Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

St Barruc's Ward, Barry Community Hospital, Cardiff & Vale University Health Board

Inspection date: 3, 4 and 5 June 2024
Publication date: 5 September 2024

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Digital ISBN 978-1-83625-580-2
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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

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1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Barry Community Hospital, St Barruc's Ward, Cardiff and Vale University Health Board on 3, 4, and 5 June 2024. The following hospital wards were reviewed during this inspection:

- St Barruc's Ward - 14 bedded young onset dementia unit situated in Barry Community Hospital.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of seven questionnaires were completed by patients or their carers and insufficient questionnaires were completed by staff. However, we spoke to staff during our inspection 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.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found a dedicated staff team that were committed to providing a high standard of care to patients. Overall, we found evidence that the service provided safe and effective care.

Staff were knowledgeable of each patient and strove to provide individualised care. We observed genuine kindness, warmth and respect between staff and patients.

We found there was limited information displayed to help patients and their families or carers understand their care.

This is what we recommend the service can improve:

- Provide health information on the ward for patients and visitors.

This is what the service did well:

- Good access to a variety of different activities for patients.

Delivery of Safe and Effective Care

Overall summary:
Staff appeared committed to providing safe and effective care. There were established processes in place to support staff to provide care. We found that in most cases staff were completing clinical processes as required.

Throughout the inspection we observed staff using effective de-escalation skills with patients, and it was evident that staff were very skilled in this area.

Suitable protocols were in place to manage risk, health and safety and infection control. However, improvements are required in relation to medication management surrounding administration of controlled drugs and Home Office pharmacy licence.

Further improvements need be made to the ward environment and hospital grounds to make it more welcoming for visitors and patients.

This is what we recommend the service can improve:

- Redecoration of ward and communal areas

- Estates response to environmental issues requires improvement
- Maintenance of the outdoor garden areas
- Access to Psychology support for patients
- Medication management.

This is what the service did well:

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff.

Quality of Management and Leadership

Overall summary:
We observed a committed staff team who had a good understanding of the needs of the patients at the hospital. We found a friendly, professional and kind staff team who demonstrated a commitment to providing high quality care to patients. There was dedicated and passionate leadership displayed by staff, the ward managers and senior leadership team.

We found an effective governance structure in place in terms of meetings to discuss incidents, complaints and issues related to patient care. However, some improvements are required in relation to the health board putting timely and appropriate measure in place regarding the isolation of the hospital and provisions for staff and patients.

This is what we recommend the service can improve:

- Availability of services and provisions to patients and staff
- Qualified nursing coverage at night.

This is what the service did well:

- Motivated and patient focussed team
- Staff teams were cohesive and positive about the support and leadership they received from ward managers, deputies and senior nurse
- Completion of mandatory training compliance.

3. What we found

Quality of Patient Experience

Patient feedback

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

Patient comments included:

"Staff are kind."
"Very good service, staff are amazing".

Person-centred

Health promotion

St Barruc's had a range of facilities to support the provision of therapies and activities along with regular access to the community for patients that were authorised to leave the hospital.

The occupational therapy (OT) staff had an excellent variety of activities programme in place, and it was clear to see that the OT department were providing some beneficial therapeutic activities for the patient group. Patients were able to participate in music in motion, buttercup choir day and a therapy dog would also attend the hospital. Patients also had access to the veteran service.

There was also input from other professionals such as physiotherapy, dietetics and speech and language therapy depending on individual patient needs. However, access to these services were limited as they were not based at the hospital, meaning that patients had limited access in comparison to patients with similar conditions based in Llandough Hospital.

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

Dignified and respectful care

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

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

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

None of the bedrooms were en-suite bedrooms, however patients had access to shared communal bathrooms. All rooms have closable observation panels that can be open or closed from the outside. Patients can lock bedroom doors, however staff could override this when necessary. We saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering.

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

The ward provided mixed gender care which can potentially present challenges around aspects of dignified care. It was therefore positive to find that staff were knowledgeable and had effective safeguards and processes in place to manage these challenges to ensure that dignified care was maintained.

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

Individualised care

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

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

Patients and family carers were fully involved in monthly multidisciplinary reviews.

Timely

Timely care

The health board held adequate bed status management and patient information meetings to discuss occupancy levels, and any emerging patient issues.

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

We found that there was a mix of acuity and dependency of patients receiving care on the ward. There were recently admitted individuals and patients assessed as suitable for discharge and awaiting suitable long term care home placement in the community. We found that the mix of patients was not causing any adverse issues at the time of the inspection. Staff told us that they were usually able to effectively meet the varying care demands due to there being enough staff on duty to provide increased, one to one support and supervision when required.

Due to the complex care needs of some patients, it was positive to see that staff, who were providing one to one support and supervision, regularly rotated to ensure that optimal care was being always provided.

We found that there were generally adequate discharge planning systems in place.

Equitable

Communication and language

All patients we spoke with stated that they felt safe and able to speak with a staff member should they need to. Patients told us they were happy at the hospital and that staff were kind and helpful. There was clear mutual respect and strong relational security between staff and patients. Throughout the inspection we observed staff engaging and communicating in a positive and sensitive way with patients, taking time to help them understand their care using appropriate language.

There was a good mix of Welsh and English-speaking staff working on the ward. This allowed patients to receive care in the language of their choice. We were told that translation services could be accessed should patients need to communicate in other languages.

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

We noted there was limited information displayed in the hospital to help patients and their families understand their care. There were no details on display about organisations that can provide help and support to patients and families affected by mental health conditions.

There was no information available on display on the role of HIW and how patients can contact the organisation. This is required by the Mental Health Act 1983 Code of Practice for Wales. In addition, there was no information on how patients or family members could make complaints.

The health board must make sure that particular attention is paid to what information is displayed. Information displayed must be relevant to patients and visitors.

Rights and equality

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

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

We reviewed the statutory documentation completed for Deprivation of Liberty Standards (DoLS) and found this to be compliant with legislation. There was evidence that patients could access advocacy and where appropriate staff could refer to advocacy on behalf of the patient.

Staff told us that patients are invited to be part of their MDT meetings and that the involvement of family members or advocates was encouraged where possible.

Delivery of Safe and Effective Care

Safe

Risk management.
Overall, we found that systems and governance arrangements were in place, which helped ensure that staff provided safe and clinically effective care for patients. There was an established electronic system in place for recording, reviewing, and monitoring patient safety incidents. Staff confirmed that de-briefs take place following incidents. Meetings we attended and evidence obtained during the inspection confirmed that incidents and use of physical interventions are checked and robustly supervised.

There were nurse call points around the hospital and within patient bedrooms and bathrooms so that patients could summon aid if needed.

A range of up-to-date health and safety policies were available and various risk assessments that had been conducted including, ligature point risk assessments and fire risk assessments. We were told of the environmental checks that are completed and saw evidence of the weekly ward manager check. However, we felt further improvements were needed to provide a safer environment for patients and staff.

The environment of the ward was tired, well-worn and in need of redecoration. There were limited storage areas available which made the ward feel cluttered and untidy. We identified several decorative and environmental issues that required attention:

- Dust on floor in clinical room
- Minimal storage space in clinical area which made the clinical area feel cluttered and untidy
- Scuffs and spillage marks on walls throughout the ward
- Hospital grounds and garden areas poorly maintained, and was not a therapeutic welcoming environment for patients
- Lack of storage with patients clothing being stored in a bathroom area.

The health board must ensure that environmental issues are resolved in a prompt and timely manner.

In addition, the current handrails located on the ward were damaged and documentation reviewed during the inspection highlighted that the handrails were frequently damaged and had caused some minor injuries to patients. Repairs were made to the handrail during the inspection; however, a full review of the handrails needs to be undertaken to ensure that it is safe for the patient group.

The health board must ensure that the handrails in St Barruc's are fully reviewed and safe for the patient group.

Staff told us that the health boards estates department did not always respond in a prompt and timely manner when environmental issues were raised. The inspection team also reviewed documentation which highlighted that many of the above environmental issues had been raised and escalated by staff to the health board.

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

A laundry room was available, however, this room was very disorganised, and staff told us that the washing machines and tumble dryers were domestic ones which often broke down.

The health board must ensure that the laundry room is organised and that patients have access to appropriate washing machines and tumble dryers.

Infection prevention and control and decontamination

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

We identified that the countertop in the clinical room was damaged and needs to be replaced as it creates an IPC issue in the clinical area.

The health board must ensure that the countertop in the clinical room is fixed or replaced.

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

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

Cleaning equipment was stored and organised appropriately. There were suitable arrangements in place for the disposal of clinical waste.

Safeguarding of children and adults

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

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

Management of medical devices and equipment

There were regular clinical audits undertaken at the hospital and we saw evidence of regular auditing of resuscitation equipment. Staff had documented when these had occurred to ensure that the equipment was present and in date.

During staff discussions, it was evident that staff were aware of the locations of ligature cutters in case of an emergency. There were up-to-date safety audits in place, including ligature point risk assessments.

Medicines management

We found that there were suitable arrangements for the safe and secure storage and administration of some medications. We saw evidence of regular temperature checks of the medication fridge to monitor that medication was stored at the advised temperature of the manufacturer. However, there were some gaps where temperature checks had not been recorded.

The health board must make sure that temperature checks are consistently recorded.

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

Cardiff & Vale University Health Board were in the process of awaiting a Home Office pharmacy inspection to secure a licence to supply controlled drugs (CDs). This meant that St Barruc's staff were having to undertake twice weekly ordering of CDs from another pharmacy within the health board which did have a home office licence. This temporary change in process had created an additional administration burden and responsibility for staff working in St Barruc's.

The health board must ensure that the process of obtaining the home office licence is expedited to relieve the additional process and pressure placed upon staff.

On the first night of the inspection, we noted that there was only one qualified nurse on duty. When asked about the process on nights for signing for controlled drugs we were told that a support worker would assist the qualified nurse. Although there was a risk assessment in place, it was unclear what training the support workers had to undertake this role or if policies and procedures had been updated to reflect this change in procedure.

The health board must ensure that they review policy, procedure, and the risk assessment to ensure that controlled drugs liable to misuse are accurately signed for by staff who are qualified and trained to do so. A review should take place across all the health board where this practice is used.

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

Effective

Effective care

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

Evidence obtained during the inspection confirmed that incidents and use of physical interventions are used, and it was positive that restraints rarely take place. This demonstrated that the use of least restrictive model of care was being used effectively at the hospital focusing on therapeutic engagement between staff and patients which created a relaxed ward atmosphere.

We found patients have limited access to psychology support on the ward. This was from review of patient records, and via staff discussion. This is a concerning unmet need for patients.

The health board must review the availability of psychology support for patients and make improvements.

Nutrition and hydration

The care records we reviewed, evidenced that assessments of patients' eating and drinking needs had been completed. Where required, input from dietetics and speech and language team was sought.

Patient records documented specific individual dietary needs to maintain sufficient nutrition and fluid consumption, monitoring documentation we reviewed was appropriately completed.

We observed mealtimes and saw staff assisting patients in a calm, unhurried and dignified way allowing patients sufficient time to chew and swallow food. We also saw staff providing encouragement and support to patients to eat independently.

It was also positive to note that family members were able to attend during mealtimes to accompany or aid their relative.

Patient records

Patient records were being kept electronically. The electronic system was password protected to prevent unauthorised access and breaches in confidentiality.

We found robust systems in place to ensure that personal information relating to patients and staff were kept securely. There was a formal information governance framework in place and staff were aware of their responsibilities in respect of accurate record keeping and maintenance of confidentiality.

We identified that there were no photographs of patients on medications charts. Given that there are four patients with the same forename the health board should consider introducing photos of patients on drugs charts to reduce the likelihood of medication errors when staff are working who are unfamiliar with the patient group.

The health board must ensure that patients are easily identifiable to unfamiliar staff to prevent medication errors.

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

At the time of the inspection no patients were detained under the Mental Health Act.

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

We reviewed the Care and Treatment Plans (CTPs) of a total of three patients.

Patient records evidenced a fully completed and current overall physical health assessment and standardised monitoring documentation such as, NEWS[1] and MUST[2]. In addition, there were standardised assessments based on the individual patient needs.

There was evidence that care plans are reviewed regularly by staff and updated to reflect current needs and risks. Physical health monitoring is consistently recorded in patient records.

Risk management plans were good with detailed risk assessments and risk management strategy plans. In addition, there was evidence of active planning and discharge planning for long term placements.

There was evidence that care co-ordinators had been identified for the patients and the CTPs reflected the domains of the Welsh Measure.

Mental Capacity Act and Deprivation of Liberty Safeguards

We reviewed five patient records that were identified as patients subject to DoLS. All records evidenced that staff had referred to the local authority to apply for a DoLS, and it was evident that the process was being applied and followed appropriately by the health board. However, there was a backlog of people waiting to be assessed by the local authority.

The health board must liaise with the local authority to ensure that the local authority is completing assessment requests in accordance with the statutory timescales set out in the Mental Capacity Act.

There was evidence that patients could access advocacy and where appropriate staff referrals to advocacy were made on behalf of the patient.

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[1] The National Early Warning Score is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs such as, respiratory rate, oxygen saturation, temperature, blood pressure, pulse/heart rate, AVPU (alert, verbal, pain, unresponsive) response.

[2] MUST (Malnutrition Universal Screening Tool) is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan

Quality of Management and Leadership

Staff feedback -

We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital. Insufficient questionnaires were completed; however, we did speak with staff during the inspection.

Staff comments included:

> *"Ward manager is fab and turned the ward around"*.
> *"Can feel isolated at times and its more difficult to access services"*.

Leadership

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

The day-to-day management of the ward was the responsibility of the ward manager, assisted by the deputy ward manager. The ward manager was supported by the senior nurse.

Documentation reviewed on the inspection identified repeated issues dating back to 2022, referencing concerns relating to access and support for St Barruc's patients and staff. The concerns related to St Barruc's being an isolated unit and as a result this impacted upon the staff and patients having limited access to support and escalation when needed.

Examples included patients not having regular access to OT and physio services as well as staff not having any access or support from patient at risk teams when patients behaviours escalate. There was no high care room for staff to use when there was a change in patients behaviours.

The health board were also aware of the possible risks of having only one registered nurse on a night shift in an isolated community hospital, by putting various risk assessments in place. All these concerns had also been raised with the clinical board but were still ongoing at the time of the inspection.

The health board must ensure they action and address the issues raised in the risk assessments relating to St Barruc's isolation and lack of access to services

and provisions in a prompt and timely manner. In addition, the health board must ensure that staff and patients have access to provisions and services equal to those provided to the same patient groups in Llandough Hospital.

There was clear dedicated and passionate leadership from ward staff, who are supported by committed ward multidisciplinary teams and senior health board managers. Staff were able to describe their roles and appeared knowledgeable about the care needs of most patients they were responsible for.

During our time on the ward, we observed a positive culture with good relationships between staff who we observed working well together as a team. Staff told us that there had been a big culture change on the ward, driven by the ward manager and the deputy who were supported by the senior management team.

Most staff spoke positively about the leadership at the hospital and from senior managers within the health board's mental health directorate. Most staff also spoke favourably about the support from colleagues working within the hospital and reported a good team-working ethos at the hospital.

The ward manager had introduced protected administration days to support nurses in completing paperwork. Staff spoken to during the inspection were very complimentary of the rostered administrative days and spoke highly of the support the ward manager provided to them.

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

Workforce

Skilled and enabled workforce

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

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

We were provided with a range of policies, the majority of which were updated however, the Equality, Inclusion and Human Rights Policy was out of date and due

for review in January 2024 as well as the Safeguarding Allegation Concerns for Those in A Position of Trust Policy was due for review in February 2024.

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

St Barruc's is the only ward to care for patient with mental health needs at this location, consequently the only ward that is staffed by employees experienced to provide this care, therefore can be regarded as isolated. This is of particular significance during late evening and throughout the night when there are fewer staff on the ward, and that senior and community mental health staff located at the hospital are not typically present.

Culture

People engagement, feedback and learning

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

The inspection team considered staff training compliance and provided with a list of staff mandatory training compliance. Training figures provided to us on the inspection indicated that overall compliance figures were 88.8 per cent.

We saw that information had been provided to staff on the new Duty of Candour requirements and internal forms had been amended to capture this data. Staff also told us that they would feel secure raising concerns about patient care or other issues at the hospital and felt confident that the health board would address their concerns. A whistleblowing policy was in place to provide guidance on how staff can raise concerns.

Information

Information governance and digital technology

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

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

Through examination of training records, we confirmed that staff had access to information governance training. The training statistics showed low level of staff compliance with information governance training at 45.71 per cent. However, it was positive to note that the ward manager had already arranged for staff to complete this training and all staff had been booked onto courses.

Learning, improvement and research

Quality improvement activities
The ward manager and deputies were relatively new in post and during interviews with them it was positive to hear of future initiatives that they were planning and implementing.

At the time of our inspection there were several ongoing improvements being made, the work of the refocusing nurse had supported staff with providing additional activities for the patient group. A new technology app was due to be launched for patients to complete daily pain assessments to support staff in determining the most effective methods of treating patients. Volunteering roles had also been created and volunteers were due to start their roles to help staff with patient engagement and activities.

Whole-systems approach

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

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

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B - Immediate improvement plan

Service: Barry Community Hospital – St Barruc's

Date of inspection: 3 – 5 June 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
1.	**No immediate assurances were identified on the inspection**					

Appendix C - Improvement plan

Service: Barry Community Hospital – St Barruc's

Date of inspection: 3 – 5 June 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 was no information available on display on the role of HIW and how patients can contact the organisation	The health board must make sure that particular attention is paid to what information is displayed. Information displayed must be relevant to patients and visitors.		Notice Boards updated to include HIW and Putting Things Right information for patients and relatives.	Ward Manager	Completed
				Patient Display Information Audit to be set up on Tendable to ensure audits take place 4 times a year to ensure the standard is sustained	Senior Nurse for Professional Standards	1/9/24
				A review of the ward patient and carer information leaflet will be undertaken in	Ward Manager, Senior Nurse and co-production leads.	1/9/24

				partnership with the Lived Experience Team.		
2.	Dust on floor in clinical room	The health board must ensure that environmental issues are resolved in a prompt and timely manner.		Immediate cleaning of clinical room undertaken.	Ward Manager	Completed
	Minimal storage space in clinical area which made the clinical area feel cluttered and untidy			Excess stock has been cleared.	Ward Manager	Completed
				Undertake a review of patient's storage and procure additional storage as required.	Ward Manager	1/8/24
	Scuffs and spillage marks on walls throughout the ward			Initial clean of walls to remove scuff marks.	Ward Team	Completed
				Estates request submitted to undertake painting and to add St Barruc's to the Capital programme for ward redecoration.	Directorate Management Team	1/9/24
	Hospital grounds and garden areas poorly			Strimming of garden area to be completed.	Estates	1/9/24

	maintained, and was not a therapeutic welcoming environment for patients Lack of storage with patients clothing being stored in a bathroom area.			Multidisciplinary Charitable funds group to agree garden improvements. To include sensory factors e.g. a water features and ornaments. Daily ward environmental check to include review of bedrooms and bathrooms Senior/Lead nurse Tendable audit to be amended to include Inspection of ward area to ensure clean and clutter free All orders for continence pads to be authorised by Ward Manager to prevent over ordering Reinstate Ward Manager and housekeeping supervisor walk arounds.	Ward Manager Ward Manager/Estates/Health and Safety Team/Directorate Manager Senior Nurse Ward Manager Senior Nurse/Head of Facilities	1/9/24 Ongoing 01/09/2024 and ongoing monitoring Completed 01/09/2024

				Undertake joint walk round between Estates and Directorate Management team to review environmental issues. Escalation of constraints with estates improvement through the Executive Reviews	Directorate Management Directorate Manager / Estates	1/8/24 Ongoing
3.	Current handrails located on the ward were damaged and documentation reviewed during the inspection highlighted that the handrails were frequently damaged.	The health board must ensure that the handrails in St Barruc's are fully reviewed and safe for the patient group.		Replacement of all broken handrails agreed with Estates.	Building Officer Estates	15/8/24
4.	The laundry room was disorganised, and staff told us that the washing machines and tumble dryers were	The health board must ensure that the laundry room is organised and that patients have access to appropriate washing		Immediate cleaning and de-cluttering of the laundry room Daily ward environmental check to	Ward Manager Ward Manager/Senior Nurse	Completed Completed and Ongoing

	domestic ones which often broke down.	machines and tumble dryers.		include laundry room to include check of equipment All staff reminded to report any faults with the washing machine and tumble dryer promptly to Estates. Provision of information to families about the laundering service and other options.	 Ward Manager Lead Nurse/Directorate manager	 Completed 1/8/24
5.	The countertop in the clinical room was damaged and needs to be replaced as it creates an IPC issue in the clinical area.	The health board must ensure that the countertop in the clinical room is fixed or replaced.		Replacement of countertop	Building Officer Estates	15/08/24
6.	There were some gaps where fridge temperature checks had not been recorded.	The health board must make sure that temperature checks are consistently recorded.		Temperature checks to be completed daily by the late shift at the same time as the oxygen check. Monthly Core Lead/Senior Nurse Tendable fridge temperature audit.	Ward Manager Senior Nurse	Completed Ongoing

				Senior Nurse audit via Tendable to check register of fridge temperature	Lead/ Senior Nurse	Ongoing
7.	Cardiff & Vale University Health Board were in the process of awaiting a Home Office pharmacy inspection to secure a licence to supply controlled drugs (CDs). This meant that St Barruc's staff were having to undertake twice weekly ordering of CDs from another pharmacy within the health board.	The health board must ensure that the process of obtaining the home office licence is expedited to relieve the additional process and pressure placed upon staff.		The licence application is in progress and is awaiting the final determination from the Home Office.	Clinical Director Pharmacy and Medicines Management	1/9/24
8.	Only one qualified nurse on duty at night meaning that support staff were countersigning Controlled drugs audit.	The health board must ensure that they review policy, procedure, and the risk assessment to ensure that controlled drugs liable to misuse are accurately signed for by		A nurse staffing establishment review to be undertaken to agree safe establishments with the MHCB/and EDON. This will include consideration of a	Lead Nurse/Clinical Board/Executive Nurse Director	1/9/2024

		staff who are qualified and trained to do so. A review should take place across all the health board where this practice is used.		Supernumerary Ward Manager and two registrants by night. Safe Care will be used to record non-compliance with this standard and actions taken to mitigate. The Senior Nurse and Lead Nurse to review red flags raised and act as appropriate.	Ward Nurses/Nurse in Charge/Ward Manager/Senior Nurses/Lead Nurse	Ongoing
9.	We found patients have limited access to psychology support on the ward	The health board must review the availability of psychological support for patients and make improvements.		Clinical Board to explore the option of funding for a minimum of 0.5 8a psychology practitioner post, as per RCPsych CCQI guidance (2019) standard 4.2.4.	Mental Health Clinical Board	1/9/24

				Current mitigation in place includes 0.6 WTE Refocusing nurse and designated time from Dementia Clinical Nurse Specialist to provide non-pharmacological approaches to care.	Clinical Nurse Specialist and Refocusing Nurse	Completed
10.	There were no photographs of patients on medications charts, given that there are 4 patients with the same forename.	The health board must ensure that patients are easily identifiable to unfamiliar staff to prevent medication errors.		All patients now have photos on their drug charts.	Ward Manager	Completed
				Patient ID bracelets have now been introduced in St Barruc's ward which work alongside the patient ID bracelets.	Senior/Lead Nurse	Completed
				Develop a set of basic principles around the use of photographs for ID purposes and a brief protocol to ensure all staff understand their responsibilities to store photographs and inform patients/ families appropriately.	Senior/Lead Nurse	1/10/24

11.	There was a backlog of people waiting to be assessed by the local authority.	The health board must liaise with the local authority to ensure that the local authority is completing assessment requests in accordance with the statutory timescales set out in the Mental Capacity Act.		All patients have now been assessed and DoLS authorisations given. A meeting will be held with the Local Authority team to agree a strategy to ensure all DoLS assessments are completed within the required timescale	Ward Manager DoLS Lead	Complete 1/9/24
12.	There were possible risks having only one registered nurse on a night shift in an isolated community hospital.	The health board must ensure they action and address the issues raised in the risk assessments relating to St Barruc's isolation.		A nurse staffing establishment review to be undertaken to agree safe establishments with the MHCB/and EDON. This will include consideration of a Supernumerary Ward Manager and two registrants by night. Mitigation has been put in place to reduce risk by rostering two registrants by night where possible and	Lead Nurse/Clinical Board/Executive Nurse Director	1/9/24

				increasing the number of HCSW by night. Safe Care will be used to record non-compliance with this standard and actions taken to mitigate. Priority will be given to with next intake of streamliners to St Barruc's for registered nurse recruitment with the aims to increase staffing at night.	 Lead and Senior Nurse	 1/10/24
13.	Patients were not having equal access to those provided for similar patient groups at Llandough hospital.	The health board must ensure that staff and patients have access to provisions and services equal to those provided to the same patient groups in Llandough Hospital.		A review of physical healthcare provision will be undertaken to establish responsibilities across the GP service and the Mental health Clinical Board medical team.	Lead Nurse/ Physical Health Care Nurse / Clinical Director	1/8/24

				Development of a standard operating Procedure for referral to the GP service and a set of principles for ward staff to ensure that patients with extended admission are not disadvantaged.	Lead Nurse/ Physical Health Care Nurse / Clinical Director	1/9/24
				All Nursing staff have received training in the application of News 2 to safely manage and escalate deteriorating patient	Lead Nurse/Physical Health Nurse	Complete and Ongoing
				The Physical healthcare nurse attends St Barruc's twice each week and the GP attends on a weekly basis to ensure regular access to physical health care services .	Senior Physical Health Nurse	Complete and ongoing

14.	The Equality, inclusion and human rights policy was out of date and due for review in January 2024 as well as the safeguarding allegation concerns for those in a position of trust was due for review in February 2024	The health board must ensure that policies are reviewed and kept up to date.		The Policy is currently under review	UHB Equality Lead	November 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): **Tara Robinson**

Job role: **Deputy Director of Nursing for Mental Health Clinical Board**

Date: **24/07/2024**