

**Mental Health Act  
Monitoring Inspection  
(Unannounced)**  
Aneurin Bevan University  
Health Board: Ysbyty  
Aneurin Bevan, Carn yr  
Cefn

**21 July 2015**

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In writing:

**Communications Manager  
Healthcare Inspectorate Wales  
Welsh Government  
Rhydycar Business Park  
Merthyr Tydfil  
CF48 1UZ**

Or via

**Phone:** 0300 062 8163  
**Email:** [hiw@wales.gsi.gov.uk](mailto:hiw@wales.gsi.gov.uk)  
**Fax:** 0300 062 8387  
**Website:** [www.hiw.org.uk](http://www.hiw.org.uk)

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## 1. Introduction

Healthcare Inspectorate Wales is the independent inspectorate and regulator of all healthcare in Wales. Since April 2009 HIW has monitored the use of the Mental Health Act 1983 on behalf of Welsh Ministers.

Our Mental Health Act Monitoring inspections cover both independent hospitals and mental health services offered by the National Health Service (NHS). Inspection visits are a key aspect of our assessment of the quality and safety of mental health and learning disability services in Wales.

During our visits we ensure that the interests of the patients are monitored and settings fulfil their responsibilities by:

- Monitoring the compliance with the Mental Health Act 1983, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS)
- Complying, as applicable, with the Welsh Government's National Minimum Standards in line with the requirements of the Care Standards Act 2000 and the Independent Health Care (Wales) Regulations 2011.

The focus of HIW's Mental Health Act monitoring inspections is to ensure that individuals accessing such services are:

- Safe
- Cared for in a therapeutic, homely environment
- Supported to be as independent as possible
- Allowed and encouraged to make choices
- Given access to a range of activities that encourage them to reach their full potential
- Able to access independent advocates and are supported to raise concerns and complaints
- Supported to maintain relationships with family and friends where they wish to do so.

## 2. Methodology

The inspection model HIW uses to deliver the Mental Health Act monitoring inspections includes:

- Scrutiny of the documentation for patients detained under the Mental Health Act 1983.
- Observation of the environment.
- Comprehensive interviews and discussions with patients, relatives, advocates and a cross section of staff.
- Examination of care documentation including the multi-disciplinary team documentation.
- Scrutiny of recreational and social activities.
- Consideration of the quality of food.

HIW uses a range of expert reviewers with extensive experience of monitoring compliance with the Mental Health Act 1983 for the inspection process. These inspections capture a snapshot of the standards of care patients receive.

### **3. Context and description of service**

Healthcare Inspectorate Wales (HIW) undertook an unannounced Mental Health Act Monitoring inspection to Ysbyty Aneurin Bevan, Carn yr Cefn, Ebbw Vale on 21 July 2015.

Carn yr Cefn is an adult mental health ward consisting of 11 beds providing care for patients with a diagnosis of mental health who require a period of in patient care.

During the day we visited the unit reviewing patient records, interviewing staff, reviewing the environment of care and observing staff-patient interactions. No patients wished to meet with us to discuss their experiences on the ward. The review team comprised of one Mental Health Act Reviewer and one member of HIW staff.

## 4. Summary

Carn yr Cefn is a purpose built mental health ward which is part of the Cwm Coch mental health service at Ysbyty Aneurin Bevan.

The unit was generally well maintained and was equipped with appropriate furniture for the patient group. There was a calm and relaxed atmosphere throughout our visit.

Following the temporary closure of the ward due to insufficient staffing numbers the health board has recruited to a number of posts to increase the nursing establishment. The staff that we met on the day of the inspection spoke of good team working and of a motivated team dedicated to the patient group. There were good links between the inpatient service and the community team which provided continuity in patient care.

We reviewed a sample of statutory documentation and found that these were compliant with the Act. We found areas of good practice regarding the provision of rights to patients however, there were a number of areas of record keeping that could be improved in line with good practice.

## 5. Findings

### *Core Standards*

#### **Ward environment**

On the day of the inspection the entrance was unlocked; the ward remains unlocked between 9am and 5pm. We were informed that if a decision is taken to lock the ward this was based on clinical decision to prevent a number of the detained patients leaving the ward unauthorised.

There was no information displayed explaining to those patients who were able to leave the ward of how to do so if they wished during the periods when the door was locked between 5pm and 9am.

On the day of our unannounced inspection the ward appeared clean, generally clear of clutter and free from any unpleasant or clinical odours throughout. On the whole the communal areas were well furnished and the fixtures and fittings were appropriate for the patient group.

The ward had a large communal area which included the lounge area and a dining area. There was an additional small lounge which patients could access.

There were a number of small rooms available for patients to use which could accommodate small groups. There were rooms at the entrance to the ward which could be used for patients to meet with family members or other visitors.

The ward was pleasantly decorated with pictures and artwork throughout the ward. The ward had a range of information posters and leaflets on display around the ward for patients and their families. It was pleasing to note a large number of "Thank You" cards from patients and family members were on display.

Patients had direct access from the communal lounge to a large enclosed garden area that was well maintained. This area is unlocked throughout the day for patients to access.

Carn yr Cefn had a smoking room which was appropriate for use; smoking was not permitted between midnight and 6 am to encourage patients to sleep. Patients had access to smoking cessation assistance if they wished.



## ***Requirement***

***The health board must ensure that information is displayed informing patients of their right to leave the ward and how to do so when the ward is locked.***

## **Safety**

Staff were able to access the health board's Observation Policy on the ward and via the health board's computer system. The hospital's fixtures and fittings were anti-ligature throughout the patient areas. Staff stated that if required, observation levels were increased to reflect the risk posed by behaviours of any patients.

We were informed that all staff working on the ward were trained in Safe Physical Intervention Techniques. We observed staff de-escalating and redirecting patients in a dignified and caring manner.

On the day of the inspection staff were not carrying personal alarms. We were informed that staff could access two-way-radio system however there were no actual alarms available at Carn yr Cefn. A number of staff said that they would feel more comfortable if they could have personal alarms if the risks posed by the patient group deemed in necessary.

## ***Requirement***

***The health board must ensure the provision of alarms for staff and visitors at Carn yr Cefn***

## **Privacy and dignity**

Patients had individual en-suite bedrooms with a shower. Patients were able to personalise their own bedrooms and these were suitably furnished with sufficient storage facilities. Patients had nurse-call buttons within their bedrooms to summon assistance if required.

Patients were able to lock their bedroom doors which staff could over-ride if required. Bedroom doors had viewing panels; however these were only controllable from outside the room. It was noted that all viewing panels were in the closed position and staff confirmed that they were only opened when staff are undertaking observations. Patients had appropriate privacy measures on their bedroom windows.

There were patient toilets and a bathroom on the ward. There was appropriate lifting and mobility aids available if required.

It was pleasing to note that there were on-site laundry facilities, and patients were able to do their own laundry with staff assistance. However, if patients were unable to do their laundry staff would do this on the patient's behalf. We were informed that staff would do laundry during the night shift so that if patient had a limited number of items of clothing that this was cleaned regularly and available for the patient. We were also informed that this minimised the impact on nursing staff time being diverted away from patient care by undertaking patients' laundry.

Patients had access to a wall-mounted pay-phone on the ward; patients who had a mobile phone were able to use this on the ward but only in the area near the pay-phone.

Throughout the inspection we observed staff interacting with patients in a caring and respectful manner.

### **The multi-disciplinary team**

The core numbers of staff for Carn yr Cefn was two registered nurses and two health care support workers during the day and one registered nurse and two health care support workers during the night. When required, Carn yr Cefn use health board bank staff.

Following the temporary closure of the ward due to insufficient staff numbers the health board have recruited to a number of posts which has increased the number of staff available for the ward. The staff that we met, on the day of the inspection, spoke of good team work links and of a motivated team dedicated to the patient group.

Carn yr Cefn had two consultants on-site. The ward did not have a dedicated occupational therapist; however the ward had two occupational therapy technicians who liaised with the community occupational therapist. Staff could refer to the health board's psychology service, speech and language therapy (SALT) and dietician service.

During our inspection in addition to ward staff we spoke to staff from the Home Treatment Team based within the same area of Ysbyty Aneurin Bevan. All staff spoke of very good links between the in-patient and community teams which provided patients with a consistent care pathway. A member of the ward team attends the Home Treatment Team meeting to maintain the links between the two teams.

### **Patient therapies and activities**

Carn yr Cefn had a programme of activities available to patients on the ward. The activity plan was displayed on the ward and in patients' bedrooms. The plan provided a variety of activities for patients including evenings and at weekends. There were a number of games and craft items available for patients to undertake ad-hoc activities.

We were informed that in addition a community project comes to the ward fortnightly to provide a variety of activities for patients.

The hospital also had a designated vehicle so that staff could facilitate taking patients to the local shops and on community trips further afield. Where appropriate, patients were also able to leave the hospital unescorted and with family and/or carers.

Patient group meetings were held fortnightly and led by the occupational therapy technicians.

### **General healthcare**

Patients' physical health needs were provided for by health board doctors available at Ysbyty Aneurin Bevan. Patients generally stay registered with their own physical health services such as GP surgeries and dentists. However, patients also had access to an emergency dentist. Patients accessed local hairdressers and barbers in the community.

### **Food and nutrition**

There were appropriate catering facilities on the ward with meals being provided from the on-site kitchen at Ysbyty Aneurin Bevan. Patients choose their meals from the hospital menu, with access to a specialist dietary menu when needed.

The hospital operates a protective mealtime policy to allow patients to eat their meals without disruption.

## ***Application of the Mental Health Act***

There were nine patients being cared for at Carn yr Cefn, all over the ages of 18. A number of patients were detained under the Mental Health Act at the time of our inspection. We reviewed a sample of statutory documentation and found that they were compliant with the Act. The documentation was well organised which allowed for ease of review; however there were a number of areas that could be improved inline with good practice.

### **Patient Detention**

Reviewing the statutory documentation, for each of the detentions under Section 2, *Admission for assessment*<sup>1</sup>, and Section 3, *Admission for treatment*<sup>2</sup>, at-least one of the doctors was Section 12 approved<sup>3</sup> and at-least one of the doctors had a previous acquaintance with the patient<sup>4</sup>. Clear reasons were given why detention under the Act was the most appropriate way of providing care and why informal admission was not appropriate.

For the detention under Section 3 the statutory documentation stated that the appropriate medical treatment was available at the hospital.

On assessment of the patients for detention under Section 2 and Section 3 the Approved Mental Health Professional<sup>5</sup> (AMHP) involved for each case had identified the patient's nearest relative<sup>6</sup>.

From reviewing the AMHP reports it was noted that the AMHP involved in the individual case may have contacted the patient's nearest relative, however on occasions there was little information about when they were contacted and whether this was done in person or by telephone.

We noted that that for one patient a copy of an AMHP report was not kept with the individual patient's detention documentation. It is good practice to kept a copy of the AMHP report with the individual patient's detention documentation.

No patients had been subject to Section 4 emergency application<sup>7</sup> or Section 5 holding powers<sup>8</sup>.

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<sup>1</sup> Section 2 - admission for assessment, patient detained under the Mental Health Act

<sup>2</sup> Section 3 - admission for treatment, patient detained under the Mental Health Act

<sup>3</sup> 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. In practice, Local Health

Boards take these decisions on behalf of the Welsh Ministers.

<sup>4</sup> Where practicable, one of the recommending doctors should have previous acquaintance with the patient, Section 12(2) of the Act.

<sup>5</sup> 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.

<sup>6</sup> 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

## **Requirement**

***The health board should ensure that copies of AMHP reports are available in individual patient's notes.***

## **Ongoing detention**

No patients had been subject to the renewal of detention under Section 20, Duration of authority.

## **Section 132 provision of information<sup>9</sup>**

Reviewing patients' notes it was evident that the patients had been informed regularly of their rights under Section 132 of the Act. The patient understands of their rights or if the patient had refused to engage in the process was recorded in their notes.

It was positive to note that when staff had provided patients with information that this was documented in the patient's notes and highlighted or underlined so that it was prominent. This good practice is worth sharing across the service.

## **Appealing against detention**

It was evident that if patients wished to appeal to the Mental Health Review Tribunals that the process was followed. The notes stated the outcome of the tribunal and that the patient had been informed.

## **Consent to treatment**

No patients were subject to Consent to Treatment provisions of Section 58 nor had a Second Opinion Appointed Doctor<sup>10</sup> (SOAD) had been required to authorise a consent to treatment

## **Section 17 leave<sup>11</sup> of absence**

No patients were authorised 17 leave of absence.

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<sup>7</sup> An application for detention for assessment of mental disorder made with only one supporting medical recommendation in cases of urgent necessity.

<sup>8</sup> The powers in Section 5 of the Act which allow hospital inpatients to be detained temporarily so that a decision can be made about whether an application for detention should be made.

<sup>9</sup> Section 132 of the Mental Health Act 1983 places a responsibility upon the hospital managers to take all practicable steps to ensure that all detained patients are given information about their rights.

<sup>10</sup> An independent doctor appointed by Healthcare Inspectorate Wales who gives a second opinion on whether certain types of medical treatment for mental disorders should be given without the patient's consent.

<sup>11</sup> Patient leave from the hospital grounds authorised by the patient's Responsible Clinician

### **Restricted patients**

No patients were detained under Part 3 of the Act, Patients Concerned in Criminal Proceedings or Under Sentence.

## 6. Next Steps

The health board is required to complete an Improvement Plan (Appendix A) to address the key findings from the inspection and submit its Improvement Plan to HIW within two weeks of the publication of this report.

The Improvement Plan should clearly state when and how the findings identified at Ysbyty Aneurin Bevan will be addressed, including timescales.

The Improvement Plan, once agreed, will be published on the Healthcare Inspectorate Wales website and will be evaluated as part of the on-going Mental Health Act Monitoring process.

## Appendix A

**Mental Health / Learning Disability: Improvement Plan**

**Health Board: Aneurin Bevan University Health Board**

**Hospital: Ysbyty Aneurin Bevan**

**Date of Inspection: 21 July 2015**

Page Number	Recommendation	Health Board Action	Responsible Officer	Timescale
<b>Core Standards</b>				
	The health board must ensure that information is displayed informing patients of their right to leave the ward and how to do so when the ward is locked.	The ward will develop an information poster and locate it in the proximity of the door to the wards to inform patients of the reasons the door may be locked and how the door can be unlocked if the patient requires to leave the ward.	Ward Manager	Completed



		As required by the Equality Act 2010 this will be made available in Welsh. This practice will be shared with all other inpatient units and the presences of the poster monitored during environmental visits. All ward leaflets will include a section informing patients of their rights to leave the ward and how to do so when they are locked.	Clinical Governance Lead	Feb 2016
	The health board must ensure the provision of alarms for staff and visitors at Carn yr Cefn	The ward manager will remind staff of the importance of carrying the alarms and highlight the appropriate policy to the staff team and will purchase additional alarms via the oracle system.	Ward Manager	Completed
<b>Application of the Mental Health Act</b>				
	The health board should ensure that copies of AMHP reports are available in individual patient's notes.	The Mental Health Act department will liaise with the AMHP leads and this issue will be raised within the AMHP forum meeting. They will be reminded that once completed a	Mental Health Act Lead and AHMP leads	Completed

		<p>copy of the report must be filed in the patient notes. This practice will be shared across the division.</p> <p>The Mental Health Act Department will update the department audit tool to include this topic.</p>	<p>Mental Health Act Lead and AHMP leads</p>	<p>Dec 15</p>
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