Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Cedar and Alder Wards, Hafan y Coed Mental Health Unit, University Hospital Llandough, Cardiff and Vale University Health Board

Inspection date: 01, 02 and 03 July 2024
Publication date: 23 October 2024

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

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

Or via

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-83625-772-1

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Hafan y Coed Mental Health Unit, University Hospital Llandough, Cardiff and Vale University Health Board on 01, 02 and 03 July 2024. The following hospital wards were reviewed during this inspection:

- Cedar Ward – a 15 bedded crisis assessment unit for adult patients
- Alder Ward – a 10 bedded Psychiatric Intensive Care Unit (PICU) for adult patients.

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 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 two questionnaires were completed by patients and six 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.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

We observed staff treating patients with respect and kindness and supporting patients in a dignified and sensitive way throughout the inspection. However, we noted instances when staff did not respond to patients, and some patients told us they would like more support from staff. The health board must explore ways to ensure staff are able to engage with patients and respond in a timely manner.

Each patient had a private ensuite bedroom, monitored by a Reassurance Observation System (ROS) housed in a lockable cabinet outside the room. This enabled staff to undertake observations without disturbing patients. However, we found some of the ROS monitor cabinets were unlocked during the inspection, which compromised patient privacy, dignity and safety. We also found improvements were required to install screening and curtains in many of the patient bedrooms and ensuite bathrooms, to provide more privacy for patients.

We found Alder Ward was supported by a dedicated Activities Coordinator and saw evidence that patients were provided with a suitable programme of therapeutic activities. However, neither ward was supported by an Occupational Therapist (OT), and we were not assured that the patients on Cedar Ward were provided with therapeutic activities to support their health and wellbeing. We identified that the health board must do more to ensure that patients are able to participate in a range of individualised therapeutic and social activities to aid in their recoveries.

This is what we recommend the service can improve:

- The health board should install seating in the garden of Cedar Ward to provide a more pleasant, therapeutic environment for patients
- The health board should ensure there are designated, gender-specific areas on both wards which can be used as required
- The health board must ensure patient bedrooms are fitted with suitable fixtures and fittings which support their privacy and dignity and allow them to rest and sleep in comfort
- The health board must ensure the patient bedroom ROS monitor cabinets are appropriately secured at all times to support their privacy, dignity and safety

- The health board must ensure patients are provided with relevant, up-to-date and accessible information to support their care
- The health board must implement a policy which provides clear guidance to staff on the procedures and protocols for locking doors to prevent unauthorised access or egress.

This is what the service did well:

- We found high staff compliance with mandatory equality, diversity and human rights training. We were told that some staff had completed additional voluntary training to improve their awareness and understanding of equality and diversity issues, which we recognised as good practice.

Delivery of Safe and Effective Care

Overall summary:

The hospital had established processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors. Staff confirmed there was a governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care. However, we saw examples of audits and environmental checklists which were incomplete, or which did not provide a true reflection of the environment observed during the inspection. Following review of these documents, we were concerned about the accuracy and quality of data being recorded by staff.

Each ward had an appointed Infection, Prevention and Control (IPC) lead and staff demonstrated a good understanding of their role and responsibility in upholding IPC. However, we noted several IPC issues which posed a potential risk to staff, patient and visitor safety. Some examples included gaps in the daily cleaning schedules, no evidence to indicate that the communal patient facilities were being cleaned after each use, and low staff IPC training compliance.

We found robust procedures in place for the safe management of medicines and Mental Health Act monitoring on both wards. The quality of clinical record keeping and patient care planning was generally appropriate on Alder Ward. However, the overall standard of record keeping was found to be poor on Cedar Ward. The Cedar Ward patient intervention plans we viewed were generally incomplete and were not individualised to patient needs. The health board must implement robust governance processes to improve the quality of the patient records.

We found the staffing levels on both wards were in line with the set establishments. However, we were told that staffing pressures and environmental

issues on Cedar Ward were causing low morale amongst staff. We noted a high turnover of staff and a high reliance on bank staff to fill vacant shifts on Cedar Ward. The health board must conduct an establishment review of Cedar Ward to ensure the staffing numbers, skillset and experience amongst staff are appropriate to support patient safety and provide patient-centred care.

Immediate assurances:

- During the inspection we were not assured that the health, safety and welfare of patients, staff and visitors was being actively promoted and protected on Cedar Ward. We considered the environment of the patient and clinical areas and found several environmental, infection control, and health and safety risks which had not been identified, monitored and where possible, reduced or prevented
- During the inspection we examined staff training records, staff rotas and Datix incident forms. Patient restraint incidents were being recorded on the electronic Datix system, but staff were not always recording restraint incidents under the correct sub-category of 'restraint' within Datix. As a result, the system could not be filtered to produce accurate restrictive practices data and posed considerable difficulty for supervisory staff to provide robust governance oversight of restraint incidents.
  Through a review of individual incidents of restraint, it was identified that some staff had been involved in incidents of restraint during the last three months who were out of compliance with their Strategies and Interventions for Managing Aggression (SIMA) training. These issues were also identified during our previous inspection of other mental health wards at Hafan Y Coed in January 2023
- During the inspection we noted that the multidisciplinary team (MDT) for both wards consisted of only two disciplines, these being a Responsible Clinician (RC) and a registered nurse. As a result, we could not be assured that clinical decisions relating to patient care and treatment were being determined through a multi-disciplinary approach that took a comprehensive and holistic view of the needs of each patient.

Our concerns regarding these issues were dealt with under our immediate assurance process. Further information on the improvements we identified, and the actions taken by the health board, are provided in Appendix B.

This is what we recommend the service can improve:

- The health board must implement robust measures to ensure that ward audit processes are fully completed, provide a true reflection of the ward

circumstances, and that staff are supported to complete them in the course of their duties
- The health board must consider the installation of emergency assistance call points within patient bedrooms and at regular intervals throughout the wards, in line with national standards
- The health board must review the cleaning roles and responsibilities for nursing staff to ensure they do not impact on the ability of staff to care for patients
- The health board must ensure patient therapeutic observation records are fully and contemporaneously completed
- The health board must ensure patient discharge planning information is routinely recorded within a separate designated area of the patient records, for ease of access and monitoring.

This is what the service did well:

- The Mental Health Act (MHA) Team provided robust and efficient systems of audit and monitoring in respect of all areas of the MHA and its application
- The MHA team provided a comprehensive programme of online and face-to-face training and had also developed a website where staff could access relevant MHA information.

Quality of Management and Leadership

Overall summary:

Established governance arrangements were in place to provide oversight of clinical and operational issues. However, we noted that several health board policies were out-dated, resulting in a lack of current guidance for staff.

There were established processes in place to ensure incidents or key issues were being effectively investigated, escalated, supervised and scrutinised to prevent reoccurrence. In general, the governance processes supported quality improvement and endeavoured to share learning. However, we identified that improvements were required to ensure actions were completed in a timely manner and learning was shared appropriately. In addition, the audit governance processes must be reviewed to ensure they are robust. Many issues which were identified during our previous inspections and during recent health board internal reviews were still present at the time of our inspection.

Staff feedback was generally positive about their immediate line managers. We found most staff had received their annual Values Based Appraisal (VBA). However, we were told that formal clinical supervision sessions were not being undertaken

with nursing staff as required, and that staff would benefit from additional supervision. We further noted that ward staff meetings did not take place on a regular basis and there had been no meetings within the last six months prior to our inspection.

Whilst we found overall mandatory training compliance rates were generally high among staff on the wards, we noted that improvements were required in respect of overall compliance with several mandatory training courses.

This is what we recommend the service can improve:

- The health board must review any out-dated policies and ensure both wards have an up-to-date operational policy to provide current guidance to staff
- The health board must implement measures to ensure all outstanding mandatory staff training is completed, regularly monitored and that staff are appropriately supported to attend the training
- The health board must ensure that staff have access to regular formal clinical supervision to support their learning and development
- The health board must ensure staff meetings are conducted on a regular basis to engage staff and encourage feedback.

This is what the service did well:

- It was positive that staff were receptive to our views, findings and recommendations throughout the inspection.

3. What we found

Quality of Patient Experience

Patient feedback

We invited patients, family and carers to complete HIW questionnaires to obtain their views on the service provided at the hospital. We received a total of two patient questionnaires, and there were 25 patients being cared for across both wards at the time of our inspection. The sample size is therefore too small to draw robust conclusions and identify themes or trends.

The patients who responded to our questionnaire generally provided positive feedback on the care and treatment they received in the hospital. They rated the care and service as 'very good,' and confirmed that staff provided care and treatment to them when needed. Both agreed that staff treated them with dignity and respect and were polite and listened to them. All agreed that staff had talked to them about their medical conditions and helped them to understand them.

Patient comments included:

> *"The setting is much enhanced by the care given by the staff. I cannot thank the staff enough."*
>
> *"The staff are a credit to the NHS... this stems from the leadership of the ward manager who leads by example and expects the best from her staff… amazing care, thanks so much for your aid in my recovery."*

We also spoke with patients on the wards when appropriate to do so. The patients we spoke with during the inspection generally told us they were treated well by staff, but some told us they would like additional support from them. Feedback and some of the comments we received appear throughout the report.

Person-centred

Health promotion

The hospital had suitable processes in place to help protect and promote the physical health of patients in addition to their mental health needs. We reviewed a sample of patient records and saw evidence that patients received appropriate physical assessments upon their admission. We also found evidence that patients

could access additional health promotion and preventative interventions as required, such as dietician support and access to GPs.

Patients had access to their own bedrooms, communal areas and the outside garden areas of the wards. Each ward had lounge areas which offered self-directed activities such as a TV, board games and books for patient use. Both wards had a secure communal garden area where patients could congregate outside. However, we found that that no outside seating was provided for patients on Cedar Ward.

The health board should install seating in the garden of Cedar Ward to provide a more pleasant, therapeutic environment for patients.

During the inspection we noted that Alder Ward had a dedicated activities coordinator and saw evidence that a suitable programme of therapeutic activities was being provided to patients. However, the ward was not supported by an Occupational Therapist (OT), as the dedicated post was vacant at the time of our inspection.

On Cedar Ward, we found little evidence that therapeutic activities were being provided to patients. We saw a timetable displayed to inform patients of ward-based and community activities, but we did not observe any patients participating in activities throughout the inspection. This issue was also reflected in the health board's December 2023 Accreditation for Inpatient Mental Health Services (AIMS) Review of Adult Acute Inpatient Standards and Services on Cedar Ward. The review outlined that '*both staff and patients agreed that therapeutic activities do not really take place on the ward. There is no OT provision and no in-reach input from the activity team…formal group activities do not take place on the ward*'.

Some patients we spoke with during the inspection complained of boredom and a lack of activities on the ward. Staff confirmed that Cedar Ward was not supported by a dedicated OT but was supported by the crisis service OT on a rotational basis. However, this post was also vacant at the time of our inspection. In the absence of sufficient OT support, we were told that patient therapeutic activities were implemented by Cedar Ward staff in addition to their clinical duties. Therefore, we were not assured that the patients on Cedar Ward were being provided with suitable and appropriate therapeutic activities which supported their health and wellbeing and recovery.

The health board must:

- **Ensure Cedar Ward patients are provided with a range of accessible therapeutic activities to support their health and wellbeing**
- **Review the provision of OT support for patients on both wards**

- **Make continued efforts to recruit to the vacant OT posts.**

Dignified and respectful care
Throughout the inspection we observed all staff treating patients with dignity and respect. Staff demonstrated a caring and understanding attitude to patients and communicated using appropriate and effective language. The staff we spoke with were passionate about their roles, and enthusiastic about how they supported and cared for the patients.

We saw an appropriate mix of staff working on the wards who were supportive in meeting the needs of the patient group. Each patient had their own bedroom with ensuite shower facilities, which maintained their privacy and dignity. During the inspection we witnessed staff respecting the privacy of patients by knocking their bedroom door before entering.

However, during our tour of the hospital, we identified that improvements were required in relation to the privacy and respectful care of patients. We found that most patient bedrooms on both wards did not have any form of privacy screening to separate the bedroom and toilet areas. We were told that the health board was trialling a new method of addressing this matter but that the situation had remained unchanged for several years. Although the ensuite bathrooms could not be seen from the doorway of the patient bedrooms, we identified that this arrangement compromised patient privacy and dignity during their stay.

The health board must undertake measures to install suitable privacy screening within all patient ensuite bathrooms.

During the inspection we noted that the patient bedroom windows were fitted with privacy glass to prevent them from being seen from outside the hospital. However, many did not have window curtains, which allowed light into the bedroom and posed a risk of disturbing their sleep and rest.

The health board must ensure patient bedrooms are fitted with suitable fixtures and fittings to allow them to rest and sleep undisturbed.

All patient bedrooms had a Reassurance Observation System (ROS) with a monitor screen housed in a lockable cabinet outside each room. This enabled staff to undertake observations from outside the bedroom, without having to open the door and disturbing the patients. However, during the inspection we found two of the ROS monitor cabinets on Cedar Ward were left unlocked on three separate occasions. We identified that this compromised patient privacy and dignity and posed a potential risk to their safety. We highlighted this issue to staff during the inspection and the cabinets were appropriately secured.

The health board must ensure that the patient bedroom ROS monitor cabinets are appropriately secured at all times to support their privacy, dignity and safety.

Both wards provided mixed gender accommodation and there were multiple quiet areas and side rooms where patients could spend time away from other patients. However, we noted there were no designated gender-specific areas on the wards.

The health board should ensure there are designated, gender-specific areas on both wards which can be used as required.

Patient information
During the inspection we found a range of information provided to help patients and their families understand their care. We saw examples of appropriate information displayed including Mental Health Act information, staffing information and visiting times. Both wards provided patients and family/carers with a leaflet which outlined helpful information to support them during their stay. We were informed that staff were also working with the health board's Recovery and Wellbeing College to develop an additional patient information guide, which was in draft format at the time of our inspection.

Whilst we found some positive examples of patient and visitor information, we noted the absence of other relevant information displayed, which included:

- No information regarding advocacy services on Cedar Ward
- No information regarding the role of HIW and how patients can contact HIW on either ward
- The NHS Wales Putting Things Right procedure was displayed within the air lock area on Cedar Ward, where it was not readily accessible to patients.

The health board must ensure patients are provided with relevant, up-to-date and accessible information to support their care.

Individualised care
We reviewed the intervention plans of 15 patients and found that the quality of the plans was variable across the wards. On Alder Ward we saw evidence that patients had individualised, person-centred intervention plans, which outlined areas where they were involved in making decisions relating to their care. However, on Cedar Ward, we found the interventions plans were not individualised to patients and did not fully reflect their needs. More findings on the intervention plans can be found in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

We saw evidence that patients could make their own food and clothing choices to support their independence. Patients were able to store possessions and personalise their rooms where appropriate. Separate rooms were available for patients to spend time away from other patients according to their needs and wishes. The ward had suitable visiting rooms where patients could see their families in private. All staff members who completed a questionnaire felt that patients were informed and involved in decisions about their care.

Timely

Timely care

We saw several examples of staff providing timely and effective patient care in accordance with clinical need. Established meeting processes were in place to support the timely care of patients, including daily meetings to establish bed occupancy levels and to discuss patient care needs. Nursing staff also attended regular multidisciplinary team (MDT) meetings in which information was shared to ensure the timely care of patients. We noted that timely patient care was also discussed as a standing agenda item during the monthly Quality, Safety and Experience meetings. Staff also attended multi-professional Sentinels and Lessons Learned meetings to discuss adverse incidents and near misses in order to identify trends and opportunities for wider service and organisational learning.

At the time of our inspection, both wards were experiencing high levels of patient acuity. Whilst we generally found patients were receiving safe and effective care, we witnessed occasions when staff did not respond when patients knocked on the Cedar Ward nursing office door to speak to them. This issue was also raised by patients, who told us that staff were '*mostly in the office*' and that they had '*learned not to knock*' on the office door. Some patients also stated that they would like more support from staff. They told us:

> *"More support when you ask instead of it getting to a break down point."*
>
> *"In here is isolating… once a night or day ask people if they would like a one-to-one chat about how [they are] feeling".*
>
> *"[Staff] don't really explain what's going on…don't know what will happen next/how long [I will] be here."*

The health board must consider our findings relating to staff and patient engagement and ensure processes are implemented to respond to patients in a timely manner.

Equitable

Communication and language

The wards used digital technology as a tool to support effective communication and ensure timely patient care by way of electronic patient record keeping, online meetings, audit processes and electronic information sharing.

During the inspection, we were told that some patients had access to their own personal electronic devices, subject to individual risk assessment. We discussed the safe and secure use of digital devices with staff. We were told that a policy was in place to provide guidance to staff regarding patients' use of electronic equipment, mobile phone devices and access to the internet. To retain their personal devices on the wards, patients were required to complete a disclaimer form and abide by strict rules to ensure their safe and appropriate use. Staff confirmed that if a patient was seen to use their devices inappropriately, the devices would be confiscated, and the matter would be escalated as appropriate.

Staff showed understanding of the importance of speaking with patients in their preferred language. We were told that ward staff completed mandatory Welsh language training and there were Welsh speaking staff members on both wards. We were told that Welsh speaking staff members were identified by a lanyard and an embroidered logo on their uniforms.

Rights and equality

We reviewed the records of four patients who were detained on the wards under the Mental Health Act. 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). All patients had access to a mental health advocate who provided information and support to patients with any issues they may have regarding their care. Further information on our findings is detailed in the Mental Health Act Monitoring section of this report.

We found satisfactory arrangements in place to promote and protect patient rights. Overall, staff compliance with mandatory Equality, Diversity and Human Rights training was 97 per cent on Cedar Ward and 95 per cent on Alder Ward. We were told that some staff members had completed additional voluntary training with Diverse Cymru, to improve their awareness and understanding of equality and diversity issues, which we recognise as good practice.

Policies were in place to help ensure that everyone had access to the same opportunities and to the same fair treatment. However, we noted that the health board's Equality, Inclusion and Human Rights Policy required a review in January 2024.

The health board must review the out-dated Equality, Inclusion and Human Rights policy to provide current guidance to staff.

Reasonable adjustments were in place so that everyone could access and use services on an equal basis. Staff provided an example of how they had recently engaged with the Welsh Gender Service to support the care of a transgender patient and ensure that their rights were upheld during their stay.

At the time of the inspection, Cedar Ward contained a mixture of informal patients and patients detained under the Mental Health Act. This meant that for safety reasons the main door to the ward was locked, and informal patients who wished to leave the ward had to request staff to open the door for them. We noted that there was no locked door policy in place to provide staff with clear guidance on managing access and egress for formal and informal patients, whilst maintaining the safety and security of the ward.

The health board must implement a policy which provides clear guidance to staff on the procedures and protocols for locking doors to prevent unauthorised access or egress.

Delivery of Safe and Effective Care

Safe

Risk management
There were established policies, processes and audits in place to manage risk and health and safety, which supported staff to provide safe and clinically effective care. We considered the processes in place to manage risks to help maintain the health and safety of patients, staff and visitors, and found the following suitable measures in place:

- The wards were accessible to all, including those with mobility difficulties
- The ward entrances were secured at all times throughout the inspection to prevent unauthorised access or egress
- Ligature cutters were appropriately stored for use in the event of a self-harm emergency, and staff knew where to find them
- The hospital had a list of restricted items that was clearly outlined for patient and family/carer awareness
- There were regular audits of emergency resuscitation equipment; staff had documented when these had occurred to ensure that the equipment was present and in date
- Personal alarms were available for staff to use in an emergency situation and we witnessed staff carrying them throughout the inspection.

However, during the inspection we were not assured that the health, safety and welfare of patients, staff and visitors was being actively promoted and protected. We considered the environment of the patient and clinical areas of Cedar Ward and found a number of environmental, infection control, and health and safety risks which had not been identified, monitored and where possible, reduced or prevented. We saw examples of potential risks to patient safety as follows:

- Throughout the ward we saw numerous examples of furniture, fixtures and fittings which were damaged. For example, many of the patient armchairs throughout the ward were worn or ripped, and we saw missing areas of skirting within the Extra Care Area. These posed environmental risks for patients and did not support effective Infection Prevention and Control (IPC)
- There was significant and ongoing water damage to areas of the flooring, skirting and lower walls throughout the ward. In some areas the damage had resulted in raised and loose flooring, which presented as a trip hazard and posed a risk to staff and patient safety. The extreme damage to the walls and floors prevented effective IPC measures from being upheld throughout the ward

- The health board's September 2023 Fire Risk Assessment identified that the swelling of the floors prevented the ward's automatic fire doors from closing completely, and therefore providing an effective seal against fire spread. We saw that the action plan outlined that remedial actions were required to be undertaken to resolve this issue within 28 days of the assessment, but they had not been completed at the time of our inspection
- We were informed by staff that a capital programme of works had been agreed to rectify these matters, but the health board was still awaiting a start date for the work at the time of our inspection.
- The environmental issues had previously been identified by HIW during an inspection of the ward in 2022, at which time we were informed that the matter would be addressed by September 2022. However, they had not been addressed at the time of our inspection.

Our concerns regarding these issues were dealt with under our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Further information on the improvements we identified, and the actions taken by the health board, are provided in Appendix B.

During the inspection we saw examples of hospital audits which had been completed within set timescales to support patient safety. We were provided with up-to-date annual ligature audits for both wards, which identified each individual risk. However, we noted that the comments section of the ligature audits was routinely left blank, with no description of the actions required to mitigate any identified risks, or whether these had been addressed. Whilst an overview of the ligature risks and actions was outlined within the general risk assessments for each ward, we identified improvements were required to ensure the audits fully described the required actions and the mitigations in place in respect of each individual risk, to support patient safety.

The health board must ensure that ligature audits are fully completed to include the actions and mitigations in respect of each identified risk.

Staff on both wards completed a comprehensive 'Daily Environment Checklist' to identify any issues to support patient and staff safety. However, we reviewed the checklists completed between April and July 2024 and found they contained numerous gaps, which indicated that not every check was being completed. It was concerning to note that on some dates the checklist had not been completed at all. We saw an example whereby the bedroom checks were not completed for almost a week on Cedar Ward. In addition, that the checklists were not being consistently signed by the Nurse in Charge as appropriate.

We saw evidence that senior staff had conducted a dip sample audit of the Daily Environment Checklists that were completed by Cedar Ward staff in October 2023, during which they identified that only 56 per cent of the checks were completed over the entire month. At the time of our inspection, we were told that the dip sample audit process had not yet been conducted on Alder Ward.

We were told that the results of the Cedar Ward audit were discussed during the Quality, Safety and Experience meetings, and a plan was developed that ward clerks should support the completion of the Daily Environmental checks wherever possible. However, at the time of our inspection it was evident that the checks were still not being appropriately completed.

We also noted instances where the checklist documentation did not provide a true reflection of the environment we observed during the inspection. For example, we were told that the hospital's disposable curtains should be changed every six months. On Cedar Ward, staff had signed the Daily Environment Checklist to confirm that the disposable curtains had been checked and would be replaced as required. However, we noted two instances where they were last changed over a year ago. Therefore, we could not be assured of the reliability of the information recorded within the checklists, and the governance processes in place to monitor their completion and address any issues identified.

The health board must implement robust measures to ensure the Daily Environment Checklists are fully completed, provide a true reflection of the ward circumstances, and that staff are supported to complete them in the course of their duties.

During our tour of the wards, we observed that there were some nurse call points within the wards' communal areas. However, only two patient bedrooms were equipped with emergency call points. We identified that this arrangement posed a potential risk to patient safety, as they would be unable to contact staff from their bedrooms in the event of an emergency.

The health board must consider the installation of emergency assistance call points within patient bedrooms and at regular intervals throughout the wards, in line with national standards.

Infection, prevention and control and decontamination

During the inspection we considered the environment of the patient and clinical areas within the hospital. The environment of care on both wards and the wider hospital was tidy and uncluttered. However, as outlined previously in this report, the fitness of the environment we observed on Cedar Ward was not reflective of a modern inpatient mental health service. We saw many examples whereby the ward

environment, furniture and fittings were not being kept in a good state of repair and did not support effective infection prevention and control.

The wards had an appointed IPC lead and the staff we spoke with during the inspection demonstrated a good understanding of their role and responsibility in upholding IPC. All staff members who completed a questionnaire provided positive feedback about the IPC arrangements in place in the hospital. They confirmed that an effective infection control policy and effective cleaning schedules were in place. They agreed that appropriate PPE was supplied and used, and that the environment allowed for effective infection control. All patients who completed a questionnaire agreed that the environment was very clean.

However, during the inspection we observed a number of IPC issues in addition to those previously mentioned in this report, which posed a potential risk to staff, patient and visitor safety:

- Daily cleaning schedules were in place to promote regular and effective cleaning of the wards, but we saw evidence that they were not always suitably completed on Cedar Ward. Staff told us they were sometimes unable to complete the daily cleaning schedules due to the level of patient acuity and care requirements on the ward
- Overall staff compliance with Level 2 IPC training on Alder Ward was 85 per cent, but we noted that overall compliance on Cedar Ward was low at 57 per cent
- The floor on the Extra Care Area within Cedar Ward was extremely dirty beneath the padded mats, and clearly had not been cleaned for an extended period of time
- The dining area of Cedar Ward was dirty and required cleaning at the time of our inspection. We viewed this area again the following day and noted the same issues were still present
- We were told that the patient washing machine and tumble dryer were not working on Cedar Ward. Staff advised that this issue had been reported to the estates department, but no action had been taken to address the matter
- We examined the Alder Ward kitchen and found that the fridge was malodorous and required cleaning
- The kitchen cabinet and fridge on Alder Ward contained patient foods which had been opened but were unlabelled, and the expiry date and date of opening could not be ascertained
- We found no documentary evidence such as labels or stickers to indicate that the patient communal equipment and facilities were being cleaned after each use and were safe to use
- The wards' disposable curtains were not being replaced at least every six months, in accordance with recommended guidance

- The hospital had recently introduced the Tendable audit platform to ensure consistent recording and governance oversight of hospital audits. We saw instances where the Tendable IPC audits indicated that the legionella water flushes were fully completed and documented for the previous month. However, the corresponding paper records indicated that the flushes were not always being completed. For example, in April 2024, the paper records evidenced that the flushes had only been completed once within the entire calendar month, but they were recorded as fully complete within Tendable. Following review of these documents, we were concerned about the accuracy and quality of the data being recorded because it did not provide a true reflection of the actions undertaken by staff
- The Tendable IPC audits indicated variable scores for staff being 'bare below the elbows.' During the inspection we witnessed some staff wearing jewellery, watches and false nails, which posed an IPC risk
- The Infection Control Procedure for Infectious Incidents and Outbreaks in University Health Board Hospitals had not been reviewed nor updated since November 2023.

The health board must:

- **Strengthen leadership and governance systems to ensure all ward areas are effectively cleaned and that cleaning schedules are fully completed within set timescales**
- **Review the cleaning roles and responsibilities of nursing staff to ensure they do not impact on the ability of staff to care for patients**
- **Improve Cedar Ward staff compliance with mandatory Level 2 IPC training**
- **Ensure all hospital areas are effectively cleaned**
- **Repair or replace the washing machine and tumble dryer on Cedar Ward**
- **Conduct a review of the hospital's IPC audits and supporting documentation to ensure they are suitably completed and provide a true reflection of the actions taken by staff**
- **Ensure patient foods are regularly checked and appropriately labelled so the opening and expiry dates can be viewed**
- **Ensure communal patient facilities are promptly cleaned and appropriately labelled after use, to support the safety of patients, staff and visitors**
- **Ensure the hospital's disposable curtains are routinely replaced within recommended timescales**
- **Ensure staff are compliant with the All Wales NHS Dress Code**

- **Review the Infection Control Procedure for Infectious Incidents and Outbreaks in University Health Board Hospitals policy, to provide current guidance to staff.**

Safeguarding of children and adults
We found suitable safeguarding measures in place in the hospital. There were established health board policies and processes in place to ensure that staff safeguarded vulnerable adults, with referrals to external agencies as and when required.

Ward staff had access to the Wales Safeguarding Procedures via the intranet. During our discussions with staff, they demonstrated good knowledge of the health board's safeguarding procedures and reporting arrangements. We were told that safeguarding incidents and concerns were regularly reviewed to help identify any themes and lessons learned. We found high compliance among staff with mandatory Level 2 and 3 safeguarding training courses across the wards. However, we noted that overall compliance with mandatory Level 1 safeguarding training was 77 per cent on Cedar Ward.

The health board must continue to improve Cedar Ward staff compliance with mandatory safeguarding training.

The patients who completed a questionnaire and patients we spoke with during the inspection told us that they felt safe at the hospital. The told us:

> *"Safe place being in here for myself. Helps you get back to you[r] normal self sometimes."*
>
> *"Safe place from abuse."*

Medicines management
Relevant policies, such as medicines management and rapid tranquillisation, were available and staff told us that they knew how to access them.

We reviewed the wards' clinic arrangements and found robust procedures in place for the safe management of medicines. All prescribed patient medications were securely stored in locked cabinets within the clinic rooms. The records evidenced that stock was accounted for when administered and that stock checks were being undertaken.

We saw evidence of regular temperature checks of the medication fridges to monitor that medication was being stored at the manufacturer's advised temperature. However, we noted two gaps in the Cedar Ward fridge temperature

monitoring checklist during June 2024. We further noted that the seven-segment display on the fridge thermometer was broken, which made it difficult for staff to read the temperature.

The health board must:

- **Ensure the clinic room fridge temperature checks are consistently completed**
- **Replace the faulty fridge thermometer on Cedar Ward.**

We saw appropriate internal auditing systems in place to support the safe administration of medication, with strong pharmacy involvement. The patient Medication Administration Records (MAR charts) we viewed were being maintained to a good standard. The charts were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. However, we noted examples where the patient Mental Health Act legal status and patient allergies sections were not completed within some of the MAR charts were viewed on Cedar Ward.

The health board must ensure that patient Mental Health Act legal status and patient allergies information is fully recorded within Medication Administration Records.

We observed safe, sensitive and appropriate prescribing of medications in accordance with patient needs. Regular medication reviews were completed to ensure patient medications were appropriate. We were told that patients were involved in decisions about their medications wherever possible. Patients and their representatives routinely attended ward round meetings during which any updates or changes to their medication were discussed and recorded. Easy read information was readily available to support patients in understanding their medication.

Staff we spoke with during the inspection demonstrated appropriate knowledge and understanding of medications management procedures. We found good systems in place to ensure medication errors were appropriately recorded, investigated and supervised, and any learning opportunities were shared with all staff.

Effective

Effective care

There was an established electronic system in place for recording, reviewing and monitoring incidents. There was a hierarchy of incident sign-off with regular incident reports produced and reviewed so that themes and trends could be

monitored and analysed. Staff confirmed that debriefs took place following incidents, and that relevant learning was shared with staff verbally and electronically.

We found the staff numbers to care for the patients on the wards met health board staffing templates during the inspection and were told that staffing levels were proportionate to ensure patient safety in the hospital. We were told that bank and agency staff were used to cover any staffing shortfalls and that the hospital actively sought to book staff who were familiar with the hospital and the patient group wherever possible.

During our discussions with staff, we were told that Alder Ward was previously a five bedded facility and had later expanded to a 10 bedded ward, with no increased ratio of staff. Following an establishment review, the staffing template for Alder ward was later increased. Staff on Alder Ward whom we spoke with during the inspection reported that their working practices had greatly improved since the review, resulting in reduced stress, increased morale and lower sickness levels amongst staff.

In contrast, some staff on Cedar Ward told us that morale on the ward was currently low, partly due to the poor state of the environment, but also due to staffing pressures on the ward. We noted a high reliance on bank staff to fill vacant shifts and were told that there was a high staff turnover on the ward. Staff reported that the ward was regularly allocated newly qualified nurses who remained for a limited time before moving elsewhere, resulting in a lack of continuity and experience within the team. We were told that eight newly qualified nurses were allocated to the ward in September 2023 alone. Recent Quality, Safety and Experience Committee meeting minutes we viewed during the inspection indicated that Cedar Ward was '*struggling with inexperienced staff*' and that there were staffing pressures on the ward due to poor staff retention.

The health board must conduct an establishment review of Cedar Ward to ensure the staffing numbers, skillset and experience amongst staff are appropriate to support patient safety and provide patient-centred care.

Each ward had a manager, deputies, staff nurses and support workers who appeared dedicated to delivering a high standard of patient care. Staff we spoke with during the inspection told us that that the team provided good peer support to each other and put the patients at the forefront of their duties. However, we noted that the multidisciplinary team (MDT) for both wards consisted of only two disciplines, these being a Responsible Clinician (RC) and a registered nurse. Staff advised that the RC of Cedar Ward was not dedicated to the ward, also having responsibility for the North Crisis Team.

We noted that neither ward was supported by an Occupational Therapist who can provide specialist functional assessments and evidence-based therapy interventions. Additionally, neither ward was supported by a dedicated psychologist to support the assessment of patients' psychological needs and the safe and effective provision of psychological interventions. We were told that the funding for a dedicated psychologist post on Cedar Ward had been removed, and that the situation had remained unchanged for several years.

Whilst we observed suitable pharmacy input into medicines management processes, staff we spoke with during inspection advised that they were not a core member of the MDT and did not attend ward round meetings where patients' care and treatment was routinely discussed. We were informed this situation also applied to other wards within Hafan y Coed.

During our review of patient records, we saw examples where only two disciplines were present during patient ward rounds. We also reviewed a sample of patient discharge case notes which evidenced that only two disciplines were involved in their discharge process, albeit with the support of various community teams.

As a result of our findings, we could not be assured that clinical decisions relating to patient care and treatment were being determined through a multi-disciplinary approach that took a comprehensive and holistic view of the needs of each patient. We highlighted our concerns to staff that an MDT consisting solely of an RC and registered nurse could prevent patients from accessing other professional therapeutic input and services that would benefit their recovery.

Our concerns regarding these issues were dealt with under our immediate assurance process. Further information on the improvements we identified, and the actions taken by the health board, are provided in Appendix B.

In general, we observed staff responding to patient needs in a timely manner and managing patient risks through therapeutic observation and engagement. We were told that observation levels for individual patients were regularly reviewed during daily handover and ward round meetings, to ensure they continued to be safe and appropriate. Staff confirmed that they would observe patients more frequently if their behaviour required closer monitoring.

Our examination of patient observation records found that they were mostly appropriately and contemporaneously completed on both wards. However, we noted a gap within the record of one Cedar Ward patient during which their observation record had not been completed over a one-hour period.

The health board must ensure that patient therapeutic observation records are fully and contemporaneously completed to maintain patient safety.

We observed a range of therapeutic activities and interventions being provided to patients on Alder Ward. Staff confirmed that the support and engagement of the Alder Ward activities coordinator greatly reduced patient challenging behaviours and the need for restrictive practices. However, we saw no evidence of therapeutic activities taking place on Cedar Ward and noted occasions when patients were left alone together, with no staff immediately present to monitor or engage with them. We were told that patient boredom and a lack of available staff were causative factors for incidents of patient violence and aggression on Cedar Ward.

The health board must ensure that the Cedar Ward staffing levels are sufficient to support patient safety and that staff engage with patients in a therapeutic and supportive manner.

The hospital had policies in place to help protect the safety and wellbeing of patients and staff. The health board's 'Restraint in The Care Management of Patients Aged 16 Years and Over With Impaired Mental Capacity' policy, described approaches required for staff to safely manage challenging behaviour. However, the policy had not been reviewed since February 2023.

It was positive to note that the hospital had adopted the 'Safewards model' as a method of reducing restrictive practices. During our discussions with staff, they showed understanding of the restrictive practices available to them, including appropriate preventative measures that can reduce the need for restrictive responses to challenging behaviour. We observed staff engaging with patients appropriately and providing reassurance, support and verbal de-escalation throughout the inspection. We saw evidence of restrictive practices being used as a last resort, with thorough monitoring around therapeutic effect and risk, and diversionary tactics in place as a method of de-escalation.

Incidents of restrictive practices were reported through the Datix system which had an established governance structure in place and incorporated a hierarchy of investigation process and incident sign-off. However, we noted that staff were not always recording restraint incidents under the correct sub-category of 'restraint' within Datix. As a result, the system could not be filtered to produce accurate restrictive practices data, which posed considerable difficulty for supervisory staff to provide robust governance oversight and monitoring of restraint incidents.

We examined staff training records, staff rotas and Datix incident forms. We were provided with training compliance figures which indicated that overall staff

compliance with Strategies and Interventions for Managing Aggression (SIMA) training was 82 per cent on Cedar Ward and 98 per cent on Alder Ward.

Through a review of individual incidents of restraint, it was identified that some staff had been involved in incidents of restraint during the last three months who were out of compliance with this training. It was concerning to note that these issues were also identified during our previous inspection of other mental health wards at Hafan Y Coed in January 2023.

Our concerns regarding these issues were dealt with under our immediate assurance process. Further information on the improvements we identified, and the actions taken by the health board, are provided in Appendix B.

Nutrition and hydration

Our examination of patient records found that patients were supported to meet their individual dietary needs and provided with diets in accordance with their medical needs. Patient nutrition and hydration needs were continually assessed, recorded and addressed as appropriate. Patients could access dietetic specialist services when needed.

There were suitable facilities available for patients to have hot and cold drinks and we were told that they could access these throughout the day. The patients who completed our questionnaire confirmed that they were able to access a drink when needed. Staff told us that patients were provided with a with a variety of meal options with due consideration for their cultural and religious needs. We observed that patients could also buy and store their own food in the hospital.

Patient records

Patient records were being maintained electronically and via paper files. Paper files were securely stored on site and the electronic system was password protected to prevent unauthorised access and breaches in confidentiality. We generally found well-organised paper and electronic records completed on the wards, which were easy to navigate when familiar with the hospital systems. However, we noted some improvements were required in terms of the standard of record keeping, particularly the quality of the patient care and treatment planning documentation. Further information on our findings 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 four patients across both wards and spoke with staff to discuss the monitoring and audit arrangements in place. We were assured that the health board's responsibilities under the Mental Health Act

were being upheld. All records were found to be compliant with the Act and Code of Practice. Clear reasons were being documented to evidence why detention under the Act was the most appropriate way of providing care for patients. There was good support available for patients from the local Independent Mental Health Advocacy service.

We found the Mental Health Act (MHA) Team at Hafan Y Coed provided robust and efficient systems of audit and monitoring in respect of all areas of the MHA and its application. The MHA files we viewed were very well organised, easy to navigate and contained detailed and relevant information. We saw appropriate escalation of relevant MHA issues to the Mental Health Legislation and Mental Capacity Committee, to share learning and drive quality improvement.

Our observations and staff discussions during the inspection evidenced that the MHA Team was very supportive to ward staff regarding the application of the MHA. We were told that the team provided a programme of online and face-to-face training and had also developed an intranet site for staff to access relevant MHA information. We identified these as examples of good practice.

Suitable arrangements were in place to document Section 17 leave appropriately. We saw that leave was being appropriately risk assessed and that the forms determined the conditions and outcomes of the leave for each patient. However, we noted that the risk assessments were recorded within the individual patient intervention plans, but not within the Section 17 leave documentation. This meant that staff had to review the patient intervention plans to locate the relevant Section 17 risk assessment, which could potentially cause delays.

The health board should ensure patient risk assessments are recorded within Section 17 leave documentation for ease of reference, timely access and monitoring.

During the inspection we found that one patient on Alder Ward was subject to emergency provisions for providing patient medication under Section 62 of the Act. However, we noted that there had been a delay in progressing this matter, in that the request had not yet been referred to a Second Opinion Appointed Doctor (SOAD) for review. We highlighted this issue to staff during the inspection and were informed that the matter would be addressed robustly by staff.

The health board must ensure that Second Opinion Appointed Doctor referrals are made in a timely manner, in the interest of patient safety.

We noted some additional improvements were required in respect of Mental Health Act monitoring. We found there were no hard copies of the MHA Code of Practice

available on either ward. Whilst staff could access the Code of Practice electronically, it was not readily accessible for patients and family/carers. We also noted that patient ethnicity was not consistently recorded within the patient MHA records we viewed.

The health board must:

- **Ensure hard copies of the MHA Code of Practice are made available on both wards**
- **Ensure patient ethnicity is routinely recorded within patient records.**

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

Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010. During the inspection we reviewed 15 patient records and intervention plans across both wards. The records were well organised and stored securely. The wards used the Wales Applied Risk Research Network (WARRN) principles and we saw evidence of comprehensive assessments and risk assessments, which reflected the needs of patients. However, we observed a variable standard of clinical record keeping across the two wards and noted that robust improvements were required in respect of the quality of the patient records.

We found the quality of the patient records and intervention plans was generally appropriate on Alder ward. We saw evidence that patient intervention plans were being assessed and monitored daily. The plans we viewed were person-centred and outcome focused, and reflected the criteria set out by the Mental Health (Wales) Measure 2010. We saw evidence that patients, family and carers were involved in their care wherever possible.

On Cedar Ward, we found most of the patient WARNN risk assessments were comprehensive and completed to a high standard. However, the general standard of clinical documentation and record keeping was poor. The patient intervention plans were not person-centred nor individualised to patient needs, and we saw no evidence of patient involvement in their care and treatment. Many intervention plans were found to be incomplete and there was no clear review date within the plans, which posed difficulties in measuring the effectiveness of the patient interventions and treatment.

It was concerning to note that the health board's AIMS review of Cedar Ward in December 2023 had identified the same issues regarding the quality of the patient records, which were still present at the time of our inspection. The report identified that the standards of documentation were '*poor*', that care planning

was '*extremely poor*,' and that patients were not collaboratively involved in care planning. The report outlined that discussions regarding patients' ongoing needs were not reflected in the patient intervention plans.

The health board must implement robust ongoing governance oversight to improve the quality of the patient records and ensure they are fully completed, person centred, and are regularly reviewed.

We saw some evidence of discharge and aftercare planning within the patient records, with discussions being held on future appropriate placements. It was positive to note that the Recovery and Wellbeing College offered a comprehensive 'Preparing for Discharge' course which supported patients through the discharge process. However, we found that some of the patient records did not contain any information regarding discharge planning arrangements. Where this was recorded, we found the information was difficult to locate within the records, being recorded within the case notes rather than being recorded separately for ease of reference.

The health board must ensure patient discharge planning information is routinely recorded within a separate designated area of the patient records, for ease of access and monitoring.

Quality of Management and Leadership

Staff feedback

Staff responses to the HIW questionnaires were mostly positive, with all staff members recommending the hospital as a place to work, and all confirming that they would be happy with the standard of care provided for their friends or family. Most staff members agreed that their current working pattern allowed for a good work-life balance.

Staff comments included:

> "*The whole team within my ward are amazing it does feel like an honest team which makes the difficult situations much easier to control … I have confidence with colleague(s) to support me and back me with whatever is taking place.*"

Most staff agreed that their organisation takes positive action on health and wellbeing. However, three out of the six respondents stated that in general, their job was detrimental to their health.

Whilst staff confirmed that they were aware of the occupational health support available to them, the health board must engage with staff to ensure their health and wellbeing is being protected.

Leadership

Governance and leadership

It was positive that throughout the inspection staff were receptive to our views, findings and recommendations. The majority of staff members who completed a questionnaire told us that the health board was supportive and takes swift action to improve when necessary. Almost all staff felt care of patients was the health board's top priority.

There appeared to be appropriate governance and oversight processes in terms of activities and meetings to discuss issues related to patient care and identify improvements. We observed everyone working well together throughout the inspection. However, as outlined previously in this report, the MDT was not well established, and we were not assured that clinical decisions relating to patient care were being determined through a multi-disciplinary approach on the wards.

Staff we spoke with during the inspection and who completed our questionnaire provided positive feedback to us about their immediate line managers. All staff felt that their manager could be counted on to help with difficult tasks at work, and that their manager gave them clear feedback on their work. Almost all agreed that their manager asked for their opinion before making decisions that affected their area of work.

Staff we spoke with during the inspection felt that senior managers were visible, but most who completed our questionnaire disagreed. Most who completed our questionnaire agreed that senior managers were committed to patient care, but half who completed our questionnaire felt that communication between senior management and staff was not effective. They told us:

> *"Senior management will make decisions regarding patients without care for ward teams thoughts. Resulting in delay of patient care."*

The health board should reflect on this aspect of feedback and consider whether improvements in relation to senior management visibility and communication with staff could be made.

During the inspection we noted a range of up-to-date health board policies were available to support staff in their roles. However, we found some policies were passed their review dates, as previously outlined in this report. We were further informed that continued delays in the health board publishing the operational policy for Alder Ward resulted in a lack of clear guidance for staff and adversely affected patient flow.

The health board must ensure both wards have an up-to-date operational policy to provide clear guidance to staff.

Workforce

Skilled and enabled workforce

Staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. All staff members who completed a questionnaire agreed that they were able to meet the conflicting demands on their time at work, and that there were enough staff on the wards to enable them to do their job properly. We were told that there were very few staffing vacancies on the wards, with one Registered Nurse vacancy on Cedar Ward and one healthcare support worker vacancy on Alder Ward. However, we noted a heavy reliance on bank staff to fill vacant shifts on Cedar Ward, and instances where staff were unable to monitor and respond to patients, as outlined in this report.

We saw that suitable processes were in place for senior staff to monitor compliance with mandatory training. It was positive to note that overall mandatory training compliance rates were generally high among staff on the wards. Most staff members who completed a questionnaire felt they had received appropriate training to undertake their role. They told us:

> *"Everything I've received gave me confidence and I've actually used and needed it all."*

However, we found improvements were required in respect of some mandatory training courses in addition to those not previously mentioned in this report as follows:

Alder Ward:

- Fire safety – 78 per cent

Cedar Ward:

- Information governance - 61 per cent
- Mental Capacity Act - 76 per cent.

The health board must implement measures to ensure all outstanding mandatory staff training is completed, regularly monitored and that staff are supported to attend the training.

Staff who completed our questionnaire were asked what other training they would find useful and commented:

> *"Would be handy to be put on to the blood level recalibration training so I can do that and not have to ask other staff for me. Besides that, everything is great!"*

> *"Bloods (training)."*

> *"Better restraint training more intense to make the staff ready for what happens on the wards."*

The health board should consider the staff feedback about suggestions for training and implement annual, individualised training needs assessments.

We saw that 84 per cent of Alder Ward staff and 82 per cent of Cedar Ward staff had received their annual Values Based Appraisal (VBA). We were told that a formal clinical supervision process was in place for all staff, including monthly supervisions for qualified nurses and quarterly supervisions for healthcare support

workers. We noted that this arrangement contradicted the recommendation made in the health board's AIMS review of Alder Ward dated May 2023, in which a recommendation was made for '*all staff to receive regular managerial supervision support on at least a monthly basis*.' Furthermore, the Cedar Ward AIMS review in December 2023 identified that only six out of 31 staff members engaged in clinical supervision, and that formal line management supervision was poorly adhered to. During the inspection, some staff told us that formal clinical supervision sessions were not being undertaken with nursing staff as required, and that they would benefit from additional supervision.

The health board must ensure that staff have access to regular formal clinical supervision to support their learning and development.

Culture

People engagement, feedback and learning

The health board had an established process in place where patients could escalate concerns via the NHS Wales Putting Things Right (PTR) process. Senior staff confirmed that formal complaints were recorded on the Datix system and were supervised by senior managers throughout the investigation. Staff told us that wherever possible they would try to resolve complaints immediately and share learning from incidents appropriately.

All staff who completed a questionnaire confirmed that they knew and understood the Duty of Candour requirements, and that the health board encouraged them to raise concerns when something has gone wrong and to share this with the patient. All staff also told us that they would feel secure raising concerns about patient care or other issues at the hospital, and most felt confident that the health board would address their concerns.

During the inspection we found there was no dedicated patient meeting process on Cedar Ward. Staff confirmed that patients could raise concerns at any time, and that they were also signposted to the complaints process via the hospital's notice boards and patient information leaflets. We were told that verbal feedback was collated, and any complaints were formally recorded and escalated as appropriate. There was a suggestion box in the air lock of Cedar Ward which invited patient and family/carer feedback, but it did not contain any feedback forms for people to complete.

The health board should consider ways to formally and routinely capture patient feedback on Cedar Ward, to enhance patient care and drive quality improvement.

On Alder Ward, we noted that the Safewards Mutual Help patient meeting process had been implemented to invite patient feedback and discuss any issues. The records indicated that the meetings should be held every weekday, but we found they did not always take place as arranged.

The health board must ensure Mutual Help meetings take place within set timescales, in accordance with Safewards model.

We were told that both wards had a dedicated staff meeting process to share concerns and feedback and strengthen staff working relationships. However, we found these meetings did not take place on a regular basis and there had been no ward staff meetings within the last six months prior to our inspection. Staff we spoke with during the inspection told us that the staff meeting process had stalled due to high patient acuity and there being no cover for ward staff to attend the meetings during their shift.

The health board must ensure staff meetings are conducted on a regular basis to engage staff, discuss issues and encourage feedback.

A whistleblowing policy was in place to provide guidance on how staff can raise concerns in the hospital. We were told there were various support systems available to staff going through the complaints process, including Human Resources, wellbeing services and Occupational Health.

Information

Information governance and digital technology

We found that paper records and data were being maintained in line with General Data Protection Regulation (GDPR) legislation, and securely stored in locked areas. All information recorded on the hospital's electronic health record system was password protected. Information was accessible to all relevant staff and there were established processes to share information with partner agencies in safe and secure way. Staff compliance with mandatory information governance training was 61 per cent on Cedar Ward and 80 per cent on Alder Ward.

Learning, improvement and research

Quality improvement activities

There were processes in place to ensure key issues were being effectively investigated, escalated, supervised and scrutinised to prevent reoccurrence. During our staff discussions we were apprised of regular audit activities and meetings to discuss incidents, findings and issues related to patient care. We

reviewed a sample of recent incidents recorded on Datix and found they had been recorded and investigated in line with policy.

The governance process in place at Hafan Y Coed generally supported continuous improvement and shared learning from incidents. However, we identified that improvements were required to ensure that some recurrent issues and points of learning were appropriately escalated and robustly addressed. We also found improvements were required to ensure hospital records could be filtered to retrieve ward-specific restraint data, to support effective governance oversight and monitoring.

It was concerning to note that the environmental issues we identified during our previous inspection of Cedar Ward in 2022 were still present at the time of our inspection. We also noted that many issues previously identified during internal audits and during the AIMS reviews conducted in May and December 2023 were still present during our inspection, as outlined in this report. Staff we spoke with during the inspection reported that although the AIMS reviews were commenced in 2023, the health board needed to complete a review of all wards in Hafan Y Coed before they could extract specific themes and develop an action plan, the last of which was completed in June 2024.

We were told that positive initial action was taken to address the issues identified during the AIMS reviews of the wards. This included frequent engagement with ward staff and the creation of a working group to discuss key themes and identify areas of learning and improvement. However, we were told that the AIMS review meeting process was delayed and that the working group project was later disbanded due to staffing changes within the teams. Senior staff we spoke with during the inspection confirmed that the hospital leadership and management systems would be strengthened to ensure our inspection findings and the findings of the AIMS reviews would be suitably addressed, and that they would review the quality of the ward documentation as a key priority.

Overall, we have made several recommendations as a result of our inspection. These have been referenced throughout the report.

The health board must strengthen the leadership and governance processes in place across Hafan Y Coed and ensure that audit management and quality improvement processes are robust. This is to ensure individual or recurrent themes are managed and addressed effectively, and learning is shared throughout the hospital.

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 which were resolved during the inspection.			

Appendix B – Immediate improvement plan

Service: Hafan Y Coed, Cedar and Alder Wards

Date of inspection: 01, 02 and 03 July 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.

Findings:

During the inspection we considered the environment of the patient and clinical areas on Cedar Ward. We found a number of environmental, infection control, and health and safety risks. This meant we could not be assured that the health, safety and welfare of patients, staff and visitors was being actively promoted and protected on Cedar ward. We noted:

- Throughout the ward numerous examples of furniture, fixtures and fittings were damaged. For example, many of the patient armchairs throughout the ward were worn or ripped, and we saw missing areas of skirting within the Extra Care Area. This poses environmental risks for patients and does not support effective Infection Prevention and Control (IPC)
- There was significant and ongoing water damage to areas of the flooring, skirting and lower walls throughout the ward. In some areas the damage had resulted in raised and loose flooring, which presented as a trip hazard and posed a risk to staff and patient safety. The extreme damage to the walls and floors prevented effective infection prevention and control measures from being upheld throughout the ward
- The health board's September 2023 Fire Risk Assessment identified that the swelling of the floors prevented the ward's automatic fire doors from closing completely, and therefore providing an effective seal against fire spread. We saw that the action plan outlined that remedial actions were required to be undertaken to resolve this issue within 28 days of the assessment, but they had not been completed at the time of our inspection.
- We were informed by staff that a capital programme of works had been agreed to rectify these matters, but the health board was still awaiting a start date at the time of our inspection.

- The environmental issues had previously been identified by HIW during an inspection of the ward in 2022, at which time we were informed that the matter would be addressed by September 2022. However, they had not been addressed at the time of our inspection.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The health board must expedite the capital programme of works and provide a timeline of when it will be completed. The health board must also provide assurance on how it can better uphold effective infection prevention and control measures in the meantime.	Delivery of safe and effective care	Six chairs have been disposed of and replacements ordered. Update: 29.07.2024 all non-IPC compliant furniture has been removed and replaced. A walk around was undertaken in partnership with the infection prevention and control team on 12.07.2024, the purpose of this being to identify which pieces of furniture pose an infection prevention and control risk and risk assess. The long-term solution for the flooring is being explored. There have been significant investigations carried out and are continuing to be carried out. The next tranche of work was to carry out water treatment and cleaning of the under-floor heating system to ensure there were no blockages or	Service Manager Service Manager Director of Estates	Complete Complete Investigations complete 3 – 4 months (subject to adequate access provided by the clinical service.)

			corrosion within any of the individual pipes from each of the manifolds, there are significant number of pipe circuits from each manifold. This is currently being undertaken and is programmed for completion by 19 July 2024. Update 29.07.2024 - complete. Immediate Works: • All doors tested and are operational this week. Further investigations into the latent defect caused by the original contractor are ongoing. At present floors are dry and doors operational, immediate works listed below for affected areas. Update 29.07.2024: complete. Update 29.07.2024: Now the assessments have been completed, a complete removal of the flooring and temporary closure of the ward (requiring the ward to move to a different area in the hospital) will be required to address the longstanding	Director of operations Director of Estates/ Director of Operations	July 2024

			issues of the damaged walls and flooring. This means other areas will need to be prepared for the transfer of Cedar, including estate considerations. This will be escalated to executive team. The immediate action of confirming all doors can close has been completed. Below are the actions that need to be taken when the ward is closed. • "Whiterock" will be applied to the walls, up to and finishing behind the handrails in the corridor areas affected, masking the skirting and the damage to the walls, with the "Whiterock" sealed at floor level. • Damaged screed will be broken up and re-laid. • The UHB instructed a Contractor to undertake a survey on all of the underfloor heating systems at HYC in October 2023. This was to identify if the system was leaking and causing a number of	Director of Estates	2 – 3 months (subject to adequate access provided by the clinical service.)

			issues with water penetration in the floors. • The survey initially started in the plantrooms. A pressure test on the system was carried out from the plantroom to the manifolds, pressure losses were found. The initial findings identified a number of problems with the manifolds, that may have caused the pressure losses. The issues with the manifolds prevented the full system from being pressure tested. The manifolds have now been repaired. It was felt unlikely that the issues with the manifolds had caused the floor issues. • The next tranche of work was to carry out water treatment and cleaning of the under-floor heating system to ensure there were no blockages or corrosion within any of the individual pipes from each of the manifolds, there are significant number of pipe circuits from each manifold. This is currently being undertaken and is		

			programmed for completion by 19 July 2024. Update 29.07.2024: Completed • Each circuit will then need to be pressure tested. Due to the nature of the wards and the need to gain access to the manifolds, in sensitive areas, the works will be completed in conjunction with the clinical services in timescales to accommodate the end users. It is anticipated that pressure checks on the system should be completed within 3 – 4 months (tbc), after the 19th July. The results of the survey will then inform the health board if there is a definite leak within the underfloor heating system and the location thereof. When the results are known, this will help provide a strategy for the UHB on how best to resolve the issues. This may result in a capital bid being put forward to complete the rectification works, or, discussions with the main contractor who completed		

			the original build, if it is deemed a latent defect. Until we know the extent of the works / defects we are unable to provide a timeline for full rectification of the problems. In both cases the areas affected will be treated with waterproof coatings prior to covering or enclosing. • Monthly IPC audits on Tendable. Update: Update 29.07.2024: Commenced 26.07.2024 • Cleaning checklist to be allocated to night staff. Update 29.07.2024: Complete • Communication regarding bare below to be re-circulated. Update 29.07.2024: Complete • Disposable curtains to be replaced. Update: 29.07.2024 The disposable curtains have been ordered to replace all 15	Lead Nurse/Senior Nurse Service Manager Ward Manager	Immediately and scheduled monthly. Completed 9.7.24 August 2024 August 2024

			curtains in the bedrooms. Awaiting delivery. 8/8/2024 All equipment has been delivered and estates will install this as a priority. • Environmental nurse allocation as a daily role to be piloted on Cedar Ward. Update 08.08.24: Underway		

Findings:

During the inspection we examined staff training records, staff rotas and Datix incident forms. We were provided with training compliance figures which indicated that overall staff compliance with Strategies and Interventions for Managing Aggression (SIMA) training was 82 per cent on Cedar Ward and 98 per cent on Alder Ward.

Restraint incidents were being recorded on the electronic Datix system. However, we noted that staff were not always recording restraint incidents under the correct sub-category of 'restraint' within Datix. As a result, the system could not be filtered to produce accurate restrictive practices data and posed considerable difficulty for supervisory staff to provide robust governance oversight and monitoring of restraint incidents.

Through a review of individual incidents of restraint, it was identified that some staff had been involved in incidents of restraint during the last three months who were out of compliance with this training.

These issues were also identified during our previous inspection of other mental health wards at Hafan Y Coed in January 2023.

Furthermore, the health board's Policy – 'Restraint In The Care Management Of Patients Aged 16 Years And Over With Impaired Mental Capacity' was out of date.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
2.	The health board must: • Ensure staff are fully compliant with their SIMA training • Ensure sufficient levels of SIMA trained staff are on duty at all times on each ward • Implement robust processes to ensure restraint incidents are correctly recorded within Datix and can be filtered to support effective investigation, supervision and governance oversight • Review the outdated Restraint policy to provide clear guidance to staff and support them in their roles • Consider why these issues were not identified in health board governance processes	Delivery of safe and effective care	All staff that are able to receive SIMA training are compliant with the exception of three staff on Cedar Ward who have been booked in and one member of staff member on Alder, all booked for re-training. The other members of staff are exempt from SIMA due to occupational health concerns. Update: Three outstanding staff booked in September. Each ward has a trained SIMA member of staff allocated as the emergency responder for hospital wide SIMA interventions should these be required. This provides SIMA trained staff additional to those in the roster. Temporary Staffing to be reminded not to engage in SIMA if out of date of compliance with training. Some Health Roster SIMA expiry dates had not been entered accurately and as a result it wasn't possible to ensure that staff booked onto bank shifts were compliant with training. All Health Roster information is being updated by the SIMA Lead manually to ensure	Ward Managers Lead Nurse SIMA Team Lead/ Ward Managers SIMA Lead	September 2024 (dates have been booked for the staff) July 2024 Complete July 2024 and ongoing

	• Ensure that these findings are not systemic across Hafan Y Coed.		accurate compliance dates. Update: commenced July, and ongoing. Exploring options for ESR to support this.		
			Rosters have been reviewed to ensure a minimum standard number of SIMA trained staff are booked on each shift. This has been calculated and rostered to ensure Cedar Ward have five SIMA trained staff by day and four by Night, Alder Ward has eight by day and six by night.	Senior Nurse	July 2024 and ongoing
			Any breach of the minimum requirement will be escalated to Shift Co-ordinator and submit a 'red flag' entered on SafeCare.	Senior Nurse	July 2024 and ongoing
			A meeting with Improvement Cymru and Mental Health providers on 18th July will explore the options for DATIX recording of restrictive practice towards an all-Wales approach. The local risk registers have been updated to reflect the challenge of recording multiple DATIX events for restrictive practice while maintaining HSE legal obligations to record V&A and RIDDORs.	Senior Nurse / Assistant Head of Health and Safety	July 2024

			Update: National work is underway but a local arrangement is now in place to record episodes of restraint. Immediate instruction to the SIMA lead to collate all SIMA interventions and restrictive practice into a spreadsheet so this can be cross referenced with the DATIX record to ensure all incidents are collated and assurance can be given about the staff and patients involved. The data collated can be shared at Health and Safety and Quality and Safety meetings. Update: Commencing from July 2024. UHB Health Board Restraint Policy has been reviewed by SIMA leads, Mental Capacity Lead, Directors of Nursing and MH Director of Operations. Policy will be ratified at the Mental Health Mental Capacity Act Legislation Committee on 6th August 2024. Agreed health roster identifies staff with the SIMA skill, how restraints are recorded on DATIX will be discussed nationally in July. Policy expiry explored and raised with Corporate Governance.	SIMA Lead Director of Operations Director of Nursing	July 2024 Due to be presented as Mental Health Mental Capacity Act Legislation Committee August 2024 July 2024

			Ensure all areas are aware of their staffing numbers who are SIMA trained.	SIMA Team Lead	August 2024

Findings:

During the inspection we were told by staff working on Cedar and Alder Wards that the multidisciplinary team (MDT) for both wards consisted of only two disciplines, these being a Responsible Clinician (RC) and a registered nurse. We were informed that the RC of Cedar Ward was not dedicated to the ward, also having responsibility for the North Crisis Team. We were informed that the dedicated Occupational Therapist (OT) post was vacant on Alder ward and that Cedar Ward did not have a dedicated OT, but shared an OT with the crisis service. However, this post was also vacant, therefore, neither ward was being supported by an OT at time of our inspection. We further noted that neither ward had a dedicated psychologist, with the funding for a psychologist post on Cedar Ward having been removed. As a result, we could not be assured that clinical decisions relating to patient care and treatment were being determined through a multi-disciplinary approach that took a comprehensive and holistic view of the needs of each patient. An MDT consisting solely of an RC and registered nurse could prevent patients from accessing other professional therapeutic input and services that would benefit their recovery.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
3.	• The health board must conduct a review of the current MDT arrangements on each ward and ensure that a multidisciplinary approach is adopted in relation to the care and treatment of patients. • The health board must provide assurances on how it ensures that clinical decisions made throughout	Delivery of safe and effective care	A review of staffing across the adult inpatient mental health wards will be undertaken to establish the resources required to provide an effective, efficient and equitable approach to multi-disciplinary care provision on all wards. The review of the inpatient establishment will be informed by multidisciplinary groups and benchmarked against QNWA standards.	Director of Operations	July 2024 – complete

	the patient pathway, from admission to discharge, are agreed by a variety of mental health professionals working together for the best interests of each patient • Ensure that these findings are not systemic across Hafan Y Coed.		Update: Nursing establishment review meeting 02.08.24, full MDT consideration meeting 08.08.24. While the multi professional work is underway, board rounds on all wards will be supported by an occupational therapist to ensure comprehensive consideration of referral to other members of the multi professional team. A safe discharge procedure is being completed. Update: Policy update meeting was undertaken on 30.07.24 and work continues to review the policy with a further meeting planned for 16.08.24 Inpatients in HYC have access to the Preparing for Discharge course run by the Recovery College.	Director of Operations	September 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):	**Rachel Rushforth**
Job role:	**Lead Nurse**
Date:	**09/08/2024**

Appendix C - Improvement plan

Service: Hafan y Coed, Cedar and Alder wards

Date of inspection: 01, 02 and 03 July 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.	No outside seating was provided for patients on Cedar Ward.	The health board should install seating in the garden of Cedar Ward to provide a more pleasant, therapeutic environment for patients.	Health promotion	External seating has been put in place since the inspection.	Director of Operations	Complete
2.	Neither ward was supported by an Occupational Therapist. We were not assured that the patients on Cedar Ward were being provided with suitable and appropriate therapeutic activities	The health board must: • Ensure Cedar Ward patients are provided with a range of accessible therapeutic activities to support their health and wellbeing	Health promotion	In the absence of a dedicated Occupational Therapist the ward Board Rounds will be attended by an Occupational Therapist to support identification of Occupational Therapy	Lead Occupational Therapist for Mental Health	Complete

	to support their health and wellbeing.	• Review the provision of OT support for patients on both wards • Make continued efforts to recruit to the vacant OT posts.	needs in the patient cohort. Patients will be referred onto Occupational Therapist as required. In Alder there is a dedicated Activities Support Worker and an OT Vacancy.		
			An Activities Health Care Support Worker position is being recruited to and their role will include leading on therapeutic activities (subject to agreement to enhanced establishments by the UHB)	Lead Nurse for Adult Mental Health	December 2024
			Mental Health Clinical Board are undertaking a review of multi-disciplinary staffing to ensure adequate	Clinical Board triumvirate	Further discussions to be progressed in the

				establishment of Occupational Therapist.		Summit 2024.
3.	Most of the patient bedrooms on both wards did not have any form of privacy screening to separate the bedroom and toilet areas.	The health board must undertake measures to install suitable privacy screening within all patient bathrooms.	Dignified and respectful care	Privacy curtains have been installed in all bedrooms since the inspection.	Lead Nurse for Adult Mental Health	Complete
4.	Many patient bedroom windows did not have curtains, which posed a risk of disturbing their rest.	The health board must ensure patient bedrooms are fitted with suitable fixtures and fittings to allow them to rest and sleep undisturbed	Dignified and respectful care	All bedrooms have now been fitted with window coverings since the inspection. A stock is available in the Cedar Store Room.	Lead Nurse Adult Mental Health	Complete
5.	We found that some of the ROS monitor cabinets were unlocked, which compromised patient privacy and dignity	The health board must ensure that the patient bedroom ROS monitors are appropriately secured at all times to support their privacy, dignity and safety.	Dignified and respectful care	The Reassurance Observation System (ROS) is accessed via a staff panel. This is audited by the service manager on a monthly	Service Manager Inpatients	9th September 2024

	and posed a potential risk to their safety.			basis and feedback to the wards. Since the inspection all panels have been checked to ensure that they can be locked. The environmental checks are to include ROS compliance aligned to the ROS procedure. The maintenance of the ROS is under close audit and any operational issues in relation to the ROS are escalated to estates and open view.		
6.	There were no designated gender-specific areas on the wards.	The health board should ensure there are designated, gender-specific areas on both wards which can be used as required.	Dignified and respectful care	All bedroom and bathroom are for individual use and therefore all sleeping	Lead Nurse Adult Mental Health	Complete

				and bathroom areas are segregated There are 4 day rooms on Cedar from which we can be designate sex-specific rooms. The Lived Experience Team will support the development of guidance on how and when Gender specific day rooms should be implemented.	Director of Operations	End of November 2024
7.	We noted the following issues in respect of patient information: • No advocacy services information displayed on Cedar Ward • There was no HIW information	The health board must ensure patients are provided with relevant, up-to-date and accessible information to support their care.	Patient information	All information has now been displayed on the ward to ensure that it is readily available for patients. An information leaflet has been co-produced and includes a wide range of information including Patient Rights, Llais and HIW contact details and	Lead Nurse Adult Mental Health Co-production Lead	Complete October 2024

	displayed on either ward • Some patient information was displayed within the air lock area on Cedar Ward and not readily accessible			advocacy details. All patients will be provided with this on admission		
8.	We witnessed occasions when staff did not respond when patients knocked on the Cedar Ward nursing office door to speak to them.	The health board must consider our findings relating to staff and patient engagement and ensure processes are implemented to respond to patients in a timely manner.	Timely care	All staff have been reminded of their responsibility to respond to patients appropriately. A review of the nurse staffing establishment has been undertaken and the outcomes have been presented to the Executive Team to consider	Senior Nurse Manager Crisis Service Clinical Board triumvirate and the Executive Team	Complete Further discussion in Summit meeting September 2024

9.	Staff confirmed that the Welsh language requirement for each individual was not always routinely recorded by staff.	The health board must ensure patient language requirements are appropriately recorded and addressed within their records.	Communication and language	Preferred language is a mandatory field within PARIS (or electronic records system) and we are 100% compliant in recording this. The Clinical Board have requested to the UHB Welsh Language Officer to support the inpatient unit with the Welsh Language Compliance.	Lead Nurse for Adult Mental Health Director of Operations	Complete December 2024
10.	The health board's Equality, Inclusion and Human Rights Policy had expired in January 2024.	The health board must review the out-dated policy to provide current guidance to staff.	Rights and equality	The Policy is currently under review	UHB Equality Lead	November 2024

11.	There was no locked door policy in place to provide staff with clear guidance on managing access and egress for formal and informal patients, whilst maintaining the safety and security of the ward.	The health board must implement a policy which provides clear guidance to staff on the procedures and protocols for locking doors to prevent unauthorised access or egress.	Rights and equality	Internal guidance for Section 17 leave is due to ratification by the end of 2024. An internal protocol to be development for the management of access and egress. This will be allocated September 2024.	Lead Nurse Adult Mental Health Director of Nursing	December 2024 December 2024
12.	Improvements were required to ensure the ligature audits fully described the actions taken in respect of each individual risk.	The health board must ensure that ligature audits are fully completed to describe the management actions taken in respect of each individual risk.	Risk management	Ligature audits are being undertaken electronically on an annual basis. Outcomes of the audits are discussed at the ligature escalation meetings to agree actions, this includes ensuring expanded details for individual risks identified.	Lead Nurse for Adult Mental Health	Complete with ongoing monitoring

				The clinical board is participating in the NHS executive patient safety programme ligature workstream. Annual quality audits are to be conducted. Quality audits will be reviewed at the clinical board Health and Safety Meeting.	Service Manager Inpatient Director of Operations	Ongoing December 2024
13.	We reviewed the Daily Environment Checklists and noted numerous gaps. The checklists were not consistently signed by the Nurse in Charge. We saw examples whereby the documentation did not provide a true reflection of the environment observed during the inspection.	The health board must implement robust measures to ensure the Daily Environment Checklists are fully completed, provide a true reflection of the ward circumstances, and that staff are supported to complete the checks in the course of their duties.	Risk management	The current nursing review that has been completed has identified the requirement for a dedicated member of staff for environment checks. Audits on the environmental checklists are completed quarterly by service manager. There has been an	Lead Nursing Adult Mental Health Service Manager	Review complete Further discussions to be progressed in the Summit in September 2024 Complete –

				improvement and feedback is being provided to ward managers. If staff are unable to completed environmental checks because of staffing establishment this is captured on Safe Care to support actions to address staffing and acuity including temporary staffing	Lead Nurse	Complete
14.	Only two of the patient bedrooms were fitted with emergency call points. This arrangement posed a potential risk to patient safety.	The health board must consider the installation of emergency assistance call points within patient bedrooms and at regular intervals throughout the wards, in line with national standards.	Risk management	Guidance will be developed to support the risk assessment of emergency call provision. This will need to be sensitive to ligature risk assessments, falls risk assessments, safeguarding and mobility / disability issues. This guidance	Director of Nursing / Lead Nurse	By December 2024

				will be developed in partnership with the Health and Safety Team. Following ratification of the guidelines we will put systems in place to undertake a risk assessment to identify where emergency call badges are to be provided for individuals where this is an identified need. This will be documented within the WARRN risk assessment. Should presentation change and this need be identified emergency call badges will be provided as clinically indicated.	Director of Nursing / Lead Nurse	January 2024

15.	We saw evidence that daily cleaning schedules were not always completed on Cedar Ward. Staff stated that they were sometimes unable to complete the schedules due to patient acuity and care requirements.	The health board must: • Strengthen leadership and governance systems to ensure all ward areas are effectively cleaned and that cleaning schedules are fully completed within set timescales • Review the cleaning roles and responsibilities for nursing staff to ensure they do not impact on the ability of staff to care for patients.	Infection, prevention and control and decontamination	A schedule of monthly IP&C being undertaken by the IP&C team are now in place in partnership With housekeeping services and IP&C.	Lead Nurse Adult Mental Health / Estates Supervisor / IP&C	October 2024
16.	The Cedar Ward dining area required cleaning and the floor of the Extra Care Area was extremely dirty under the mats.	All hospital areas must effectively cleaned to support patient safety.	Infection, prevention and control and decontamination	Both the dining room and the extra care area were cleaned following the inspection These areas will be captured in the IP&C audit	Senior Nurse Managers and House keeping	Complete Complete with ongoing monitoring

17.	The Cedar Ward patient washing machine and tumble dryer were not working. Staff advised that this issue had been reported but no action had been taken to address the matter.	The faulty washing machine and tumble dryer on Cedar Ward must be repaired or replaced.	Infection, prevention and control and decontamination	Procurement and fitting of an industrial washing machines and dryer are currently being explored on the advice of IP&C. Until this is in place interim measures have been put in place to support patients to use a washing machine and dryer on another ward.	Director of Operations	December 2024
18.	Following review of the Tendable IPC documentation, we found the data being recorded did not provide a true reflection of the actions undertaken by staff.	The health board must review the hospital's IPC audits and supporting documentation to ensure they are suitably completed and provide a true reflection of the actions taken by staff.	Infection, prevention and control and decontamination	A schedule of monthly IP&C being undertaken by the IP&C team are now in place in partnership with housekeeping services and IP&C.	Lead Nurse Adult Mental Health / Estates Supervisor / IP&C	October 2024

19.	The Alder Ward kitchen fridge was malodorous and required cleaning.	The fridge must be effectively and regularly cleaned.	Infection, prevention and control and decontamination	The fridge was cleaned at the time of the inspection. The fridge will be part of the housekeeping nursing walk rounds	Lead Nurse Adult Mental Health	Complete October 2024
20.	The Alder Ward kitchen cabinet and fridge contained patient foods which had been opened but were unlabelled, so the expiry date and date of opening could not be ascertained.	Patient foods must be regularly checked and appropriately labelled so the opening and expiry dates can be viewed, to support patient safety.	Infection, prevention and control and decontamination	Staff now have access to labels for the food. A reminder has been put onto the fridge door to ensure expiry and opening dates are visible.	Ward Management	Complete
21.	We saw no labels nor documentary evidence to indicate that the patient communal equipment and facilities were being cleaned after each use and were safe to use.	Communal patient facilities must be promptly cleaned and appropriately labelled after use, to support the safety of patients, staff and visitors.	Infection, prevention and control and decontamination	Cleaning of the beverage bay has been included on the environmental checklist.	Ward Management	Complete

22.	The hospital's disposable curtains were not being replaced at least every six months, in accordance with recommended guidance.	The disposable curtains must be routinely replaced within recommended timescales.	Infection, prevention and control and decontamination	All curtains have been replaced and dated. Review of the dates has been included in the environmental checklist. Stock is available on Cedar store cupboard.	Adult Mental Health Service manager	Complete and Ongoing
23.	We saw Tendable IPC audits which indicated variable scoring in relation to staff being 'bare below the elbows'. We witnessed some staff wearing jewellery, watches and false nails, which posed an IPC risk.	The health board must ensure staff are compliant with the All Wales NHS Dress code.	Infection, prevention and control and decontamination	A decision has been made that clinical staff can no longer wear watches. This has been discussed with IP&C and our executive nurse. Tendable IP&C audits will now accurately reflect the changed position and compliance with this measure will be monitored.	Executive Director of Nursing Senior Nurses/ IP&C Senior Nurse Manager for	Complete Complete and ongoing monitoring Complete

				All staff have been reminded of the All Wales dress code	Inpatient and Crisis	
24.	The health board's Infection Control Procedure for Infectious Incidents and Outbreaks in University Health Board Hospitals had expired in November 2023.	The health board must review the policy to provide current guidance to staff.	Infection, prevention and control and decontamination	The procedure is currently being reviewed and is being presented to the Infection Prevention and Control group on 24th September 2024 for ratification	IP&C	24/09/24
25.	Overall staff compliance with mandatory Level 1 safeguarding training was 77 per cent on Cedar Ward.	The health board must continue to improve Cedar Ward staff compliance with mandatory safeguarding training.	Safeguarding of children and adults	85% is the expectation of achievement for departments, and we are now at 89% compliant on Level 1 safeguarding on cedar. Registered Nurses are 100% compliant on Cedar.	Lead Nurse for Adult Mental Health	Complete
26.	We noted two gaps in the Cedar Ward fridge temperature monitoring checklist during June 2024. The seven-segment display	The health board must: • Ensure the clinic room fridge temperature checks	Medicines management	Compliance with daily fridge temperature will be audited through Tendable	Ward Manager/Senior Nurse/lead Nurse Audit	Complete and Ongoing

	on the fridge thermometer was broken, which made it difficult for staff to read the temperature.	are consistently completed • Replace the faulty fridge thermometer on Cedar Ward.		Thermometer to be replaced.	Service Manager	September 2024
27.	We noted examples where the patient Mental Health Act legal status and patient allergies sections were not completed within some of the MAR charts were viewed	The health board must ensure that patient MHA legal status and patient allergies information is fully recorded within Medication Administration Records.	Medicines management	Audits to be undertaken to monitor compliance.	Clinical Senior Nurse	Monthly
28.	We noted a high reliance on bank staff to fill vacant shifts on Cedar Ward. Recent meeting minutes we viewed indicated that Cedar Ward was '*struggling with inexperienced staff*' and that there was poor staff retention.	The health board must conduct an establishment review of Cedar Ward to ensure the staffing numbers, skillset and experience amongst staff are appropriate to support patient safety and provide patient-centred care.	Effective care	A staffing review has been undertaken and the outcome has been presented to the Executive Team.	Clinical Board triumvirate and Executive Team	Further discussion September 2024

29.	We noted a gap within the record of one Cedar Ward patient during which their observation record had not been completed over a one-hour period.	The health board must ensure that patient therapeutic observation records are fully and contemporaneously completed to maintain patient safety.	Effective care	Monthly audits of observations, NEWS, Medication charts, ward environment checks to be conducted by Clinical Senior Nurse and Physical Health Senior Nurse. This information to be fed back to the ward manager and service manager.	Physical health Senior Nurses and Clinical Senior Nurse	Monthly
30.	We noted occasions when Cedar Ward patients were left alone together, with no staff immediately present to monitor or engage with them.	The health board must ensure that the Cedar Ward staffing levels are sufficient to support patient safety and that staff engage with patients in a therapeutic and supportive manner.	Effective care	There are occasions when staffing establishments fall below the required numbers. When this occurs, it impacts on the availability of staff to be present with all patients and to engage with them therapeutically. Low staffing numbers should be captured on SafeCare. The Senior Nurses, Lead Nurses and Directors of	Clinical Triumvirate and Executive Team	Further meeting with execs in Review complete subsequent to discussions in the Summit in September 2024

				Nursing are notified of this, and can put in place measures to mitigate risk. A staffing review has been undertaken and the outcome has been presented to the Executive Team. These discussions are ongoing as it will require significant investment but this is reflecting in our Intermediate Term Plan. Plans are in place to recruit into all vacant posts, a HCSW recruitment event took place on 28/9/24. Communication will be sent to all staff to remind them of their responsibility to ensure a presence in	Director of Nursing	October 2024

				the communal areas of the ward at all times. Mobile devices for staff can be used on the ward to support them to undertake admin tasks in communal patient areas. A review of the availability of all mobile devices for electronic record keeping is being undertaken with devices being ordered where required, to support staff working in an agile manner around the ward	Director of Operations	October 2024
31.	The Section 17 leave risk assessments were recorded within the individual patient intervention plans but not within the Section	The health board must ensure patient risk assessments are recorded within Section 17 leave documentation for ease of	Mental Health Act monitoring	Section 17 forms will be electronic in the future. The Section 17 leave forms have a statement that requires a signature stating "this leave is to be given at the discretion of	Mental Health Act Manager	Please refer to factual accuracy

	17 leave documentation.	reference, timely access and monitoring.		nursing staff risk assessment and is in compliance with the Care Plan". When the new Mental Health Act begins Mental Health Act Offices will agree a standard version of local forms in a national forum. The inclusion of risks on the S17 form is not a legal requirement and this is being raised for awareness of the expectations of staff to sign their awareness of risk management and pending national changes to MHA forms.		
32.	One Alder Ward patient was subject to emergency provisions under Section 62 of the Act but there had been a delay in progressing this matter as the request had not yet been	The health board must ensure that Second Opinion Appointed Doctor referrals are made in a timely manner.	Mental Health Act monitoring	Staff have a 3 week reminder from the Mental Health Act Office to begin Consent to Treatment Certificate completion. Where translators are required it is the Clinical Board's expectation that Responsible Clinicians	Lead Nurse Adult Mental Health	Complete

	referred to a SOAD for review.			action this promptly to prevent any delay. Any delays with translation services are to be escalated to the Clinical Board and the MHA office. Delays will also be reported on the MHA exception reports to the Mental Health Act Legislation Committee.		
33.	There were no hard copies of the MHA Code of Practice available on either ward.	The health board must ensure hard copies of the MHA Code of Practice are made available on both wards	Mental Health Act monitoring	It has been confirmed that MHA Code of Practices are on the wards.	Mental Health Act Manager	Complete
34.	Patient ethnicity was not consistently recorded within the patient MHA records we viewed.	The health board must ensure patient ethnicity is routinely recorded within patient MHA records	Mental Health Act monitoring	Automatic prompts are present on the PARIS clinical system to alert staff to the need to complete ethnicity information. Ethnicity is confirmed by the patients and there are occasions when this can not be completed until the patient is well enough to inform staff of their ethnicity.		

				All staff will be reminded to record the reasons for not entering ethnicity when it is not possible to capture this information. Completion of an annual audit of recording of ethnicity	Director of Operations Director of Operations	October 2024 October 2024
35.	We noted one instance whereby an Alder Ward patient's physical assessment was not conducted at the point of their discharge.	The health board must ensure patient physical assessments are conducted and recorded at the point of discharge as appropriate.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	The clinical board were concerned to hear about this, we would appreciate the specific information from the HIW inspection. However, we routinely conduct physical health S136 assessments on admission and where appropriate throughout the inpatient stay.	Director of Nursing	Please see factual accuracy

				The clinical board can confirm all inpatients in HYC have received a physical health assessment at the appropriate time.		Complete
				All patients should have a physical health care assessment during their admission.		Complete
				There has been a physical health link role developed on Alder Ward to support this.		Complete
				Physical Healthcare needs are addressed in the ward round (this is within the template)		Complete

36.	On Cedar Ward the general standard of clinical documentation and record keeping was poor.	The health board must implement robust ongoing governance oversight to improve the quality of the patient records and ensure they are fully completed, person centred, and are regularly reviewed.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	**Standard of Documentation will be included with caseload supervision for all staff.** **An audit will be undertaken by practice and development nurse and clinical senior nurse.**	Ward Managers Practice and Development Nurse and Clinical Senior Nurse	September 2024 Complete
37.	Some patient records did not contain any information regarding discharge planning arrangements. The information was also difficult to locate within the records, being recorded within the case notes rather than separately for ease of reference.	The health board must ensure patient discharge planning information is routinely recorded within a separate designated area of the patient records, for ease of access and monitoring.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	We have reviewed the PARIS record system and added a separate case note type called “discharge planning” for Cedar Ward. This was not previously available on Cedar. This has been addressed by our digital team. Risk assessment, handover information,	Director of Operations Lead Nurse	Complete November 2024 November 2024

				and information related to individuals nursing intervention care plan to be held in a folder for easy access for all staff and updated as changes made. This will be audited routinely by the ward managers. The Clinical Board have developed an Inpatient Discharge Policy. This will be taken to our Controlled Documents Oversight Group for ratification. This will need review in future to ensure it aligns with the National inpatient Safety Programme.	Director of Nursing	
	Three out of the six staff respondents to our questionnaire	The health board must engage with staff to ensure	Staff feedback	It is recognised that staffing pressures can mean that staff are		

	stated that in general, their job was detrimental to their health.	their health and wellbeing is being protected.		working in challenging circumstances. Compassionate Response Information Sharing and Support and Team Immediate Meetings have been implemented to support staff experiencing such challenges. This involves a non-traumatising approach to post incident support.		
				Staff are provided with dedicated time within their off duty to access clinical supervision. Clinical supervision is used to support staff and is undertaken by staff members away from their clinical area.	Lead Nurse for Adult Mental Health	Complete

				An employee wellbeing room has been set up on Cedar ward for all staff to access and to support access Canopi in this environment	Ward Manager	Complete
				A team building day is being planed once a new ward manager is appointed to Cedar.	Ward Managers	January 2025
				Regular supervision is offered daily and ward huddles offer clinical discussion and support. Ward managerial supervision groups have recently been reviewed. Monthly supervision of staff has been implemented and will be captured on		Complete on cedar Aim for October to be complete on Alder

				supervision templates.		
39.	Most staff who completed our questionnaire felt that senior managers were not visible and half felt that communication between senior management and staff was not effective.	The health board should reflect on this aspect of feedback and investigate whether improvements in relation to senior management visibility and communication with staff could be made.	Governance and leadership	This has been reflected by the clinical board and have explored ways to support staff when the acuity is increased. This has included daily huddles, twice weekly Directorate led Bed Huddles, weekly clinical board meetings. The Lead Nurse visits the Wards with the Consultant Psychologist on a weekly basis.	Lead Nurse for Adult Mental Health / Consultant Psychologist	Ongoing
40.	We were told that continued delays in the health board publishing the operational policy for Alder Ward resulted in	The health board must ensure both wards have an up-to-date operational policy to provide clear guidance to staff.	Governance and leadership	The Operational Policy is under development. This will be progressed following the National Association of	Ward Manager and Consultant psychiatrist PICU	January 2025

	a lack of clear guidance for staff and adversely affected patient flow.			Psychiatric Intensive Care Units to benchmark against national policies.		
41.	We found improvements were required in respect of staff compliance with several mandatory training courses.	The health board must implement measures to ensure all outstanding mandatory staff training is completed, regularly monitored and that staff are supported to attend the training.	Skilled and enabled workforce	Make up shifts are being utilised to support staff in completing mandatory training. Compliance is monitored on a monthly basis in September 2024 this 86.32 for Alder and 88.42 on Cedar. The expectation is for wards to be at 85%.	Directorate Manager	Complete
42.	Staff who completed our questionnaire were asked what other training they would find useful and provided comments.	The health board should consider the staff feedback about suggestions for training and implement annual individualised training needs assessments.	Skilled and enabled workforce	Value Based Appraisal (VBA) compliance VBA rates on Cedar are 85.7% and 84.85% on Alder. The target for all services is 85%. All staff are asked within their VBA about their specific	Lead Nurse for Adult Mental Health	Ongoing

				developmental needs and an individualised developmental plan is developed		
43.	Staff told us that formal clinical supervision sessions were not being undertaken with nursing staff as required, and that they would benefit from additional supervision.	The health board must ensure that staff have access to regular formal clinical supervision to support their learning and development.	Skilled and enabled workforce	There are over 100 trained clinical supervisors within the clinical board. All staff have been provided with the names of clinical supervisors and are provided with protected time to attend clinical supervision and has been added to the preceptorship. The clinical board has also made clinical supervision available for Health Care Support Workers and are encouraging uptake.	Lead Nurse for Adult Mental Health	Ongoing

44.	There was no dedicated patient meeting process on Cedar Ward. The suggestion box in the air lock of Cedar Ward did not contain any feedback forms to complete.	The health board should consider ways to formally and routinely capture patient feedback on Cedar Ward, to enhance patient care and drive quality improvement.	People engagement, feedback and learning	The patient suggestion box is kept in the cedar ward air lock to control access to loose pens/ previously pulled off walls. Patients can be supported to access the suggestion box as they wish. The Happy or Not Kiosks are being reintroduced into Hafan Y Coed and the location of their placement has been agreed in partnership with patients. A dedicated Civica Mental Health survey is in place to capture patient experience. To explore having QR	Lead Nurse for Adult Mental Health Patient Experience Team Lead Nurse Adult Mental Health	Ongoing December 2024 December 2024

				codes on the wards for Civica Survey Patient community meetings have been re-introduced to Cedar (when staffing/ acuity allows) weekly on a Sunday.	Ward Manager	Complete
45.	Safewards Mutual Help patient meetings did not always take place within set timescales on Alder Ward.	The health board must ensure Mutual Help meetings take place within set timescales, in accordance with the Safewards model.	People engagement, feedback and learning	The aim is for these meetings to take place weekly, however it is recognised that in periods of high acuity these can be cancelled. This meeting is conducted by the Activities Healthcare Support Worker. Alder also has a safe ward lead	Alder Safe Ward Lead/ Senior Nurse Manager	Complete

46.	Ward staff meetings did not take place on a regular basis and there had been no meetings within the last six months prior to our inspection.	The health board must ensure staff meetings are conducted on a regular basis to engage staff, discuss issues and encourage feedback.	People engagement, feedback and learning	The ward Managment has commenced bi-monthly business and quality and safety meetings for the wards. Minutes are shared with the Service Manager and Senior Nurse Manager.	Senior Nurse Manager/ Service Manager.	Has commenced and is ongoing on a bimonthly basis
47.	We have recommended a number of improvements as a result of our inspection.	The health board must strengthen the leadership and governance processes in place across Hafan Y Coed and ensure that audit management and quality improvement processes are robust. This is to ensure individual or recurrent themes are managed and addressed effectively, and learning is shared throughout the hospital.	Quality improvement activities	We are in the process of recruiting two permanent 8a Clinical Leads in the Inpatient environment for Service Improvement Monies, one is already in place on a secondment basis and the second is a new position. In addition, our teams are closely involved in the National Inpatient Safety Improvement Work. The Clinical Board team and Directorates are meeting with inpatient service managers at MH Inpatient Summit meetings to move towards new	Director of Operations	Further Summit meeting September 2024

				establishments, MDT improvements and working to meet standards in line with CQC and QNWA.		

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: Directorate Management Team (adult mental health)

Name (print): Daniel Crossland and Tara Robinson

Job role: Director of Operations and Interim Deputy Director of Nursing

Date: 04.10.2024