasons for the restrictions placed on them.

[1] Prior to this date the responsibilities had been taken forward by the Mental Health Act Commission who fulfilled the role on an England and Wales basis.

1.5 In addition, we check all records and paperwork related to the restrictions placed on the individual and ensure that the requirements set out in the Act and the Code of Practice for Wales (the Code) have been met. We can require the production of any records in relation to a patient's detention for inspection.

1.6 We also explore other pertinent issues related to an individual detained under the Act which include the environment of care in which a patient is detained, patients' privacy and dignity, food and nutrition, access to general healthcare, care and treatment planning.

1.7 Detailed findings and associated recommendations were provided through verbal feedback throughout the inspection and more formally at the feedback meeting at the end of the visit, so that immediate action could be taken to discharge the recommendations.

Iorwerth Jones Centre (the Centre)

1.8 The Centre is a mental health hospital situated in Llanishen, Cardiff. It was originally a local authority residential home but was taken over by the Health Board in 2008. There are two wards caring for people with a dementia related illness who have behavioural and psychiatric symptoms requiring highly specialist care. A third ward provides care for people with enduring mental health problems who require specialist rehabilitation mental health services.

1.9 As part of the inspection we visited two wards, Coed y Felin, which is a 19 bed male older person Mental Health ward, and Coed Y Nant ward, a 16 bed female older person Mental Health ward.

2. Findings

2.1 This chapter sets out the findings from our visit. The recommendations arising from these findings are covered in Chapter 3 of this report.

The Environment

2.2 The Centre was not purpose-built for the care of dementia patients requiring hospital treatment. The wards comprised of short and winding corridors with some bedrooms, bathrooms and toilets located in recesses off the main corridors. The configuration of the wards was disorientating for some patients, especially those in advanced stages of dementia. The layout also inhibited staff's ability to observe patients. The configuration of the wards was inappropriate for the client group.

2.3 To differentiate between the communal areas on the ward staff referred to them by a colour, such as 'the Blue Lounge', 'the Green Dining Room', etc. To further aid patients to identify the different areas and orientate themselves when on the ward the Health Board should consider incorporating the colours into the decoration of the area.

2.4 Each patient had a single bedroom, however when patients were not in their bedrooms staff locked the patient bedroom, as patients had not been given a key to their rooms they were unable to access them without assistance from a member of staff. Staff told us that they locked the bedroom doors once patients got up in the morning as they were unable to manage the risks associated with the poor ward layout in any other way. Staff also explained that part of the rationale for this decision was that some patients were unable to differentiate between the bedrooms and as a result often wandered in to the wrong one.

2.5 Patient bedrooms were adequately furnished and patients had sufficient storage for personal items. Patient cupboards were fitted with locks,

but again no patients had a key to their individual storage, and relied on staff to lock and unlock these.

2.6 Patients' bedrooms were not en-suite; however each room had a wash-basin. We were informed by staff that these did not have an overflow facility and hence there had been occasions when patients had left taps running and the bedrooms had been flooded.

2.7 Some patient bedrooms had been individualised by the patients or their relatives. Whilst bedroom windows had blinds and curtains there were a number of bedrooms where the blinds had sections missing and the curtains would not meet correctly, therefore patients were unable to cover their windows to gain some privacy or to stop light entering their bedroom at night.

2.8 There were observation panels on patient bedroom doors which could be opened and closed by staff from the outside the bedroom and by patients from inside their bedroom. However, it was common practice for staff to set the observation panels to open. We would expect the panels to be set to the closed position and only opened by staff when they undertake observations.

2.9 Although patients were able to control the observation panels on their bedroom doors from inside their bedrooms, the anti-ligature design of the patient control system made this difficult for some patients to operate. In addition, some patients did not have the capacity to operate the observation panels, re-enforcing the importance of the default setting being to the closed position.

2.10 Whilst Coed y Felin ward had 19 bedrooms, one bedroom (G112) was out of use. The room had been temporarily closed due to it being unsuitable for patient use; the bedroom had a strong stale odour due to urine penetrating the flooring of the room. Staff were unable to confirm when the bedroom would be restored for patient use.

2.11 Each ward had communal toilets and two bathrooms, with each bathroom containing a bath, shower and toilet. However, the shower cubicles in the bathroom were too small for staff to assist those patients requiring support to shower. Staff reported that the shower facilities on the wards were rarely used due to this issue.

2.12 We were informed by both staff and patients' families that due to the limited availability of baths and inappropriateness of the showers, patients bathed no more than twice a week. At the time of our visit only one of the baths on the Coed y Nant ward was in use as the other was awaiting repair. Staff also raised concerns that insufficient hot water was available; reporting that the water would run cold when two baths had been run.

2.13 On Coed y Felin ward a number of the toilets had timer settings on their lights; staff reported that when using these toilets patients were often left in the dark due to the short time intervals set. The result was that patients would only use the toilet facilities within the bathrooms, which in turn caused pressures on the availability of these facilities. Staff advised that they had reported this issue to the Health Board's Estates Department on numerous occasions; however this fault had not been prioritised by the Estates Department. It was clear that this issue was having a significant impact on patient care. Further, some of the ward toilets had their seats missing, and these had also been awaiting repair for some time.

2.14 Staff reported that the boilers at the Centre had been problematic since the unit opened in 2008, resulting in difficulties with adequately heating the wards and as referred to earlier, providing enough hot water for baths. We were informed that despite regular maintenance by the Health Board's Estates Department the problem had not been rectified.

2.15 Staff and patients' families informed us that heating throughout the winter months had been insufficient to adequately warm the patient bedrooms and lounge areas. One patient's relative reported to us that they had purchased additional bedding to ensure that their relative remained warm

throughout the night. We noted that a portable heater was in use to heat patient bedrooms and that this was moved from bedroom to bedroom throughout the night in an attempt to minimise the effect of the insufficient heating system.

2.16 On the first evening of the inspection it was very noticeable that the ward areas were very hot. Some of the radiators on the wards were very warm and in an attempt to cool the wards staff had opened the majority of the windows. Staff had no facility to manage the temperature of the wards and some of the thermostatic valves were not operating so radiators were not automatically turning off when they reached a pre-set temperature. We were unable to confirm whether the temperature of the radiators exceeded the Health and Safety Executive's guidance[2] of 43 °C where vulnerable people may come in to prolonged contact with hot surfaces, this needs to be followed up by the Health Board as a matter of urgency.

2.17 The communal lounges on both wards were poorly furnished, with mismatched furniture and a shortage of side-tables for patients to place drinks and snacks upon. The seating was old, worn and in some cases torn affording little comfort to patients. Further, the seating was positioned in an institutional style around the walls of the stark lounges.

2.18 The relatives of patients had raised funds for the purchase of new seating for the communal lounges, however concerns had been raised by the Health Board that the furniture was not suitable for the patient group. At the time of our visit this matter was yet to be resolved and while the furniture had been delivered it was not in use.

2.19 Some pictures and photographs were on display in the lounge areas; we were informed that this was a recent improvement made by the Health Board. However, these were rather standard images of landscapes and animals, for such a client group we would expect to see images depicting

[2] Published by the Health and Safety Executive (Sep 2012) http://www.hse.gov.uk/pubns/hsis6.htm

scenes that patients could relate to and which would stimulate memories for patients, such as historic pictures of Cardiff. That said we did notice that in some corridors images of original packaging of cooking products were on display that would help stimulate memories for some patients.

2.20 Both wards had very limited storage space for items such as wheelchairs, Zimmer Frames, hoists and commodes. Staff were using a vacant bedroom on the Coed y Felin ward to secure and store such items.

2.21 The wards appeared clean and staff confirmed that cleanliness had improved over recent months; however some flooring had been penetrated by urine causing unpleasant odours. The areas outside the wards were unkempt with a number of pieces of furniture and blinds discarded in these non-patient areas.

2.22 The patient laundry service was provided by the Health Board's laundry service. Staff and patients' relatives reported slow turnaround times and that items had gone missing. Staff also raised concerns that at weekends and during bank holidays there was often insufficient linen for patients' bedrooms.

2.23 There were only a very limited number of keys available for gaining access to rooms and medication and these were shared between staff. On Coed y Nant ward keys were hung on small hooks throughout the ward, this is inappropriate because patients or visitors to the wards could easily access the keys. On Coed y Felin ward we observed that a significant amount of staff's time was spent locating those individuals in possession of keys. The Health Board had started to address this issue with the Health Board's Estates Department prior to the completion of our inspection.

2.24 There were a number of issues in relation to the on-going maintenance of the wards. For example, a number of widow handles were broken and the repairs made to a fire door were inadequate leaving it unsecure with a loose window.

2.25 The emergency fire hose reels located on the wards were not tamper proof. A member of staff showed us where one had been broken by a patient and not replaced. The Health Board must ensure that emergency equipment is tamper proof and fully functional at all times, any defects must be addressed immediately.

Patient Activities

2.26 Games, books, newspapers, soft toys, and large playing cards were available on the wards. In addition there was a large communal area just off the wards near the entrance to the Centre. However, during the three days of our visit we saw little evidence of activities taking place on the wards or in the lounges.

2.27 We were informed by staff that a Refocusing Nurse had been appointed to each ward whose role it was to undertake dementia care mapping, assist patient's to complete 'getting to know you' forms and admit patients. One of the Refocusing Nurse posts had been filled prior to our visit after a vacancy of approximately one month. The Refocusing Nurses were intended to be supernumerary to ward staffing numbers, however due to ongoing staff shortages and high sickness levels they were being regularly used to cover staff shortfalls and had therefore been unable to undertake their refocusing nurse activities.

2.28 The Centre is situated on a housing estate on the outskirts of Cardiff and is somewhat isolated from the centre of the community with no dedicated hospital transport for the unit. There was no regular plan of activities or external trips, staff and relatives reported that for over a year there had been no external visits organised by the hospital. Patients rarely left the unit and staff relied on patients' relatives to facilitate community trips.

2.29 It was apparent that there was a lack of regular and differentiated stimulation and that activities were not tailored to patients' interests or individual needs.

2.30 On the evening of the first day of our inspection we observed the patio doors leading into the garden area to be open, however, the exit to the garden were blocked by benches. Staff informed us that the doors were opened to help ventilate the ward and that the exit to the garden was blocked to prevent patients from going into the garden area because staff were concerned about patient safety and the risk of patients falling. Patients rarely accessed the garden areas because staff were under the impression that all patients needed to be escorted.

Food and Nutrition

2.31 The dining areas on both wards were spacious, however as they were located in the wards' conservatories the temperature was extremely variable. The lighting in the dining room on Coed y Felin ward was poor and caused difficulties for some patients when eating.

2.32 On Coed y Felin ward tables were not set at mealtimes and patients were not seated at the table appropriately prior to their meal being served. Little attempt was made by staff to assist patients that required support.

2.33 It was positive to note that during our visit the Speech and Language Therapy (SALT) Team carried out a mealtime observation exercise on the Coed y Nant ward. Appropriate assistance was provided to patients by staff and, where necessary patients had been provided with specialist cutlery to assist them with eating. Such support was not evident on Coed y Felin ward.

2.34 There did not appear to be a dedicated member of staff with overall responsibility for the mealtime sessions. At mealtimes a member of staff on each ward should be responsible for ensuring mealtimes are structured

appropriately and that patients who require assistance receive the support they require.

2.35 Both wards operated protected mealtimes. However patients' relatives told us that since the introduction of changes to visiting hour's relatives were now required to seek permission from ward staff to attend and support their relatives during meal times, and that this was not always permitted. While the purpose of protected mealtimes is to ensure that there are no unnecessary and avoidable interruptions during this time, we do expect staff to encourage patients' relatives or carers to be part of patient mealtimes where they may help to ensure an environment that is conducive to eating and provide patients with support and assistance.

2.36 While drinks and snacks were regularly available to patients outside of mealtimes from the ward kitchen. Staff raised concerns regarding the lack of choice for patients and the repetition of menu.

Clinical Practice

2.37 The clinic rooms, on both wards, where medication was stored were small with limited storage and poor lighting; overall they were inappropriate given the requirements of the wards. To compound the problems due to limited ward storage, staff were not only storing medication but many other articles in clinic rooms such as plastic bags and clothing. Only one controlled drug cupboard was in use despite a cupboard being available on each of the wards. In addition to the ward clinic rooms there was a central clinic room where additional stocks of medication were stored.

2.38 Due to the size and arrangement of the medication trolleys in use medication could not be separated by individual patient prescription. Staff attempted to store medication alphabetically on the trolley; however we observed this to not always be correct. Patients were being given commonly used medication in addition to medication that had been specifically prescribed for individual patients. There was a large amount of medication on

the trolleys and due to this staff took longer to find the medication for each patient.

2.39 We were informed that the Health Board had identified an appropriately sized medication trolley, which would assist with medication management and administration. However at the time of our visit, these trolleys were still to be ordered.

2.40 Our review of records highlighted several instances where the Health Board's Medication Administration Policy had not been adhered to by staff. This included signatures and/or the reasons why medication had not been administered missing from the Medication Administration Records[3] (MAR Charts). We also observed a nurse completing the MAR Chart for a patient retrospectively because they had forgotten to do this at the time when medication had been given. These are significant issues; as they could lead to incomplete or incorrect information about the medication received and hence result under or over administration of medication.

2.41 An un-empathetic assembly-line approach to the administration of medication was observed. One qualified member of staff read the patient's prescription; another qualified staff prepared the medication, who in turn passed this to a nursing assistant to give to the patient. There was little inter-action or discussion with patients regarding their medication. We also observed one patient being offered a ferrous[4] medication whilst eating a sandwich, which he declined; there were no further attempts by staff to offer the medication after he had eaten his sandwich.

2.42 Poor practice regarding hygiene was noted when a trained nurse dropped an administration cup and picked it up and attempted to use it again until we intervened.

[3] http://www.wales.nhs.uk/sites3/page.cfm?orgid=371&pid=47669
[4] Medicine used for iron supplements

2.43 Staff were unable to provide evidence of an audit of medication taking place since June 2012 and there was no evidence of an action plan being put in place following this audit.

2.44 An electronic patient record system, known as PARIS was used for maintaining patient documentation and nursing records. Until the week of our inspection there was only one computer available on each ward. The lack of computers was impacting the ability of staff to access the system to update records and to gain experience of using the computer based system.

2.45 The patient records we reviewed contained limited individualised patient information. In particular patients' Care and Treatment Plans and risk assessments contained the minimum of information and had not been reviewed and updated on a regular basis.

2.46 Throughout our inspection we observed the interaction between staff and patients to be positive. Staff were sensitive and caring towards patients and we observed staff helping patients to maintain their dignity in difficult circumstances. Staff were also seen to manage difficult behaviours appropriately with the use of distraction and de-escalation techniques.

2.47 Due to pressures on staff time policies, procedures and good working practices were not always followed. For example, we observed a member staff not following the correct procedures for disposing incontinence aids and soiled clothing which compromised the patient's dignity and contravened basic hygiene and infection control procedures.

2.48 In the year preceding our inspection sickness levels on both wards had been high. We were advised that there had been difficulties in addressing these gaps in staff rotas because there was limited cover from the Health Board's Bank Staff[5], either due to staff not having the appropriate skills to

[5] Staff employed by an organisation on a session basis when required not necessarily full or part time but some bank staff may ne contracted on a regular basis.

provide care on the wards or staff unwilling to work at the Centre. Low staff numbers had impacted on the quality of care staff could provide and staff morale.

2.49 A full Multi-Disciplinary Team (MDT) was not operating at the Centre until January 2013 and at the time of our visit it was in the early stages of development. However, the MDT has responsibilities across the whole of the Health Board's Older People's Mental Health Services directorate and therefore it is important that the Health Board monitors and reviews the adequacy of the MDT provision to ensure that it meets the requirements of the patient group.

Staff Training and Development

2.50 We were informed that training and development records were computerised but our review highlighted that with the exception of a few entries for mandatory courses records were blank. The only formal training records made available to us dated back to 2009, we were therefore unable to ascertain how much mandatory training had been undertaken by members of current staff.

2.51 Some training had taken place recently on one ward; however this was only evidenced by entries made on pieces of paper kept in the ward file. The physical condition of the training records available on the wards was poor.

2.52 Staff reported difficulties in accessing training due to cancellations or changes in venue. Others reported a lack of training opportunities and a delay in update training because of staff shortages.

2.53 The Centre's training room was under equipped and did not promote a stimulating learning environment. Throughout our three days at the Centre we did not see any evidence of learning and teaching culture being in place.

Mental Health Act

2.54 At the time of our visit only one patient was detained under the Mental Health Act. This patient was detained under Section 3[6] of the Act. Initially there was confusion as to whether there was a second patient detained under Section 37/41[7] of the Act; however there was no appropriate legal documentation available on the ward. We followed this up with the Health Boards Mental Health Act Administration Department and it was confirmed that there was only one patient detained under the Act.

2.55 The patient's detention documentation was available on the ward. This included a full record of the examination undertaken on their detention and evidence that at least one of the sectioning doctors had previous acquaintance with the patient and that one was Section 12 approved[8]. Clear reasons were given by the sectioning doctors as to why detention under the Act was appropriate. However, there was no evidence in the patient's records of their rights under Section 132[9] of the Act being explained to them and of relevant information being provided to the patient or their relatives.

2.56 The Approved Mental Health Professional[10] (AMHP) had identified the patient's Nearest Relative[11] as defined by the Act and had contacted the Nearest Relative informing them of the detention and their rights.

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[6] Section 3, Admission for treatment
[7] Section 37, Powers of courts to order hospital admission or guardianship. Section 41, Powers of higher courts to restrict discharge from hospital.
[8] A doctor who has been approved by the Welsh Ministers (or the Secretary of State) under the Act as having special experience in the diagnosis or treatment of mental disorder.
[9] Section 132, Duty of managers of hospitals to give information to detained patients.
[10] A professional with training in the use of the Act, approved by a local social services authority to carry out a number of functions under the Act.
[11] A person defined by Section 26 of the Act who has certain rights and powers under the Act in respect of a patient for whom they are the nearest relative

2.57 The patient was subject to Consent to Treatment Provisions of the Act and had had their medication authorised by a Second Opinion Appointed Doctor[12] (SOAD); a copy of the relevant certificate was available in the patient's Medication Administration Record. However, there was no evidence in the patient's records that their Responsible Clinician[13] had informed the patient of the outcome of the SOAD visit. Also, there was no record of the Statutory Consul tee's consultation with the SOAD.

2.58 Throughout our inspection the doors to the wards remained lock. There was no information displayed informing patients who were not detained under the Act of their right to leave the ward, and how to do this if they wished. The Mental Capacity Acts first principle is that a person must be assumed to have capacity to make a decision or act for themselves unless it is established that they lack capacity in relation to those matters. However there was limited evidence of capacity assessments being undertaken, either regarding a patient's capacity to safely leave the ward or in relation to other matters such as, managing finances, personal hygiene and incontinence.

2.59 We were concerned that in the absence of assessments of capacity the current locked-door arrangements and some blanket approaches to the management of risks there is a high possibility that De facto detentions[14] have or will take place. The Mental Health Code of Practice for Wales, paragraphs 19.54-19.56 states:

> "The safety of informal patients, who would be at risk of harm if they wandered out of a clinical environment at will, should be ensured by adequate staffing levels, positive therapeutic engagement and good observation, not simply by locking the doors of the unit or ward.

[12] An independent doctor appointed by Healthcare Inspectorate Wales who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patients consent.
[13] The approved clinician with overall responsibility for the patient's care
[14] The patient has no practical means of exercising their theoretical right to leave hospital, yet they have not been 'sectioned' under the Act and so do not have the rights of a detained patient.

> "Some informal patients, whether or not they understand the risk, may persistently or purposefully try to leave a ward or hospital. In these cases, consideration must be given to whether they are in fact being deprived of their liberty and, if so, whether authorisation needs to be sought under the Deprivation of Liberty Safeguards (DoLS) of the Mental Capacity Act. Alternatively, assessment for formal detention under the Mental Health Act should be considered or the person moved to a safer environment.
>
> "If managing entry and exit by permanently locked external doors is considered the most appropriate approach to maintaining patients' safety, there must be a process of regular reviewing this policy, to ensure there are clear benefits for patients of such action, and that it is not simply used for staff convenience."

2.60 The Health Board must ensure that capacity assessments are undertaken to determine the care, support and safeguards that need to be put in place for each individual patient. Our conversations with staff gave rise to concerns that staff were assuming the outcome of capacity assessments rather than ensuring that such assessments had been undertaken. This is unacceptable practice and the Health Board must assure itself that this is not common practice across the Health Board's Older People's Mental Health Services directorate.

2.61 We were unable to ascertain how much, if any, formal Mental Health Act or the Mental Health (Wales) Measure 2010 training had been undertaken by staff.

Service Development

2.62 It was evident that the Centre has required development and improvement for a number of years and the Health Board accepted this.

2.63 At the time of our visit the Health Boards plans for the Centre's redevelopment were in the early stages of implementation. It was clear that the Health Board needed to engage with ward staff, patients and their families to ensure that the process is successful; the Health Board had initiated this process. We were informed by staff and relatives alike that they are willing to invest time and effort in to improving the care provided at the Iorwerth Jones Centre and the Health Board must capitalise on this.

2.64 While we accept that such major redevelopment will take time there are a number of issues highlighted in this report relating to the environment that cannot wait as they have a negative impact on patient care.

2.65 Despite the issues identified in this report we feel that overall staff were doing their best to care for patients and maintain their safety and wellbeing in difficult circumstances. We require the Health Board to provide us with regular updates on progress so that we can be assured that the necessary improvements to patient care are made at the Iorwerth Jones Centre. In addition, we will increase the frequency of our visits until we are satisfied that progress as been made.

3. Recommendations

3.1 In view of the findings set out in Chapter 2 of this report we make the following recommendations.

Reference	Recommendation	Paragraph Reference
The Environment		
1.1	The Health Board should redecorate the ward areas to assist patients' to orientate themselves.	2.3
1.2	The Health Board must ensure that the default position for bedroom door observation panels is closed.	2.8
1.3	The Health Board must ensure that shower facilities enable staff to assist patients when required.	2.11
1.4	The Health Board must ensure that sufficient baths are available for patient use.	2.12
1.5	The Health Board must ensure that toilet lighting is appropriate for patient use.	2.13
1.6	The Health Board must ensure that there is sufficient hot water available at all times.	2.14
1.7	The Health Board must ensure that the heating system is appropriate.	2.14 2.15
1.8	The Health Board must ensure that radiators thermostatic values are fully operational and set to the right temperature.	2.16
1.9	The Health Board must ensure that lounge seating is not arranged in an institutional fashion.	2.17
1.10	The Health Board must ensure that the communal lounges are appropriately furnished to ensure the comfort of patients.	2.17 2.18
1.11	The Health Board must ensure that pictures and photographs that assist in stimulating patients'	2.19

Reference	Recommendation	Paragraph Reference
	memories are displayed throughout the Centre.	
1.12	The Health Board must review ward storage facilities to ensure empty patient bedrooms are not being used to store ward items.	2.20
1.13	The Health Board must ensure that the external areas of the Iorwerth Jones Centre are regularly maintained.	2.21
1.14	The Health Board must ensure that the laundry service meets the needs of patients.	2.22
1.15	The Health Board must ensure that staff are able to easily access keys.	2.23
1.16	The Health Board must ensure regular environmental maintenance audits of the Centre are undertaken and the maintenance issues identified are rectified promptly.	2.24 2.25
Patient Activities		
2.1	The Health Board must ensure that there is a structured programme of regular activities that is tailored to meet the needs of the patients.	2.26 2.27 2.29
2.2	The Health Board must ensure that there is a programme of external trips for patients.	2.28
2.3	The Health Board must ensure that the garden areas are suitable for patients to access.	2.30 2.31
Food and Nutrition		
3.1	The Health Board must ensure that there dining room lighting is appropriate.	2.31
3.2	The Health Board must identify a lead member of staff to oversee mealtimes to ensure that they are appropriately structured and that patients receive assistance when required.	2.34
3.3	The Health Board must review the menu to ensure	2.36

Reference	Recommendation	Paragraph Reference
	it is varied and meets the needs of the patient group, some of whom are long-stay patients.	
Clinical Practice		
4.1	The Health Board must review the clinic rooms to ensure they meet the requirements of the wards.	2.37
4.2	The Health Board should confirm whether new medication trolleys have been ordered and received.	2.39
4.3	The Health Board should ensure that Medication Administration Records are always completed in full.	2.40
4.4	The Health Board should review the medication administration process.	2.41
4.5	The Health Board must ensure that staff follow sound cleanliness and infection control practices.	2.42
4.6	The Health Board must ensure that regular medication audits are undertaken.	2.43
4.7	The Health Board must ensure that patient documentation is completed in full and details of individual patient care needs are regularly reviewed and updated. This must include regular audits of patient documentation.	2.44 2.45
4.8	The Health Board must ensure that staff uphold the privacy and dignity of patients' when undertaking their roles.	2.47
4.9	The Health Board must monitor and manage sickness levels and staffing levels so that a full establishment of ward staff is maintained.	2.48
4.10	The Health Board must ensure that full Multi-Disciplinary Team input to Iorwerth Jones Centre is monitored and reviewed to ensure that the	2.49

Reference	Recommendation	Paragraph Reference
	requirements of the patient group are met.	
Staff Training and Development		
5.1	The Health Board must ensure that comprehensive staff training records are maintained.	2.50 2.51
5.2	The Health Board must ensure that staff are able to access training.	2.52
5.3	The Health Board must ensure that the Centres training room is appropriately furnished to enable staff to undertake on-site training.	2.53
Mental Health Act		
6.1	The Health Board must ensure that there is a clear record in patient notes of the provision of information under Section 132 as set out in the Code, paragraph 22.34	2.55
6.2	The Health Board must ensure that Responsible Clinicians record that they have informed the patient of the outcome of any Second Opinion Appointed Doctor visit.	2.58
6.3	The Health Board must ensure that Statutory Consultees document their conversation with the Second Opinion Appointed Doctor within the patient's records.	2.59
6.4	The Health Board must ensure that its wards comply with the Health Board's locked door policy and that wards are locked as and when required and not as standard practice. The Health Board should ensure that it follows the guidance set out in the Code and make a formal assessment tool available to staff to help them make decisions as to when the door should be locked.	2.59
6.5	The Health Board must ensure that information is	2.59

Reference	Recommendation	Paragraph Reference
	displayed informing patients who are not detained under the Act of their right to leave the ward and how they can do this.	
6.6	The Health Board must ensure that it has no De facto detentions.	2.59
6.7	The Health Board must ensure that staff undertake capacity assessments to determine in which circumstances and in relation to which areas individuals have capacity and can therefore act independently and in what circumstances they require assistance.	2.60
Service Development		
7.1	The Health Board must ensure that it fully engages with staff, patients and their relatives as it takes its plans for the development of the Iorwerth Jones Centre forward.	2.63

4. Next Steps

4.1 The Health Board has submitted an action plan to address the key issues highlighted in this report and it is available at Annex C.

4.2 Cardiff and Vale Health Board has confirmed that all actions will be completed by xxx, within xx months of the inspection. HIW has assessed the action plan and is satisfied that the concerns raised by the inspection will be appropriately addressed.

4.3 HIW will monitor the progress of Cardiff and Vale Health Board implementing the actions at the Iorwerth Jones Centre and across the Health Board. Based on the level of assurance we receive, we may request further information and will consider the findings of this review at future Cardiff and Vale Health Board Mental Health Act Monitoring reviews.

Annex A

The Roles and Responsibilities of Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all healthcare in Wales. HIW's primary focus is on:

- Making a significant contribution to improving the safety and quality of healthcare services in Wales.
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative and employee.
- Strengthening the voice of patients and the public in the way health services are reviewed.
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Government and healthcare providers that services are safe and good quality.

Services are reviewed against a range of published standards, policies, guidance and regulations. As part of this work HIW will seek to identify and support improvements in services and the actions required to achieve this. If necessary, HIW will undertake special reviews and investigations where there appears to be systematic failures in delivering healthcare services to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent healthcare providers in Wales and is the Local Supervising Authority for the statutory supervision of midwives.
HIW carries out its functions on behalf of Welsh Ministers and, although part of the Welsh Government, protocols have been established to safeguard its

operational autonomy. HIW's main functions and responsibilities are drawn from the following legislation:

- Health and Social Care (Community Health and Standards) Act 2003.
- Care Standards Act 2000 and associated regulations.
- Mental Health Act 1983 and the Mental Health Act 2007.
- Statutory Supervision of Midwives as set out in Articles 42 and 43 of the Nursing and Midwifery Order 2001.
- Ionising Radiation (Medical Exposure) Regulations 2000 and Amendment Regulations 2006.

HIW works closely with other inspectorates and regulators in carrying out cross sector reviews in social care, education and criminal justice and in developing more proportionate and co-ordinated approaches to the review and regulation of healthcare in Wales.

Annex B

Mental Health Act Monitoring

The role of the Review Service for Mental Health, within Healthcare Inspectorate Wales, is to keep the use of the Mental Health Act 1983 under review and check that the Act is being used properly.

The Review Service for Mental Health is independent of all staff and managers of hospitals and mental health teams. We use Mental Health Act Reviewers which could include doctors, nurses, social workers, lawyers, psychologists, service users and other people with knowledge of the Act and mental health services.

Reviewers can visit all places where patients are detained under the Mental Health Act, and meet with them in private. In certain circumstances, the Review Service also arranges for an independent doctor to provide a second opinion if a patient is not able or willing to consent to their treatment.

The Review Service may investigate certain types of complaints.

The Review Service publishes a report of its activities and findings every year.

How do the Reviewers do it?

Reviewers can visit all wards where patients are detained under the Mental Health Act 1983 and may also visit other settings to meet with patients subject to Guardianship or Supervised Community Treatment (SCT) to check:

- that such patients are lawfully detained and well cared for
- that such patients are informed about their rights under the Act
- that such patients are given respect for their qualities, abilities and diverse backgrounds as individuals, and that account is taken of their

needs in relation to age, gender, sexual orientation, social, ethnic, cultural and religious backgrounds
- that the Mental Health Act Code of Practice for Wales is being followed
- that the right plans are made for patients before they are discharged from hospital.

During visits, Reviewers meet and talk to detained and informal patients in private. Reviewers also meet with managers and other staff to talk about things that affect patients' care and treatment, and to raise issues on behalf of patients.

What the Review Service for Mental Health cannot do

The Review Service:

- cannot discharge patients from their section under the Mental Health Act 1983
- cannot discharge patients from hospital
- cannot arrange for patients to have leave
- cannot transfer patients to another hospital
- cannot offer individual medical advice
- cannot offer individual legal advice
- cannot help informal patients

This is because the law is very clear about what we can and cannot do, not because we don't want to help. The Review Service can advise where else help could be obtained from.

Annex C

Action Plan

Reference	Recommendation	Action	Responsible Officer	Timescales
The Environment				
1.1	The Health Board should redecorate the ward areas to assist patients' to orientate themselves.	(a) Identify whether any decoration is planned for the Iorwerth Jones Unit. (b) Interior designer to be appointed and a meeting schedule arranged. (c) Carers and staff to be identified to participate in interior design process.	Directorate Manager Head of Estates	Complete
1.2	The Health Board must ensure that the default position for bedroom door observation panels is closed.	(a) Daily environment check sheer to be developed and utilised by the Ward Sister / Charge Nurse. The Checklist will include observation panels. (b) Urgent uses identifies through use of the checklist will be escalated to the Senior Nurse who will support timely action being taken.	Lead Nurse	31 July 2013

Reference	Recommendation	Action	Responsible Officer	Timescales
		(c) The Directorate management team will review the findings of the environment checklist each week as part of the performance / improvements monitoring arrangements with the clinical ward team.		
1.3	The Health Board must ensure that shower facilities enable staff to assist patients when required.	(a) All issues which affect the effective working of shower / bathroom facilities to be discussed between the Directorate and Estate teams and action by the Estate Team agreed. (b) Directorate Team to monitor progress of the agreed plan and escalate any slippage or failure to resolve to the Clinical Board Team.	Head of Estates Lead Nurse	31 July 2013
1.4	The Health Board must ensure that sufficient	(a) All issues which affect the effective	Head of Estates	31 July 2013

Reference	Recommendation	Action	Responsible Officer	Timescales
	baths are available for patient use.	working of bath / bathroom facilities to be discussed between the Directorate and Estate teams and action by the Estate Team agreed. (b) Directorate Team to monitor progress of the agreed plan and escalate any slippage or failure to resolve to the Clinical Board Team.	Lead Nurse	
1.5	The Health Board must ensure that toilet lighting is appropriate for patient use.	(a) Lighting to be of sufficient power. (b) Timer switch to be replaced with standard light switches.	Directorate Manager	Complete
1.6	The Health Board must ensure that there is sufficient hot water available at all times.	(a) Heating system to be repaired. (b) Sufficiency of supply to be monitored as part of the daily environment checklist. Issues to be escalated to the Senior Nurse in a timely way.	Head of Estates Lead Nurse	Completed Monitoring to commence in July 2013
1.7	The Health Board must ensure that the heating	(a) Heating system to be repaired.	Head of Estates	Completed

Reference	Recommendation	Action	Responsible Officer	Timescales
	system is appropriate.	(b) Sufficiency of supply to be monitored as part of the daily environment checklist. Issues to be escalated to the Senior Nurse in a timely way.	Lead Nurse	Monitoring to commence in July 2013
1.8	The Health Board must ensure that radiators thermostatic values are fully operational and set to the right temperature.	(a) As Action 1.2: To be incorporated into daily environment checks.	Lead Nurse	31 July 2013
1.9	The Health Board must ensure that lounge seating is not arranged in an institutional fashion.	(a) All seating to be in as "homely" a configuration as possible. (b) Monitoring of environment / seating to be incorporated into daily environment checks.	Ward Sister / Charge Nurse Lead Nurse	Immediate 31 July 2013
1.10	The Health Board must ensure that the communal lounges are appropriately furnished to ensure the comfort of patients.	(a) New, appropriate range of furniture to be purchased and installed.	Directorate Manager	31 August 2013
1.11	The Health Board must ensure that pictures and photographs that assist in stimulating	(a) Pictures, photographs and other items to be agreed upon and purchased.	Lead Nurse	31 July 2013

Reference	Recommendation	Action	Responsible Officer	Timescales
	patients' memories are displayed throughout the Centre.	(b) Estates to be contacted to install pictures around the ward.		
1.12	The Health Board must review ward storage facilities to ensure empty patient bedrooms are not being used to store ward items.	(a) Ward Sister / Charge Nurse to ensure that all rooms are cleared of stored items (if any), via environment checklist.	Lead Nurse	Immediate
1.13	The Health Board must ensure that the external areas of the Iorwerth Jones Centre are regularly maintained.	(a) Identify whether any garden maintenance plan is in place for Iorwerth Jones from the estates team. (b) Discuss maintenance schedule inclusions / exclusions to this schedule. (c) Explore possibility of working with local allotment group to maintain garden, considering health and safety etc. (d) Explore possibility of occupational therapy developing an activity programme that would enable the patients to participate in gardening if they	Lead Nurse Estates Manager Directorate Manager	Complete Complete Complete 31 July 2013

Reference	Recommendation	Action	Responsible Officer	Timescales
		wish.		
1.14	The Health Board must ensure that the laundry service meets the needs of patients.	(a) Directorate to purchase a "marking machine" to enable timely and discreet marking of patient clothing. (b) Laundry management system to be reviewed.	Directorate Manager	31 September 2013
1.15	The Health Board must ensure that staff are able to easily access keys.	(a) More keys to be purchased for the unit allowing 1 key per nurse, with key monitoring system in place.	Directorate Manager	Completed
1.16	The Health Board must ensure regular environmental maintenance audits of the Centre are undertaken and the maintenance issues identified are rectified promptly.	(a) As Action 1.2: To be incorporated into daily environment checks.	Lead Nurse	31 July 2013
Patient Activities				
2.1	The Health Board must ensure that there is a structured programme of regular activities that is tailored to meet the needs of the patients.	(a) Refocusing Nurse to have protected time for 50% of role. (b) Rotas to be audited for this and	Ward Sister / Charge Nurse Nurse and Lead	31 July 2013 31 August 2013

Reference	Recommendation	Action	Responsible Officer	Timescales
		presented to Iorwerth Jones Steering Group. (c) Each patient to have Individual Therapeutic Plan including social and therapeutic individual and group activities – group activities to be displayed. (d) PALs assessments to be undertaken for each patient to inform activities planning. (e) Staff to undertake observations of care therapeutically, noting their therapeutic conversations on 24 Hour Behaviour chart. (f) Staff challenging behaviour management training updates to be assured as part of Mandatory Training review as well as Personal Appraisal and Development Review process.	Nurse Ward Sister / Charge Nurse	31 August 2013

Reference	Recommendation	Action	Responsible Officer	Timescales
		(g) Dementia Care Mapping to be used on a monthly basis to evidence improvements in psychological care. (h) SONAS Activation Personal Community training to be invested in for new Refocusing Nurses and Lead Healthcare Support Workers.	Lead Nurse Lead Nurse	To commence July 2013-08-01 To be reviewed end of August 2013
2.2	The Health Board must ensure that there is a programme of external trips for patients.	(a) Programme of trips and activities to be drawn up for coming year.	Lead Nurse	31 July 2013
2.3	The Health Board must ensure that the garden areas are suitable for patients to access.	(a) As Action 1.13		
Food and Nutrition				
3.1	The Health Board must ensure that there dining room lighting is appropriate.	(a) Dining room lighting to be assessed by ward manager and appropriate lighting procured if necessary.	Lead Nurse	31 July 2013
3.2	The Health Board must identify a lead member of staff to oversee mealtimes to ensure that	(a) Ward managers to ensure one member of staff is present at each	Lead Nurse	31 July 2013

Reference	Recommendation	Action	Responsible Officer	Timescales
	they are appropriately structured and that patients receive assistance when required.	mealtime to supervise and assist patients as necessary		
3.3	The Health Board must review the menu to ensure it is varied and meets the needs of the patient group, some of whom are long-stay patients.	(a) Menu reviewed as part of Plan, Do, Study, Act (PDSA) cycle which commenced on 26 June 2013. Will continue to be monitored as part of Free to Lead, Free to Care[15] implementation.	Directorate Manager	Complete
Clinical Practice				
4.1	The Health Board must review the clinic rooms to ensure they meet the requirements of the wards.	(a) Additional treatment rooms to be equipped, and situated on the wards.	Directorate Manager	Complete
4.2	The Health Board should confirm whether new medication trolleys have been ordered and received.	(a) Appropriate trolley to be ordered.	Lead Nurse	15 August 2013
4.3	The Health Board should ensure that Medication Administration Records are always	(a) Medication recording to be audited at 6 monthly intervals.	Lead Nurse	First audit by 15 August 2013

[15] http://wales.gov.uk/docs/phhs/publications/empowering/090427empoweringen.pdf

Reference	Recommendation	Action	Responsible Officer	Timescales
	completed in full.			
4.4	The Health Board should review the medication administration process.	(a) Administration process and compliance with professional guidelines to be audited.	Lead Nurse	15 August 2013
4.5	The Health Board must ensure that staff follow sound cleanliness and infection control practices.	(a) Hand hygiene audits to commence and be completed monthly.	Lead Nurse	From 15 August 2013
4.6	The Health Board must ensure that regular medication audits are undertaken.	(a) Medication audits to be undertaken in Unit on a 6 monthly basis.	Lead Nurse	First audit by 15 September 2013
4.7	The Health Board must ensure that patient documentation is completed in full and details of individual patient care needs are regularly reviewed and updated. This must include regular audits of patient documentation.	(a) Documentation audits to continue at 6 month intervals. (b) The new "Building the Team Around the Patient" model of care requires atleast weekly reviews of care plans, which will commence from August 2013.	Lead Nurse	First audit by 15 August 2013
4.8	The Health Board must ensure that staff	(a) Continue to roll out dignity training to	Lead Nurse	First

Reference	Recommendation	Action	Responsible Officer	Timescales
	uphold the privacy and dignity of patients' when undertaking their roles.	all staff. (b) Identify any potential breaches of privacy through dementia care mapping and unscheduled observations of care and respond either with training, staff development or other managerial interventions as deemed appropriate and proportionate. (c) 1:1 discussions between senior nurse and all staff on the Unit focussing on staff behaviour inline with the UHB Strategic Framework – Organising for Excellence.		unscheduled visit by 30 September 2013
4.9	The Health Board must monitor and manage sickness levels and staffing levels so that a full establishment of ward staff is maintained.	(a) Detailed, comprehensive "sickness panels" to be conducted on both wards. Sickness to reduce by 2% by end of year.	Lead Nurse / Directorate Manager	30 December 2013
4.10	The Health Board must ensure that full Multi-	(a) Impact of new multi-disciplinary team	Clinical Director	31 March 2014

Reference	Recommendation	Action	Responsible Officer	Timescales
	Disciplinary Team input to Iorwerth Jones Centre is monitored and reviewed to ensure that the requirements of the patient group are met.	to be evaluated as part of Directorate Quality and Safety processes, and will be reported through Directorate / Clinical Board Quality and Safety structure.		
Staff Training and Development				
5.1	The Health Board must ensure that comprehensive staff training records are maintained.	(a) Ward Sister / Charge Nurse to keep full records of all staff training, both professional and mandatory. This will be monitored at monthly intervals through the Directorate Performance Management framework.	Lead Nurse	To be audited by 31 August 2013
5.2	The Health Board must ensure that staff are able to access training.	(a) Complete all Performance and Development Reviews (PADR) for staff on Coed y Nant and Coed y Felin. (b) Review development and training needs for themes emerging from PADR. (c) Establish training priorities from 1:1s.	Lead Nurse	30 September 2013

Reference	Recommendation	Action	Responsible Officer	Timescales
		PADR and discussions with wider MDT. (d) Complete a staff training matrix		
5.3	The Health Board must ensure that the Centres training room is appropriately furnished to enable staff to undertake on-site training.	(a) MDT to submit list of requirements to equip training room and purchases to be made to Directorate Manager.	Lead Nurse	31 August 2013
Mental Health Act				
6.1	The Health Board must ensure that there is a clear record in patient notes of the provision of information under Section 132 as set out in the Code, paragraph 22.34	(a) Compliance to be verified as part of regular documentation audits.	Lead Nurse	First audit by 31 August 2013
6.2	The Health Board must ensure that Responsible Clinicians record that they have informed the patient of the outcome of any Second Opinion Appointed Doctor visit.	(a) Compliance to be verified as part of regular documentation audits.	Lead Nurse	First audit by 31 August 2013
6.3	The Health Board must ensure that Statutory Consultees document their conversation with	(a) Compliance to be verified as part of regular documentation audits.	Lead Nurse	First audit by 31 August 2013

Reference	Recommendation	Action	Responsible Officer	Timescales
	the Second Opinion Appointed Doctor within the patient's records.			
6.4	The Health Board must ensure that its wards comply with the Health Board's locked door policy and that wards are locked as and when required and not as standard practice. The Health Board should ensure that it follows the guidance set out in the Code and make a formal assessment tool available to staff to help them make decisions as to when the door should be locked.	(a) Advanced Nurse Practitioner and Lecturer / Practitioner to provide training and tools on locked door decision making. (b) Compliance to be monitored and reported through the Directorate Quality and Safety Group.	Lead Nurse	30 September 2013
6.5	The Health Board must ensure that information is displayed informing patients who are not detained under the Act of their right to leave the ward and how they can do this.	(a) Information to be displayed on ward notice boards immediately.	Lead Nurse	15 July 2013
6.6	The Health Board must ensure that it has no De facto detentions.	(a) Deprivation of Liberty Safeguards (DoLS) / Capacity reviews to be	Clinical Director	31 July 2013

Reference	Recommendation	Action	Responsible Officer	Timescales
		conducted on all patients on Coed y Nant and Coed y Felin by psychiatrists.		
6.7	The Health Board must ensure that staff undertake capacity assessments to determine in which circumstances and in relation to which areas individuals have capacity and can therefore act independently and in what circumstances they require assistance.	(a) DoLS / Capacity reviews to be conducted on all patients on Coed y Nant and Coed y Felin by psychiatrists.	Clinical Director	31 July 2013
Service Development				
7.1	The Health Board must ensure that it fully engages with staff, patients and their relatives as it takes its plans for the development of the Iorwerth Jones Centre forward.	(a) The Iorwerth Jones action plan to be reviewed on a weekly basis with Iorwerth Jones staff. (b) Continue to present the plan to carers through the Community Health Council (CHC) / carers meetings and discuss progress. (c) The principles underpinning the plan	Lead Nurse	Review progress in January 2014

Reference	Recommendation	Action	Responsible Officer	Timescales
		have been discussed at the first of two Iorwerth Jones away days and will be revisited at future development events with the unit.		