Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

NHS Learning Disability Hospital Inspection Report (Unannounced)

03631 - NHS Hospital Setting, Aneurin Bevan University Health Board

Inspection date: 22, 23 and 24 April 2024
Publication date: 8 August 2024

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Digital ISBN 978-1-83625-535-2

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 of a learning disability hospital setting at Aneurin Bevan University Health Board on 22, 23 and 24 April 2024.

Our team for the inspection comprised of two HIW healthcare inspectors and three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer).

During the inspection we spoke with patients and their families or carers to find out about their experience of using the service. We also invited staff to complete a HIW questionnaire to tell us their views on working at the hospital. A total of 5 questionnaires were completed by staff. 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.

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We observed friendly and respectful interactions taking place with staff communicating in a kind, proactive and engaging manner with patients. There had been an improvement since our previous inspection in the range of information now available to patients. This included information on Putting Things Right and services such as the Patient Advice and Liaison Service and advocacy.

Patients had access to their own bedrooms which they could personalise. Patients were able to wear their own clothing and appeared well-kempt.

It was positive to note that an Occupational Therapist had been recruited since our previous inspection. However, we did not always see a variety of creative activities on offer to engage patients. We recommend that the existing programme of therapeutic activities is reviewed to strengthen their effectiveness.

This is what we recommend the service can improve:

- Some loose boards in the decking area of the garden must be repaired as they currently present as a falls risk to patients
- The telephone line in the nursing office was not working and therefore needs to be fixed so that patients can use it should they wish.

This is what the service did well:

- There were positive examples where staff have worked with patients to create laminated cards which helped staff to be aware and understand how to manage and de-escalate the patient if required
- Easy read versions describing key information such as the patient guide and patient rights under the Mental Health Act had been created for patients to help them understand in a more accessible way.

Delivery of Safe and Effective Care

Overall summary:
We found suitable infection prevention and control arrangements in place. Staff members were clear on how to apply safeguarding procedures in the context of their duties. We noted a significant improvement in the appearance and tidiness of the clinic room at the unit since our previous inspection. Medication was now well organised and stored securely.

The statutory detention documentation we reviewed verified that patients were being legally detained. Patient records reflected the criteria set out by the Mental Health Measure Wales 2010 and were well detailed, individualised and reflected a wide range of multidisciplinary team involvement.

It was positive to see that some improvements had been made to the internal environment of the unit since our previous inspection. However, we identified further environmental issues during this inspection, and have recommended that all maintenance issues identified by staff must be resolved in a timely manner and that estates work is undertaken to improve the external appearance of the building and the adjacent areas outside the unit.

This is what we recommend the service can improve:

- The process of auditing and monitoring the Hospital Environment Board checklists must be improved to ensure that any issues identified are prioritised and actioned in a timelier manner
- Storage capacity on the unit must be reviewed and any broken or unwanted equipment must be removed
- A risk assessment for the administration of intramuscular medication to patients while under restraint must be developed to ensure it is undertaken safely
- Any periods of Section 17 leave granted for patients must be suitably risk assessed and documented on the Section 17 leave form
- Staff compliance with Mental Health Act training must be improved
- The language choice and preference for each patient must be identified and recorded so relevant language needs can be met.

This is what the service did well:

- We observed a training day workshop that centred on the history of one of the patients on the unit and found it to be an excellent example of person-centred multidisciplinary teamwork.

Quality of Management and Leadership

Overall summary:
It was positive to see improvements had been made since our previous inspection. There appeared to be a good culture and attitude among staff to work towards improving the quality of care and treatment provided to patients. However, we saw that some actions that had been marked as completed in the service improvement plan had not been kept up to date or been implemented. We recommended that actions from the improvement plan must be embedded into the business processes for the service and monitored to track progress.

During the inspection we observed a positive culture with good relationships between motivated staff who we observed working well together as a team. Staff members who completed a questionnaire generally provided positive experiences about working at the unit.

We saw clear information displayed about how patients and their families or carers could provide formal feedback about their care.

During our previous inspection we identified that several health board policies were out of date. It was therefore disappointing to find that some health board policies remained out of date. We have asked the health board to provide an update to HIW on when the policies identified in this report, and our previous inspection report, will be ratified.

This is what we recommend the service can improve:

- The 'You said, we did' board must be kept up to date to keep patients informed of actions taken in relation to any current issues raised.

This is what the service did well:

- We saw evidence of appropriate discharge and aftercare planning in the care and treatment plan we reviewed, with good involvement from the MDT, care co-ordinators and relevant partner services within the local community.

3. What we found

Quality of Patient Experience

Person-centred

Health promotion
We saw evidence that the physical health needs of patients were being assessed and managed in a timely and appropriate manner. For example, a diabetes management plan had been developed by staff for one patient to help monitor their blood sugar levels. Patients also received support to improve their health through smoking reduction and increased mobility initiatives. We also observed an activity taking place during the inspection where patients were encouraged to make healthy smoothies.

Patients had access to an enclosed garden area. We noted that there were some loose boards in the decking area which presented as a falls risk to patients.

The health board must ensure that the loose decking boards are repaired.

Dignified and respectful care
We observed good standards of care being displayed by staff throughout the inspection. This included friendly and respectful interactions taking place with staff communicating in a kind, proactive and engaging manner. This was a positive improvement since our previous inspection where we had observed some instances of patients not being actively listened to, acknowledged or respected.

Patients were able to wear their own clothing and appeared well-kempt. Patients could socialise in a mixed-sex communal area which was monitored by staff. All patients had their own bedrooms, some with ensuite facilities. Access was controlled by a key which both patients and staff had access to for safety purposes. We viewed one bedroom, and it was positive to see it was visibly clean, tidy and had been personalised to provide a homely feel. Bedroom doors had viewing panels so that staff could undertake observations without opening the door and potentially disturbing the patient. We noted that viewing panels were in the closed position when observations were not being undertaken which helped maintain patient privacy and dignity.

All staff members who completed a HIW questionnaire agreed that the privacy and dignity of patients is maintained.

We saw that the 'patient safety at a glance' board was kept in an appropriately secure area and was covered when not being used to help protect patient confidentiality.

Individualised care
During our last inspection we recommended that the service should consider recruiting a full-time Occupational Therapist (OT) and develop a comprehensive programme of therapeutic activities for patients. It was therefore positive to note that an OT had subsequently been recruited. However, while we saw some activities taking place during the inspection, we felt that further improvement could be made in relation to the creativity and variety of activities on offer to increase engagement and support patients for their discharge. Two out of the five staff members who completed a questionnaire also said that there are not enough appropriate activities for patients.

The health board must review the existing programme of therapeutic activities and work with patients to strengthen the quality, variety, and effectiveness of the activities on offer for patients.

We saw that patients were being supported to carry out every day personal tasks to help promote their independence. Patients were able to do their own laundry and were encouraged to maintain their own personal hygiene with assistance available if required.

We saw evidence that patients were being involved in how they wanted to be supported. We saw a positive example where a colour chart of escalating behaviour and corresponding actions to take by staff had been developed by staff with the patient. Laminated cards were then provided to all staff members so they were aware and understood how to support the patient and de-escalate if required.

Timely

Timely care
Clinical staff and multidisciplinary team (MDT) members appeared to be very positive and proactive towards the care and treatment of patients. We observed patients receiving timely care in accordance with clinical need. This was supported by appropriate opportunities to review patient needs and to take action where appropriate, including shift handovers, staff and patient meetings, and ward rounds.

Senior managers across the health board held adequate bed status management meetings to establish bed occupancy levels, and to discuss progress of patients who were awaiting discharge.

Equitable

Communication and language

We found that staff members had a good knowledge of each patient's individual needs and expectations. However, we spoke with some patients and their families or carers, and a concern was raised to us that in some instances staff accidentally used language or phrases that were known trigger points to patients on the unit.

The health board must ensure that all staff members are aware, and understand, whether there are specific words and phrases that should not be used around patients in case it risks escalating behaviour.

Despite this, we observed good examples of positive communication between staff and families, who appeared to have good involvement in decisions made about the care provided to the patients. The majority of staff members who completed a questionnaire felt that patients and/or their advocates are informed and involved in decisions about their care.

We have seen a positive increase since our last inspection in relation to the range of information that was available to patients. This included information on Putting Things Right and services such as the Patient Advice and Liaison Service and advocacy. We also saw that a new patient guide had been produced which was presented as an easy read booklet which we noted as good practice. An up to date 'Who's who' board was also on display which informed patients about the staff members working at the unit in line with the 'Safewards' model of care.

Rights and equality

We reviewed the legal records of three patients that had been detained at the hospital under the Mental Health Act (MHA). The documentation we saw was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code). Further information on our findings is detailed in the Mental Health Act Monitoring section of this report.

Easy read information was available to patients to inform them of their rights under the Mental Health Act. All patients had weekly access to a mental health advocate who provided information and support to patients with any issues they may have regarding their care.

A private room was available for patients to meet with family and friends in private. Access to their own mobile phone was suitably risk assessed for each patient. We were told that a telephone was available in the nursing office for patients to use should they wish. However, during the inspection the telephone line wasn't working.

The health board must ensure the telephone line is repaired so patients can use it should they wish to do so.

Delivery of Safe and Effective Care

Safe

Environment
It was positive to see that improvements had been made to the internal environment of the unit since our previous inspection. The laundry room had been tidied and reorganised, the activity room had been decluttered and estates work had been undertaken such as replacement water and boiler tanks. However, we were told that challenges still existed in relation to ongoing maintenance of the environment. At the time of the inspection the lights were not working in the staff room, and the external light outside the main entrance was not working. We were also told that the staff toilet regularly gets blocked.

We also found broken glass on the paths outside the unit, and we were told that staff have regularly reported anti-social behaviour that has occurred on the wider hospital site at night. Our team felt that this would not provide a good first impression to patients and their families as a safe place to receive care. Two out of the five staff members who completed a questionnaire also answered that the environment was not suitable for patient needs.

The health board must ensure maintenance issues identified by staff are resolved in a timely manner and that estates work is undertaken to improve the external appearance of the building and the adjacent areas outside the unit.

It was difficult to find the unit on the first night of the inspection as it was not well signposted throughout the hospital site. The health board may wish to consider improving the signage to ensure patients, families and visitors are able to easily locate the unit.

Risk management
We were not fully assured that there were processes in place to suitably manage and review risks to help maintain the health and safety of patients, staff and visitors at the unit. Staff wore personal alarms which they could activate in the event of an emergency. Staff knew where the ligature cutters were located throughout the unit for use in the event of a self-harm emergency. There were weekly audits of resuscitation equipment and staff had documented when these had occurred to ensure that the equipment was present and in date.

However, some improvements were required.

We saw that the Occupational Health and Safety Policy was due for a review in March 2022 and was therefore out of date.

The health board must ensure that policy is updated and shared with staff once ratified.

Regular ligature point risk assessments had been undertaken which identified what actions had been taken to remove or manage potential ligature points. However, we noted though that the most recent ligature risk assessment undertaken in February 2024 did not identify a bariatric bed in a patient bedroom as a potential ligature risk. We raised this with staff who immediately updated the ligature risk assessment to include this risk and the factors taken to mitigate against it. We understand that it is not possible to identify and eliminate every potential ligature risk. However, our team felt that the ligature risks associated with bariatric and other medical beds are well known and should have been identified as part of the original risk assessment.

The health board must ensure that all ligature risks are identified (within reason) as part of their ligature risk assessment.

We were told that a 'Hospital Environment Board' (HEB) checklist had been introduced since our previous inspection. The HEB checklists were being carried out every three months to identify any issues throughout the unit. However, we were not assured that there was suitable oversight of the completed HEB checklists to ensure that actions would be taken in response to any risks that had been identified. For example, during the first night of our inspection we saw that a fire extinguisher in the communal bathroom had not been serviced since 2021. We raised this with staff who arranged for the fire extinguisher to be serviced the following day. During a review of previous HEB checklists, we noted that it had been identified in May 2023 that the fire extinguisher required servicing. It is not acceptable that this issue was not resolved until our inspection.

The health board must improve the process of auditing and monitoring the HEB checklists to ensure that any issues identified are prioritised and actioned in a timelier manner.

Infection, prevention and control (IPC) and decontamination
We found suitable IPC arrangements in place on the unit. An up-to-date IPC policy was available that detailed the various procedures in place to keep staff and patients safe. All areas of the unit appeared to be visibly clean and tidy.

A designated IPC lead had been appointed and there appeared to be a collective approach towards implementing IPC procedures among nursing, housekeeping, and

maintenance staff. Regular audits, such as hand hygiene audits, had been completed to check compliance with IPC procedures.

The majority of staff members who completed a questionnaire agreed that there were effective infection prevention and control practice measures in place. We saw evidence that staff had completed appropriate IPC training and the staff we spoke with during the inspection showed good awareness of their responsibilities around infection prevention and control.

We were told by staff members that storage was an issue, with one of the unused patient bedrooms currently being used to store broken or unwanted equipment.

The health board must review the storage capacity on the unit and ensure that any broken or unwanted equipment is removed in a timely manner.

We noted that staff were required to wear uniforms while working at the unit. However, we were told that there were no changing facilities on the unit, which meant staff had to often change in the staff toilet which created an infection control risk.

The health board must provide suitable changing facilities for staff to change their uniforms prior to and following their shifts.

Safeguarding of children and adults
We found suitable measures in place to safeguard vulnerable adults. An up-to-date safeguarding policy was in place which set out the procedures for staff to follow in the event of a safeguarding concern. The staff members we spoke with during the inspection were clear on how to apply these procedures in the context of their duties. This included identifying and acting upon safeguarding matters. We reviewed training data and found that staff received regular training relevant to their roles.

There was good oversight of safeguarding matters at a management level by senior nursing and health board safeguarding teams. These matters were discussed at relevant governance meetings for review and monitoring.

Management of medical devices and equipment
Staff informed us that they had previously submitted a request to the health board for medical equipment to undertake blood pressure and oxygen checks on patients. However, the medical equipment has not yet been supplied which has meant that staff have had to purchase and use one bought externally from a shop.

The health board must ensure all required medical equipment is provided to the unit and calibrated and serviced appropriately to ensure accurate patient observations can be undertaken.

Medicines management
We found suitable medicines management procedures in place. We noted a significant improvement in the appearance and tidiness of the clinic room. Medication was now well organised and stored securely. We observed staff locking the medication cupboards and fridges when not in use. We saw that daily temperature checks of the clinic room and medication fridge were being recorded. However, we found a small number of gaps on the temperature recording sheets for both.

The health board must remind staff of the importance of undertaking and documenting such checks.

A pharmacist visited the unit each week to provide support to staff. This included undertaking regular stock checks. We saw that controlled drugs were being recorded and signed for correctly. A file was being kept in the clinic room for staff to record all medication ordered and subsequently delivered to the unit. However, we noted some instances where staff were not signing to record that the medication had been received.

The health board must remind staff of the importance of undertaking and documenting such checks for audit purposes and stock control.

It was positive that discussions by the MDT members about the dose and effectiveness of medication prescribed for patients were taking place during ward rounds. However, we did note that one patient was receiving regular medication via intramuscular injection (IM) which was often being administered using supine restraint. We were told that the patient was due to be discharged soon from the unit, and that the patient would not require IM medication when they are in the community. This meant we were not assured that the prescription for receiving IM medication while in the unit was appropriate for the patient, particularly given that it has been administered using supine restraint on occasions.

The health board must review the prescription of IM medication for the patient, and the use of supine restraint to administer, to ensure it continues to be in the best interest of the patient.

We viewed a sample of Medication Administration Records (MAR charts) and found they were being maintained to a good standard. The MAR charts were consistently signed and dated when medication was prescribed and administered, and a reason

recorded when medication was not administered. We noted that photographs of the patients were now included alongside the MAR charts, which was an improvement since our previous inspection. However, we saw that consent to treatment certificates were being stored in a separate folder to the MAR charts, which made it more difficult for nursing staff to check whether they were administering medication that reflected the consent to treatment forms.

The health board should ensure that all consent to treatment forms are stored alongside the MAR charts to make them more easily accessible to nursing staff.

Effective

Effective care

The unit has adopted the principles of the safewards model. Principles of positive behavioural support (PBS) were being used to determine level of risk and encourage positive risk taking. PBS plans were detailed and included personalised strategies for preventing and managing challenging behaviour.

However, as previously mentioned in the report, we noted that IM medication was often being administered to one patient using supine restraint. We did not see evidence within the PBS plan for this patient that the MDT had agreed and prescribed supine restraint as the least restrictive or safest option to administer the IM medication.

The health board must ensure that PBS plans detail any prescriptions of supine restraint when administering IM medication and the rationale for why this intervention is required as opposed to alternative less restrictive options. The PBS should also detail the review arrangements in place in relation to the prescription.

We also could not see evidence of a risk assessment in place that determined its suitability and the mitigations in place to ensure the administering of IM medication while under restraint is undertaken safely.

The health board must develop a risk assessment for the administration of IM medication while under restraint to ensure it is appropriate and undertaken safely.

We were told that staff would observe patients more frequently if patients continued to present with increased risks. An enhanced care area was available on the unit should patients require extra monitoring or support. We saw that the enhanced care area was fit for purpose and that observations could be carried out

through a monitoring window. We reviewed the enhanced observation documentation and saw that the records were being completed appropriately, which was a positive improvement since the last inspection.

Incidents of restraint were being recorded electronically by staff on Datix. However, we noted that the reporting proformas did not capture the reasons for why restraint was used, or what actions had been taken prior to the restraint taking place. This meant it was difficult to conclude whether the restraint had been undertaken as a last resort. We raised this with staff who amended the proformas to include this information going forward.

We did not see evidence of individual restraint or restrictive practice reduction plans in place. We raised this with staff, who discussed the possibility of implementing a template that was currently being used by community learning disability teams.

The health board must provide an update on progress made towards ensuring restraint or restrictive practice reduction plans are developed for patients that require them.

During the inspection we observed a training day workshop that centred on the history of one of the patients on the unit. The workshop was well attended by professionals from the MDT and local community. The session was jointly led by the patient and a psychologist, and discussions centred on identifying triggers and patterns between the patient, staff and other patients to mitigate escalating behaviour. The workshop also discussed interventions that could be used such as family therapy alongside other therapies. We found the workshop to be an excellent example of person-centred multidisciplinary teamwork.

Nutrition and hydration

We saw evidence that the dietary needs of patients had been assessed on admission using the Malnutrition Universal Screening Tool (MUST). We saw that specific dietary needs had been identified where necessary. We were told that a Speech and Language Therapist was available on site who assesses each patient and provides advice where necessary. Patients could also be referred to the dietetic service when required.

We saw evidence that specific dietary needs had been identified within the care and treatment plans, and saw evidence that patients were receiving ongoing weight management checks during their time on the unit.

Food was provided to patients by the local general hospital. Patients were able to choose their meals from a menu each morning. A pictorial guide was available for

patient to understand the breakfast menu, which we noted as good practice. Staff informed us that they were working on producing visual aids for other mealtimes as well. Patients had access to hot and cold drinks and could have their own snacks. Staff told us that they monitor the number and types of snacks patients have to ensure they don't have a negative impact.

Patient records

Patient records were being maintained on paper files and electronically. We saw that paper records were being stored securely. The electronic records were password protected to prevent unauthorised access and breaches in confidentiality.

During the inspection we undertook a comprehensive review of the patient records for one of the patients on the unit. It was not always easy to navigate due to some information being available online and some information being kept in paper files. For example, we saw some assessments were being stored electronically on the Welsh Community Care Information System (WCCIS), while other information such as PBS and care and treatment plans were being maintained on paper. The health board may wish to consider reviewing where information is stored to make it easier for staff to find relevant information regarding the care and treatment of each patient.

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.

Mental Health Act monitoring

We reviewed the statutory detention documents of three patients on the unit. All records verified that the patients were being legally detained. Clear reasons were being documented to evidence why detention under the Act was the most appropriate way of providing care for patients.

The statutory documentation was being stored electronically, on paper files at the unit, and on paper files in the Mental Health Act administrator's office in St Cadoc's Hospital. This added some confusion in finding relevant documentation. For example, the Approved Mental Health Professional (AMHP) paperwork was being stored at St Cadoc's and not at the unit. We raised this with the administrator who assured us that copies of the AMHP paperwork would be stored on the unit in future.

We also noted that records of the Statutory Consultees consultations with the Second Opinion Appointed Doctors (SOAD) were not being kept. We again raised

this with the administrator who told us that they would develop a form for Statutory Consultees to complete following their consultations with a SOAD.

The health board must provide an update to HIW on progress made with the development of the Statutory Consultees form and whether this has been embedded into practice.

Some improvements were required in relation to the documentation for patients granted leave under Section 17 of the Mental Health Act. We did not see evidence on the Section 17 forms of any identified risks in relation to each period of leave and any mitigating factors to take to reduce any risks.

The health board must ensure that any periods of Section 17 leave are suitably risk assessed and documented on the Section 17 leave form.

We also noted that although there was space on the Section 17 form to record whether patients had received, or been offered, a copy of the form, this wasn't always being completed.

The health board must ensure that staff record on the Section 17 leave form whether patients have received or been offered and refused, a copy of the form.

We noted some instances where patients were being referred to with different names throughout their patient records and legal documentation. For example, Datix incidents and Section 17 leave forms were being completed for one patient but contained different names on each. The health board should ensure that staff use the same name for the patient to avoid confusion, particularly on the legal documentation.

We saw that monthly audits of the legal documentation were being undertaken to monitor compliance with the statutory requirements. We were informed that a new Audit Management and Tracking (AMaT) system was due to be implemented by the health board which includes scrutiny of 15 areas of service which will include compliance with the Mental Health Act.

We saw that compliance with Mental Health Act training amongst staff members was low at 38 per cent. We were told that an informal training programme was being rolled out throughout the division to improve compliance.

The health board must ensure that all staff complete their Mental Health Act training and provide on update to HIW on the latest compliance figure.

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

The care and treatments plan we reviewed reflected the criteria set out by the Mental Health Measure Wales 2010. It was well detailed, individualised and reflected a wide range of MDT involvement. Entries were comprehensive and recognised assessment tools were used to monitor mental and physical health. The care and treatment plan identified a range of interventions, including therapeutic and social activities, which were appropriate and able to meet the patient's needs. It was also evident that the patient had been involved in co-producing their care and treatment plan.

We noted that the patient's language choice and preference had not been recorded within the care and treatment plan.

The health board must ensure that the language choice and preference for each patient is identified and recorded so relevant language needs can be met.

We saw evidence that the care and treatment plan had been reviewed regularly and in a timely way.

Efficient

Efficient

Arrangements for discharge and admission out of and into services appeared to be robust and efficient. Patients are discharged with a contingency plan should readmission be required. The MDT monitor patient progress post discharge to enable early intervention if needed. We saw evidence that families and/or carers of patients are invited to be involved in discussions about discharge planning when appropriate. We were told of instances where unit staff have actively worked alongside patients in the community following their discharge to help provide additional support.

Quality of Management and Leadership

Staff feedback

All five staff members who completed a questionnaire said that they were satisfied with the quality of care and support they give to patients and that they would recommend their setting as a place to work.

Four out of the five staff members who completed a questionnaire agreed that care of patients is their organisation's top priority and that they were happy with their organisation's efforts to keep staff and patients safe.

All five staff members who completed a questionnaire agreed that their current working pattern provided a good work-life balance. However, two out of the five staff members disagreed with the statements 'In general, my job is not detrimental to my health' and 'My organisation takes positive action on health and wellbeing'. The health board should consider this aspect of the feedback and engage with staff to identify any areas for improvement.

Other staff questionnaire results appear throughout this section of the report.

Leadership

Governance and leadership
It was positive to see that improvements had been made in several areas since our previous inspection at the hospital. There appeared to be good culture and attitude among staff in working towards improving the quality of care and treatment provided to patients.

An action plan had been developed following our previous inspection and we saw that good progress had been made, with most actions being completed. However, staff must ensure that the implemented actions are embedded into the day-to-day working of the service. For example:

- One completed action was the introduction of pen profiles for each patient describing their likes and dislikes. When we reviewed the pen profiles, we saw that two current patients did not have pen profiles, while there were pen profiles for two patients who were no longer at the unit
- Another completed action was the implementation of a healthy eating initiative, which included identifying a healthy living champion and re-introducing the healthy living group. However, when we spoke with staff they told us that the healthy eating initiative had not been implemented.

The health board must ensure that actions from the improvement plan are embedded into the business processes for the service and monitored to track progress.

All five staff members who completed a questionnaire said that they knew who the senior managers were at the organisation and that they were committed to patient care. Four out of the five staff members who completed a questionnaire felt that communication between senior management and staff was effective.

Workforce

Skilled and enabled workforce

During the inspection we observed a positive culture with good relationships between motivated staff who we observed working well together as a team. Staff we spoke with during the inspection felt well supported by the unit manager, senior managers and on-call staff. All five staff members who completed a questionnaire provided positive feedback about their immediate line manager.

Two out of the five staff members who completed a questionnaire felt that they did not have enough time to give patients the care and attention they need and also felt that there were not enough staff for them to do their job properly. One member of staff gave the following answer when asked how the setting could improve the service it provided:

> *"Provide adequate staffing to allow for mental health breaks - time off the observations and manage other daily tasks on the ward as well as keep up compassion levels and ensure staff well-being/safety."*

However, staffing levels appeared to be appropriate to maintain patient safety within the unit at the time of our inspection. Nonetheless, the health board should be mindful of the comments and feedback provided by staff. It was positive to note that the use of agency staff had been reduced since our previous inspection.

We saw that suitable processes were in place for senior staff to monitor compliance with mandatory training. Compliance levels amongst staff with mandatory training were high. Four out of the five staff members who completed a questionnaire told us that training helped them do their job more effectively and deliver a better patient experience.

The introduction of the staff training days appeared to be a valuable addition to the development of the team. Staff provided positive feedback during the inspection and felt that they were a useful tool to help disseminate important information to the team.

Senior managers informed us that 90 per cent of staff members had received their annual appraisal to discuss their performance and set annual objectives. All five staff members who completed a questionnaire confirmed that they had received an appraisal of their work in the last 12 months.

Culture

People engagement, feedback and learning
Weekly 'mutual help' meetings took place where patients could engage and provide informal feedback to staff about any issues they may have. A 'You said, we did' board was on display which highlighted the actions taken by staff in response to issues raised by patients. However, although the board was dated April 2024, we noted that one of the actions on the board informed patients that food would soon be provided by the local general hospital rather than by the local county hospital. This change occurred in November 2023, so we were not assured that the board was displaying the most recent information.

The health board must ensure the 'You said, we did' board is kept up to date to keep patients informed of actions taken in relation to any current issues raised.

We saw clear information displayed on the unit about how patients and their families or carers could provide formal feedback about their care. A 'How do I make a complaint?' poster was displayed by the entrance which contained the names of the unit manager, senior nurse and the Putting Things Right lead. We also noted that the contact details for local advocacy services and HIW were displayed should patients wish to make contact. Four out of the five staff members who completed a questionnaire said that they received regular updates on patient experience feedback.

All staff members who completed a questionnaire said that their organisation encouraged them to report errors, near misses or incidents and agreed that their organisation takes action to ensure such incidents are not repeated.

Information

Information governance and digital technology
We saw that there were established local procedures in place to provide guidance to staff. However, during our previous inspection we identified that several health board policies were out of date. It was therefore disappointing to find that some health board policies remained out of date. These included key policies for patient safety such as medicines management, use of restrictive physical intervention and safeguarding.

The health board must review any outdated policies as a matter of priority to ensure that policies and procedures are kept up to date and provide clear guidance to staff. The health board must also provide an update to HIW on when the policies identified in this report, and our previous inspection report, will be ratified.

Learning, improvement and research

Quality improvement activities

We observed an improvement since our previous inspection in relation to the oversight of audit activities and reportable incidents to monitor the quality of the care and treatment being provided. It appeared that staff had been empowered to take more ownership and accountability. The unit manager now had responsibility to investigate and sign-off incidents. A Service Improvement Manager had been recruited to help drive forward improvements. The introduction of the new AMaT system will also help staff evaluate its service provision.

We saw that a range of regular management meetings were taking place to discuss issues with staffing, bedding and incidents. This included a quarterly Quality Patient Safety and Experience meeting. However, we noted that there had been no attendance from unit staff members at the previous two meetings (November 2023 and February 2024. The health board should ensure that the unit is represented at these meetings whenever possible to ensure ongoing communication is maintained.

Whole-systems approach

Partnership working and development

We saw evidence of appropriate discharge and aftercare planning in the care and treatment plan we reviewed, with good involvement from the MDT, care co-ordinators and relevant partner services within the local community.

Four out of the five staff members who completed a questionnaire agreed that partnership working with other organisations is effective.

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: NHS Hospital, Aneurin Bevan University Health Board

Date of inspection: 22, 23 and 24 April 2024

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

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
No immediate assurance issues were identified on this inspection.					

Appendix C - Improvement plan

Service: NHS Hospital, Aneurin Bevan University Health Board

Date of inspection: 22, 23 and 24 April 2024

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan, telling us about the actions they are taking to address these areas.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	There were some loose boards in the decking area of the garden which presented as a falls risk to patients.	The health board must ensure that the loose decking boards are repaired.	Health promotion	Immediately escalated to Works and Estates for repair.	Ward Admin/Manager	Complete 03/05/24
				Now part of Weekly Check and Garden Risk Assessment to ensure any issues are escalated to Works and Estates immediately.		Complete and ongoing from 03/05/24
2.	We felt further improvement could be made in relation to the creativity and variety of therapeutic activities on	The health board must review the existing programme of therapeutic activities and work with patients to strengthen the quality, variety, and effectiveness of the	Individualised Care	A personalised timetable is now completed each week for each individual.	OT/Ward Clinical Lead/Ward Manager	Complete 03/07/24
				'Healthy Eating' Group has been developed, led by HCSW.	Ward Manager	From 31/08/24
				‘Mutual Help’ are now established meetings and continue to be held every	Ward Manager	Ongoing

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	offer to patients.	activities on offer for patients.		Monday where the week's activities are discussed and planned.		
				Itinerary of all activity equipment being completed.	Ward Manager	By 31/07/24
				OT exploring further options for therapeutic activity based on assessment of occupational need and 'mutual help' meetings and will continue to work with MDT to increase provision.	Occupational Therapist	By 31/07/24
				The OT has increased time they are ward-based.		04/06/24
3.	A concern was raised to us that in some instances staff accidentally used language or phrases that were known trigger points to patients on the unit.	The health board must ensure that all staff members are aware, and understand, whether there are specific words and phrases that should not be used around patients in case it risks escalating behaviour.	Communication and language	This feedback has been addressed in Ty Lafant Away/Training Days.	Ward Manager	Completed 21/05/24 and 25/06/24
				This is also described in the individual's 'pen profile' for staff awareness and understanding.	Ward Manager	Complete

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
4.	The telephone line in the nursing office wasn't working during the inspection.	The health board must ensure the telephone line is repaired so patients can use it should they wish to do so.	Rights and equality	Handset has been replaced and phone now working.	Ward Manager	Completed 01/05/24
5.	We found areas for improvement in relation to the internal and external appearance of the unit and building.	The health board must ensure maintenance issues identified by staff are resolved in a timely manner and that estates work is undertaken to improve the external appearance of the building and the adjacent areas outside the unit.	Environment	As soon as estates issues are raised, they are triaged for urgency and appropriate staff attend to resolve the issue as soon as possible. Any delays will continue to be escalated via the Directorate/Divisional Management team.	Divisional Manager, Facilities	Ongoing
				Unresolved maintenance issues will continue to be escalated to Directorate Manager for escalation to General Manager if they remain unresolved.	Directorate Manager	Ongoing
6.	The Occupational Health and Safety Policy was due for a review in March 2022 and was	The health board must ensure that policy is updated and shared with staff once ratified.	Risk management	This is currently under review, led by the Health and Safety team.	Head of Health and Fire Safety	November 2024

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	therefore out of date.					
7.	The February 2024 ligature risk assessment did not identify a bariatric bed in a patient bedroom as a potential ligature risk.	The health board must ensure that all ligature risks are identified (within reason) as part of their ligature risk assessment.	Risk management	Ward Ligature Risk Assessment was updated 23 April 2024. Ward Managers must review the environmental ligature risk assessment when any new furniture or large equipment is brought on to the unit. A prompt will be included in the weekly checklist for clinical lead nurses. This will be shared across the Division	Clinical Lead Nurse, Ty Lafant	Completed 23/04/24
8.	We noted that an issue (out of date fire extinguisher) had been identified in the May 2023 HEB checklist but that it had not been resolved until our inspection.	The health board must improve the process of auditing and monitoring the HEB checklists to ensure that any issues identified are prioritised and actioned in a timelier manner.	Risk management	Fire Extinguisher has been replaced.	Ward Admin/Fire Safety Officer	Immediately Completed 23/04/24
				The Health Board commissions an external company to complete appropriate checks. This issue was raised to the Fire Safety Officer for awareness.	Deputy Head QPS	Complete 16/07/24
				Updated contact details of Fire Officers have been shared with the Division.	Deputy Head QPS	Complete 17/07/24

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
9.	We were told that storage was an issue within the unit, with one of the unused patient bedrooms currently being used to store broken or unwanted equipment.	The health board must review the storage capacity on the unit and ensure that any broken or unwanted equipment is removed in a timely manner.	Infection, prevention and control (IPC) and decontamination	Broken equipment has been disposed of.	Ward Manager	Completed 01/05/24
				Unused bedrooms have been repurposed to storage area.	Ward Manager/ Senior Nurse	Completed 16/07/24
10.	We were told that staff often have to change in the staff toilet as there were no changing facilities on the unit.	The health board must provide suitable changing facilities for staff to change their uniforms prior to and following their shifts.	Infection, prevention and control (IPC) and decontamination	Changing areas identified as the Staff room in Alders House (opposite) and/or Staff room on Ty Lafant as the door can be locked.	Ward Manager/Admin	Completed 14/06/24
				Email to be sent to all staff to advise of this.	Service Improvement Manager	Completed 24/07/24
11.	Staff are currently using medical equipment purchased externally from	The health board must ensure all required medical equipment is provided to the unit and calibrated and serviced appropriately	Management of medical devices and equipment	New machine ordered Expected delivery 21 August 2024.	Ward admin	Ordered 16/07/24 Completion anticipated August 2024

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	a shop rather than medical equipment supplied by the health board.	to ensure accurate patient observations can be undertaken.		The Division's physical health monitoring policy includes a checklist of equipment required in each ward area and an audit tool to be completed every 6 months by the Ward Manager or their delegate. Reminder email sent across the Division to alert WMs to the standards required within the policy and ensure these are built into the ward accreditation audits.	Deputy Head of QPS	24/07/24
12.	We found a small number of gaps on the clinic room and medication fridge temperature recording sheets.	The health board must remind staff of the importance of undertaking and documenting such checks.	Medicines management	Medication fridge and clinic room temperature monitoring audits are now completed as part of the weekly ward audit schedule.	Clinical Lead Nurse	Complete 24/04/24 and ongoing
				Ward Manager will review on a weekly basis and escalate any concerns to Senior nurse, who will monitor for any themes. Any themes will be reported via the Directorate QPS meeting for learning and resolution.	Ward Manager/ Senior Nurse	Complete 19/07/24 and ongoing
13.	We saw some instances where staff	The health board must remind staff of the importance of	Medicines management	Review of these records is now part of ward weekly checks.	Clinical Lead Nurse	Complete 24/04/24 and ongoing

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	were not signing to record that medication had been received by the unit.	undertaking and documenting such checks for audit purposes and stock control.		Ward Manager will review on a weekly basis and escalate any concerns to Senior nurse, who will monitor for any themes. Any themes will be reported via the Directorate QPS meeting for learning and resolution.	Ward Manager/ Senior Nurse	Complete and Ongoing 19/07/24
14.	We were told that one patient was receiving regular medication via intramuscular injection (IM), which was often being administered using supine restraint.	The health board must review the prescription of IM medication for the patient, and the use of supine restraint to administer, to ensure it continues to be in the best interest of the patient.	Medicines management	The patient is reviewed at the weekly multi-disciplinary meeting to ensure that care is proportionate to need. This has involved the oversight of another consultant psychiatrist to ensure good governance. IMHA is actively involved in this care review. Ward Reducing Restrictive Practice guidance to be developed to ensure this procedure is clear and followed for all patients. This will be developed to encompass the themes raised in points 16-18 of this plan too.	Ward Manager Deputy Head of QPS	Complete and ongoing weekly End of September 2024
15.	Consent to treatment certificates	The health board should ensure that all consent to treatment	Medicines management	Certificates were immediately refiled to same file as MAR charts.	Ward Manager	Completed 24/04/24

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	were being stored in a separate folder to the MAR charts.	forms are stored alongside the MAR charts to make them more easily accessible to nursing staff.				
16.	One patient was receiving IM medication which had not been included in the prescription section of the patient's PBS plan.	The health board must ensure all relevant prescribed medication is included in the PBS plans for each patient.	Effective care	This was updated immediately and discussed further with staff as part of ward training day.	All staff/Ward Clinical lead	Completed 24/04/24 and Training Day 25/06/24
				Risks continue to be formulated in the WARRN and management plans reviewed at the weekly MDT meeting.	Nursing staff	Ongoing
				PBS plans continue to be updated as required following weekly MDT meeting and will be reviewed as part of weekly checks.	Ward Manager	Ongoing
				Ward Manager has reminded staff of completing all sections of the plan.	Ward Manager	Completed Training day 25/06/24
17.	We did not see evidence of a risk assessment in place to determine the	The health board must develop a risk assessment for the administration of IM medication while under	Effective care	Where a patient has received IM medication in restraint on 2 occasions, this will trigger PBS plan review. The PBS plan must be updated to include the risk	Ward Manager	Completed 17/07/24

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	mitigations in place to ensure the administration of IM medication while under restraint is undertaken safely.	restraint to ensure it is appropriate and undertaken safely.		assessment to guide this practice in the future and the threshold for further review if required outside of the weekly MDT meeting.		
				Ward Manager will review on a weekly basis and escalate any concerns to Senior nurse, who will monitor for any themes. Any themes will be reported via the Directorate QPS meeting for learning and resolution.	Ward Manager/ Senior Nurse	Completed 17/07/24
18.	We did not see evidence of individual restraint or restrictive practice reduction plans in place.	The health board must provide an update on progress made towards ensuring restraint or restrictive practice reduction plans are developed for patients that require them.	Effective care	The Directorate will test the template used by community LD teams with a view to amending it as required for inpatient.	Lead Nurse, LD	By end of July 2024
				The Health Board will also liaise with other Health Boards to discover what plans are in use elsewhere and further discuss at the Division's QPS meeting in September 2024.	Deputy Head of QPS	October 2024
19.	Records of the Statutory Consultees consultations with the Second Opinion	The health board must provide an update to HIW on progress made with the development of the Statutory Consultees form and	Mental Health Act monitoring	SOAD documentation has been requested from the MHA Admin department and will be added to the appropriate patients' paper notes.	Ward Manager	Completed 15/07/24

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	Appointed Doctors (SOAD) were not being kept anywhere.	whether this has been embedded into practice.				
20.	Section 17 forms did not indicate any identified risks in relation to each period of leave and any mitigating factors to take to reduce any risks.	The health board must ensure that any periods of Section 17 leave are suitably risk assessed and documented on the Section 17 leave form.	Mental Health Act monitoring	Risks and mitigating factors are recorded in the clinical records rather than the s17 leave form. The Health Board's S17 leave form is devised in accordance with para 27.17 MHA Code of Practice (Wales) 2017. This issue to be raised at the Senior Psychiatrists Forum (RCs are currently all psychiatrists in ABUHB) for awareness and discussion. It is also noted that there are frequently times when adding mitigations to forms (which patients are offered a copy of) may not clinically be in their best interests, as this can alert to information which would increase the clinical risk profile.	Deputy Head of QPS	September 2024

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
21.	We also noted that although there was space on the Section 17 form to record whether patients had received, or been offered, a copy of the form, this wasn't always being completed.	The health board must ensure that staff record on the Section 17 leave form whether patients have received or been offered and refused, a copy of the form.	Mental Health Act monitoring	Ward RCs made aware of this to ensure documentation has been appropriately completed.	Ward Staff/Ward Manager/Consultants	Implemented Immediately 24/04/24
				Checklist developed to identify whether patients have been offered a copy of the Section 17 form.	Ward Manager	Completed 15/07/24
				This will be checked in the weekly Ward Round.	Ward Manager	Completed 15/07/24
22.	We saw that compliance with Mental Health Act training amongst staff members was low at 38 per cent.	The health board must ensure that all staff complete their Mental Health Act training and provide on update to HIW on the latest compliance figure.	Mental Health Act monitoring	Ward Manager liaising with MHA Trainer to arrange bespoke training updates for Ty Lafant staff. NB. Dates requested following the holiday period to facilitate better attendance.	Ward Manager	End of September 2024
23.	The patient's language choice and preference had	The health board must ensure that the language choice and preference for each	Monitoring the Mental Health (Wales)	Language choice and preference has been updated in this person's records.	Ward Manager	Completed 15/07/24

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	not been recorded within the care and treatment plan.	patient is identified and recorded so relevant language needs can be met.	Measure 2010: care planning and provision	'Top Tip Tuesday' briefing poster to be circulated within the Division to remind staff of the importance of recording language and communication choices.	Deputy Head of QPS	End of July 2024
24.	We saw some actions that had been marked as completed in the improvement plan had not been kept up to date, or actually been implemented.	The health board must ensure that actions from the improvement plan are embedded into the business processes for the service and monitored to track progress.	Governance and leadership	Healthy Eating Group will commence 31 August 2024.	Ward manager	August 2024
				PEN profiles have been completed for all individuals on the ward.	Ward Manager	Completed
				The presence of a quality PEN profile in the clinical notes has been added to ward's weekly clinical audit, to ensure ongoing monitoring and oversight, with appropriate escalation to Ward Manager and/or Senior Nurse as required.	Ward Manager/ Senior Nurse	From 19/07/24
25.	We were not assured that the 'You said, we did' board was displaying the most	The health board must ensure the 'You said, we did' board is kept up to date to keep patients informed of actions taken in	People engagement, feedback and learning	Issues are added in the weekly 'Mutual Support' meeting. Ward Manager now audits this weekly.	Ward Manager	Completed

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	recent information.	relation to any current issues raised.				
26.	Some health board policies remained out of date.	The health board must review any outdated policies as a matter of priority to ensure that policies and procedures are kept up to date and provide clear guidance to staff.	Information governance and digital technology	Medicines Management Policy is currently being reviewed.	Head of Pharmacy, Operational Services	October 2024
				Draft Restrictive Physical Interventions Policy is complete. Consultation to be arranged as part of ratification process.	Head of Health, Safety and Fire	August 2024
				Equality and Diversity Policy is under review.	Equality, Diversity and Inclusion Specialist, WOD	November 2024
				Note: the safeguarding policy used within ABUHB is the 'Wales Safeguarding Procedures' which are within date.	N/A	N/A
27.	Some health board policies remained out of date.	The health board must also provide an update to HIW on when the policies identified in this report, and our previous inspection report, will be ratified.	Information governance and digital technology	The Head of Corporate Governance will provide updates as requested when policies are complete.	Head of Corporate Governance	October 2024

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): Nadine Gould

Job role: Interim Divisional Lead Nurse, MHLD

Date: 17 July 2024