Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Hospital Inspection Report
## (Unannounced)
## Suite 2, Tonna Hospital, Swansea Bay University Health Board

Inspection date: 30 September, 1 and 2 October 2024
Publication date: 02 January 2025

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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 978-1-83715-087-8

# 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 Suite 2, Tonna Hospital, Swansea Bay University Health Board on the evening of 30 September, and the following days of 1 and 2 October 2024.

The following hospital ward was reviewed during this inspection:

- Suite 2 - 18 bed mixed gender ward providing older person dementia care and older persons with functioning illness.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of three questionnaires were completed by patients or their carers, although there were insufficient questionnaires completed by staff. However, we spoke to staff during our inspection and some of their comments are highlighted 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:
Patient or carer responses to our questionnaires were low. We therefore considered the wards internal patient feedback, any complaints, and patient discussion data, to help us gain a better understanding of the overall patient experience. Feedback was generally positive. All patients we spoke with said they felt safe and were able to speak with staff when needed, and that they were happy at the hospital, and that staff were kind and helpful.

The ward has a mix of shared dormitories and single bedrooms, although some without ensuite facilities. Shared bedrooms do not reflect modern mental health care provision, because of the impact on the privacy and dignity of patients, in addition to the risks of infection prevention and control. Patient privacy is supported with a patient's ability to lock their bedroom door, although staff override access was in place for safety.

There is a range of activities in place providing therapies to patients, to support and stimulate them as part of their recovery. However, there was limited space for Occupational Therapists to work independently and privately with patients. In addition, it was positive to see staff supporting patients to engage in activities, such as bath bomb making, herb gardening and baking. Visits from pets for therapy dogs were also taking place.

Patients had an individualised weekly activity planner, which included personal and group sessions based within the hospital, and in the community (when leave authorisation was in place).

Overall, we found that patients are provided with timely care, and their needs are promptly assessed upon admission, and staff appropriately providing care and assisting patients when required. Staff were knowledgeable of each patient and strove to provide individualised care. We observed genuine kindness, warmth and respect between staff and patients. Most patients we spoke with spoke highly of staff and told us that they were treated well by staff and felt safe.

This is what we recommend the service can improve:

- Access to activities co-ordinator
- Improvements to outdoor environment
- The provision of single ensuite bedrooms to support privacy, dignity and modern mental healthcare is considered.

This is what the service did well:

- Good team working and motivated staff
- Patients and carers spoke highly of staff and told us they were treated well.

## Delivery of Safe and Effective Care

Overall summary:
Overall, we found appropriate systems and governance arrangements in place, which helped ensure the provision of safe and effective care for patients. A range of up-to-date health and safety policies were in place and various risk assessments had been completed, such as ligature point risk assessments and fire risk assessments. We also found evidence of clinical audit taking place, which was monitored by the clinical leads.

Appropriate processes were in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required. Ward staff had access to the health board safeguarding procedures, which were supported by the Wales Safeguarding procedures, accessible via the intranet.

The arrangements for the management of medicines and their safe and secure storage were appropriate. An automated medication dispensing cabinet system was in place which aids the safe storage of medication. Stock is checked by pharmacy staff. However, improvement is required to ensure a patent's legal status is recorded in regard of consent and taking prescribed medication.

It was positive to find that physical interventions of patients (such as restraint) rarely take place. This demonstrates that the use of least restrictive model of care was being used effectively, and the focus was on therapeutic engagement between staff and patients which created a relaxed ward atmosphere. Whilst the incidences of physical intervention were infrequent, we reviewed staff compliance with Physical Intervention training, and this was extremely low. We were therefore not assured that the safety of patient and staff is maintained if there is a need for physical intervention. This issue was dealt with under our immediate assurance process, and further details can be found in Appendix B.

Patient records were well organised, and improvements had been made relating to patient records since our last inspection, which were supported by the recruitment of a ward clerk. We found that patient data and their records were kept securely.

Whilst no patients were detained under the Mental Health Act (MHA) during inspection, we reviewed some historical records of patients who had been detained. We identified the absence of formal assessments when these should have

been undertaken, to establish a patient's capacity to receive treatment and take medication under the MHA.

We saw a good standard of care planning which reflected the domains of the Welsh Measure. Care plans were well detailed, individualised, and reflected a wide range of Multi-disciplinary Team (MDT) involvement, and there was clear and documented evidence of patient involvement.

This is what we recommend the service can improve:

- Improve patient access to Speech and Language Therapist
- More variety of choices for patient on International Dysphagia Standardisation Initiative level 4 diet (IDDSI).[1]

This is what the service did well:

- Staff interacted and engaged with patients respectfully
- Good standard of care planning
- Fundamentals of care documentation
- Range of robust audits undertaken by clinical leads
- Safe and effective medication management.

## Quality of Management and Leadership

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

There was a clear organisational structure in place, which provides clear lines of management and accountability. Staff defined these arrangements during the day, and with senior management and on-call systems in place for the night. Staff felt the culture on the ward was positive and said they would feel confident in raising a concern and knew the process of how to do so, and we saw evidence to confirm this.

Most staff spoke favourably about the support from colleagues working within the ward and hospital and reported a good team-working ethos. However, staff

[1] The IDDSI framework is made up of levels and describes food textures and drink thickness. Level 4 is puréed foods and extremely thick drinks. Puréed foods don't require chewing, so you should find them easier to swallow.

indicated that the environment changed when agency staff (who were unfamiliar with patients) worked on the ward, as this often-placed extra demand and responsibilities on the regular ward staff.

Formal team meetings do not take place but occur on an ad-hoc basis during handover or clinical supervision. We therefore recommend that efforts are made to implement structured staff meetings, and when these take place, they are minuted, and these are made available to all staff.

Staff described how the service engaged with others which supports partnership working in the interest of patient care, and to initiate and implement developments. There is ongoing engagement with outside partner agencies, such as local authorities, General Practitioners, community health services, and care homes to ensure a whole systems approach to patient care.

Immediate assurances:
HIW highlighted the following training deficiency for mandatory training which required immediate action by the health board. Please note this list is not exhaustive and full details are contained in Appendix B:

- Improve mandatory training compliance in respect of Physical Intervention Training
- Promote patient safety in the interim.

This is what we recommend the service can improve:

- Ensure mandatory training courses are accessible and available, and staff have opportunities to attend training
- The health board must review the hospital's current staffing template to consider whether it continues to support effective patient care and staff welfare requirements.

This is what the service did well:

- Strong leadership provided to staff by the ward manager, clinical leads and multi-disciplinary team.
- Resilient and supportive staffing group.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

# 3. What we found

# Quality of Patient Experience

## Patient feedback

We provided HIW questionnaires to patients and family/carers during the inspection, to obtain their views and experiences of the service provided at the hospital. We received only six responses, therefore when referencing these, we are mindful that this is a poor representation of people's experiences overall, however the responses we received were positive.

To support our patient experience findings, we also reviewed the ward's internal patient feedback, any complaints, and other survey data, to help us gain a better understanding of the overall patient experience. Feedback forms are provided to patients when they are leaving hospital to enable them to provide feedback on their stay and to suggest how improvements can be made.

Patients and family/carers we spoke with during the inspection told us that patients were treated well, and that staff were kind and helpful.

Patient and carer comments included:

> *"Excellent care"*
>
> *"How grateful we all are for the care given to our loved one. Caring for us as well as the patient"*
>
> *"Ward is lovely"*

## Person-centred

### Health promotion

Suite 2 aimed to support health promotion with patients, by providing a table displaying information for patients and carers, such as advocacy support, complaints process and health information. This contained relevant and appropriate information, but the area was cluttered with empty boxes and irrelevant items, making it difficult to access key information.

**The health board must ensure the information table and surrounding area is made more presentable and easier to navigate by patients and carers.**

There is a range of activities in place providing a range of therapies to patients, to support and stimulate them as part of their recovery. The Occupational Therapy (OT) staff had a variety of therapeutic activities in place which were suitable and beneficial for the patient group. However, there was limited space in Suite 2 for OT to work independently and privately with patients.

We observed staff supporting patients to engage in activities, such as bath bomb making, herb gardening and baking. Visits from pets for therapy dogs were also taking place. It was positive to see patients using and enjoying these activities throughout the inspection.

Although staff were engaging in activities with patients, most staff we spoke with stated that an activities co-ordinator would be beneficial to help support the specialist needs of the patient group and would prevent staff trying to offer both nursing care and activities.

**The health board should consider an activities co-ordinator to support staff and patients with activities.**

Services are also provided by other professionals, such as physiotherapy, dietetics, in line with individual patient needs. Patients can also access a GP service, dental service and other physical health professionals where required. We found that patient records evidenced the appropriate physical assessments and ongoing monitoring.

**Dignified and respectful care**

We found that staff engaged with patients appropriately and treated them with dignity and respect, which included ward staff, senior management, and administration staff.

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

Suite 2 entrances were locked and an intercom system to the ward prevented any unauthorised access. Within the ward, there was a mix of single bedrooms and shared dormitories, and bedrooms without ensuite facilities. This does not reflect modern mental health care provision, because shared bedrooms can impact on the

privacy and dignity of patients, in addition to the risks of infection prevention and control. In addition, there was no access to a television or radio device in bedrooms due to lack of electrical sockets.

Whilst we acknowledge the cost involved with renovating a ward environment and the disruption this may have to bed availability during renovation, it would be beneficial to patients if the shared bedrooms were adapted to allow patients the privacy of their own room, along with having ensuite provisions.

**The health board should ensure that patients have access to television and electronic devices and sockets in their bedrooms.**

**The health board should consider how it can improve the patient experience and maintain their privacy and dignity, for those who must share a bedroom.**

All patient rooms have closable observation panels that can be open or closed from the outside, to enable staff to monitor a person when necessary. Patients can lock their bedroom doors; however, staff could override this when necessary. We saw staff respecting the privacy of patients by knocking on bedroom and bathroom doors before entering.

There were no rooms available for patients to meet their families in private or for patients to use for therapeutic activities. In addition, there were no additional rooms for patients to have quiet time other than their bedrooms. Senior management spoke about the proposals to relocate Suite 2 but plans to relocate and modernise Suite 2 had not been progressed.

### Individualised care

There was a clear focus on rehabilitation on the ward. Individualised patient care was supported by least restrictive practices, both in care planning and hospital practices.

Patients had an individualised weekly activity planner, which included personal and group sessions based within the hospital, and in the community (when leave authorisation was in place). We also found that patients and their family/carers were fully involved in monthly multidisciplinary reviews.

## Timely

### Timely care

The hospital has patient flow/bed management processes in place, which includes patient information communications, to discuss and consider bed occupancy levels, and to help plan for any emerging patient admission or discharge issues.

Overall, we found that patients are provided with timely care during their ward admission. Their needs are promptly assessed upon admission, and we observed staff appropriately providing care and assisting patients when required. There was a mixed acuity and dependency of patients receiving care on the ward, and due to the complex care needs of some patients, it was positive to see that staff, were providing one to one support and supervision to patients when appropriate.

## Equitable

**Communication and language**
All patients we spoke with said they felt safe and were able to speak with staff when needed. They also said they were happy at the hospital, and that staff were kind and helpful. There was a clear mutual respect and strong relational security between staff, patients and family /carers.

Throughout the inspection, we observed staff engaging and communicating in a positive and sensitive way with patients, taking time to help them understand their care, and using appropriate language or communication styles.

We were told that there were some Welsh and English-speaking staff working on Suite 2. This allowed staff to provide the active offer of speaking to patients in Welsh. We were told that translation services can also be accessed should patients need to communicate in other languages other than English or Welsh.

For specific meetings, and where applicable, patients can receive support from external bodies to provide support and guidance, such as solicitors or patient advocacy. With patients' agreement, and wherever possible, their families or carers were included in these meetings.

There was no information available on display on the role of HIW and how patients can contact the organisation. This is required by the Mental Health Act 1983 Code of Practice for Wales.

**The health board must ensure that information is displayed on the role of HIW and how patients and family / carers can contact the organisation.**

**Rights and equality**
We found good arrangements in place to promote and protect patient rights.

There were facilities for patients to meet their families in private, however as highlighted above there were no private areas available for patients to spend time away from other patients. A communal hall was available for families and patients to meet, however there was no privacy, and this area was used by other patients within the hospital.

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

All patients have access to advocacy services, and we were told that advocates visit the hospital when required. Staff told us that patients are invited to be part of their MDT meeting and that the involvement of family members or advocates was encouraged where possible.

# Delivery of Safe and Effective Care

## Safe

**Risk management**
Overall, we found that appropriate systems and governance arrangements were in place, which helped ensure the provision of safe and effective care for patients. Staff had recently implemented a patient supervision process entitled 'Baywatch system', where a staff member would always be present in the lounge area. This means that staff are on hand to maintain patient safety and deal with any situations as they occur, prevent falls, and maintain observations where required. At the time of the inspection, the health board was monitoring and evaluating this innovation to determine if it was effective in reducing and preventing falls.

There was an electronic system in place for recording, reviewing, and monitoring patient safety incidents, and staff confirmed that de-briefs take place following any incidents.

A range of up-to-date health and safety policies were in place and various risk assessments had been completed, such as ligature point risk assessments and fire risk assessments. We saw evidence of comprehensive clinical audits, monitored by the clinical leads. Nurse call points were also located around the suite and within patient bedrooms and bathrooms, so patients could summon assistance if needed.

The environment was clean and tidy, however, some areas require improvement. For example, some of the handrails on the corridor were broken and required replacing. The grounds of the sensory garden were unkempt, unsafe with broken greenhouse panels and broken bird feeding ornament and was not therapeutic or welcoming for patients and visitors.

The garden courtyard area was also untidy with trip hazards, such as unused pots, compost bags and parasols. The paving stones were covered in debris and when wet could become slippery for the patient group. We were told that plans were already in place to clean up the courtyard garden.

**The health board must ensure that handrails are made safe at all times for the patient group.**

**The health board must ensure that the sensory and courtyard garden are made safe for patients and visitors.**

It was positive to see that the estates department attended whilst the inspection was ongoing, to repair the broken handrails on the ward corridors and to make the garden areas safe, pending further work.

**Infection, prevention and control and decontamination**
We found suitable Infection Prevention and Control (IPC) arrangements in place which were supported by a range of up-to-date policies to maintain patient and staff safety. Regular ward audits had been completed to review the cleanliness of the environment and check compliance with hospital procedures. All were appropriate and compliance was checked by senior ward staff.

We saw evidence to confirm that staff had conducted the necessary risk assessments and relevant policies and procedures were updated accordingly. Staff also explained their responsibilities in line with infection prevention and control.

We found that staff had access to and were appropriately using Personal Protective Equipment (PPE). Staff told us that PPE was always readily available, and we saw that sufficient hand washing and drying, and sanitisation facilities were available.

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

Staff compliance with mandatory IPC training was currently at 80%.

**Safeguarding of children and adults**
Appropriate processes were in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

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

**Management of medical devices and equipment**
There were regular clinical audits undertaken at the hospital and we saw evidence of regular auditing of resuscitation equipment. Staff had documented when this had occurred to ensure that the equipment was ready for use and in date.

During staff discussions, it was evident that staff were aware of the locations of ligature cutters in case of an emergency.

**Medicines management**
We found suitable arrangements in place for the management of medicines and its safe and secure storage. We also saw evidence of regular temperature checks of the medication fridge to maintain safe temperature storage.

The ward had an automated medication dispensing cabinet system in place, which aids the safe storage of medication. Stock is checked daily by registered staff, and weekly audits are undertaken by the clinical leads and pharmacy staff.

There was a regular pharmacist input at the ward and audits were undertaken regularly, which monitored the management, prescribing and administration of medication.

We observed several medication rounds, and saw staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately. We saw fully compliant governance around controlled drugs.

We noted that The Medication Administration Records (MAR Charts)[2] are completed electronically but there was no record of patient legal status being recorded or completed on the electronic records we viewed. In addition, staff working on the ward were unaware of the prompt in CO2[3] and CO3[4] (Consent to Treatment) forms in the administration field of the Hospital Electronic Prescribing and Medicines Administration (HEPMA).

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[2] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

[3] CO2 form is used if the patient has consented to that treatment and their Approved Clinician has certified that the patient has the capacity to make this decision because they have been assessed as understanding the nature, purpose and likely effects of the treatment being proposed

[4] CO3 form is used if a patient cannot or chooses not to consent and the Approved Clinician considers the medication necessary for the patient. In this circumstance a Second Opinion Appointed Doctor (SOAD) is requested, who completes the CO3 form which provides the lawful authorisation for the treatment to be given. Resource: Mental Health Law in Nursing, Richard Murphy, Philip Wales

In addition, the CO2/CO3 forms should be available or attached to the medicines trolley to ensure legal administration of medication.

**The health board must ensure that all staff on Suite 2 are recording a patient's legal status within clinical records. In addition, that Suite 2 staff are aware of the details highlighted in Consent to Treatment forms of the Hospital Electronic Prescribing and Medicines Administration (HEPMA).**

## Effective

### Effective care

Overall, we found appropriate governance arrangements in place which helped ensure that staff provide safe and clinically effective care for patients. However, we have highlighted key areas below that require improvements.
Staff confirmed that de-briefs take place following incidents. Meetings we attended and evidence obtained during the inspection confirmed that incidents and use of physical interventions are checked, analysed, and supervised.

Incidents and use of physical interventions (such as restraint) were infrequent, and it was positive to find that physical interventions of patients rarely take place. This demonstrated that the use of least restrictive model of care was being used effectively and the focus was on therapeutic engagement between staff and patients, which created a relaxed ward atmosphere. The inspection team witnessed positive redirection and de-escalation of difficult behaviours during the inspection, all of which were done respectfully and in a very supportive manner.

However, we reviewed the staff training compliance for Physical Intervention and the figures were extremely low. We were therefore not assured that the safety of patient and staff is maintained if there is a need for physical intervention. The health board acknowledged this risk and added the risk to the risk register. During the inspection we asked to review evidence to demonstrate that risks are being managed appropriately, however this data was not provided to us during the inspection. These issues were dealt with under our immediate assurance process, and further details can be found in Appendix B.

There was an established electronic system in place for recording, reviewing, and monitoring incidents. Incidents were entered on to the health board's incident reporting system (DATIX).

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed so that the occurrence of incidents could be reviewed and analysed.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation.

**Nutrition and hydration**
All patients have a nutritional assessment on admission. The hospital provided patients with regular meals on the ward, making their choices from the hospital menu.

Patients were supported to meet their dietary needs, and we were told that specific dietary requirements were accommodated as appropriate. However, we were told that the menu is not varied for patients on a IDDSI diet.

**The health board must ensure consideration is given to the food menu, to ensure it is more varied to people who require IDDSI level 4 diet.**

Family / carers told us that fresh fruit was provided for patients, however, there was limited choices available.

**The health board must ensure that a variety of fresh fruit is available to patients daily.**

The inspection team observed positive practice during mealtimes, where all patients requiring assistance with feeding were helped. We also saw staff providing encouragement and support to patients to eat independently. Kitchen staff also made fresh sandwiches for patients who were off the ward or were sleeping during mealtimes.

Access for patients to Speech and Language Therapy (SALT) was very limited and we were told that only urgent referrals were made for swallow assessments. It is important that staff and patients have regular access to SALT to support with language communication, information processing, as well as providing support and guidance to staff to help patients with eating, drinking and swallowing.

**The health board must ensure that patients have regular access to SALT in line with their needs, and staff are appropriately supported by SALT.**

**Patient records**
Patient records were a combination of paper and electronic documents. The files were well organised, and improvements had been made since the last inspection, with the introduction of the ward clerk.

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

Further information on our findings in relation to patient records and care plans is detailed in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

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

We reviewed the Care and Treatment Plans (CTPs) of six patients. The records evidenced a fully completed and current overall physical health assessment and standardised monitoring documentation, such as NEWS[5] and MUST[6]. In addition, there were standardised assessments based on the individual patient needs. Management of patients' behaviours were reflected in their care plans and risk management profile, along with staff training, to use skills to manage and defuse difficult situations.

It was positive to see that the clinical records clearly showed patient and family involvement in care discussions, which were patient focussed. Records also included evidence of the patients' voice to reflect their views.

There was evidence that care plans are reviewed regularly by staff and updated to reflect current needs and risks. Physical health monitoring is consistently recorded in patient records. Risk management plans were good with detailed risk assessments and risk management strategy plans. In addition, there was evidence of active planning and discharge planning for long term placements.

The records we reviewed contained detailed evidence of appropriate discharge and aftercare planning, with good involvement from the MDT, care co-ordinators and relevant partner services within the local community.

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

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

An area of noteworthy practice was the additional Fundamentals of Care Nursing plan document containing very thorough, and clearly detailed goals and a plan on how to meet patient needs and goals.

**Mental Capacity Act and Deprivation of Liberty Safeguards**
At the time of the inspection no patients were detained under the Mental Health Act (MHA).

We reviewed some historical records of patients detained under the MHA and identified an absence of formal assessments undertaken, to establish a patient's capacity to take medication under the MHA, and reason why the patient lacks capacity.

The Codes of Practice for Wales states that patients should be assessed whether they have capacity to consent to a particular form of medical treatment and that assessment should be recorded. Implementation of this would ensure that the health board have a robust system in place to evidence detailed capacity assessments have been completed.

**The health board must ensure that detailed capacity assessments are completed for patients' ability to consent to treatment or medication in line with the MHA.**

We also found examples where clinical records should have appropriate information recorded about the rationale for discharging the MHA and why a DOLS is necessary.

**The health board must ensure that a detailed rationale is documented in patient records relating to decision making on discharging patients from the MHA and onto DOLS.**

It was positive to find that the nurse director undertakes quality assurance reviews which take place monthly and are unannounced. The reviews include input from the MHA manager, head pharmacist, nurse director, human resources, nurse education, patient experience and the learning development team. Any improvements or changes are shared with the staffing group, and any lessons learnt, or changes required are immediately shared.

# Quality of Management and Leadership

## *Staff feedback*

We invited staff to complete HIW questionnaires following the inspection to obtain their views and experiences on the service provided at the hospital. However, insufficient questionnaires were completed, although we were able to gain views and experiences from the staff we spoke with during the inspection.

Staff told us that the culture on the ward was positive, and that they would feel confident in raising a concern and knew the process of how to do so, and we saw evidence to confirm this. Staff also said they enjoyed working on the ward and they were a supportive team.

## Leadership

**Governance and leadership**
There was a clear organisational structure in place, which provides clear lines of management and accountability. Staff defined these arrangements during the day, and with senior management and on-call systems in place for the night and out of hours.

The day-to-day management of the ward was the responsibility of the ward manager, assisted by the deputy ward manager. The ward manager was supported by the senior nurse. During interviews with staff, we were told that the ward manager was a caring and supportive leader.

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

We observed a positive staff culture on the ward with good relationships between staff who worked well together as a team. Most staff spoke positively about the leadership at the hospital and from senior managers within the health board's mental health directorate. Most staff also spoke favourably about the support from colleagues working within the hospital and reported a good team-working ethos at the hospital. However, staff did indicate that the environment changed when agency staff (who were unfamiliar with patients) worked on the ward, as this often-placed extra demand and responsibilities on the regular ward staff.

Staff told us that formal team meetings do not take place but occur on an ad-hoc basis during handover or clinical supervision. We recommended that further efforts be made to implement structured staff meetings, and when meetings do take place that they are minuted, and minutes are made available to all staff, who should confirm that they have read them.

**The health board must ensure that staff meetings are recorded, and minutes are produced and shared with all staff and should be available to view when requested.**

We found that during the ward round meeting, the consultant psychiatrist made the ward round a good learning environment for staff, and it was positive to see that all staff were encouraged to participate and share their views and opinions.

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

## Workforce

### Skilled and enabled workforce

Staff we interviewed spoke passionately about their roles, and throughout the inspection we observed a strong and cohesive team working together.

Staff were able to access and produce most documentation requested made by the inspection team in a prompt and timely manner, therefore, demonstrating good governance processes.

There were appropriate systems in place to ensure that recruitment followed an open and fair process. Prior to employment. staff references are sought, Disclosure and Barring Service (DBS) checks are undertaken, and professional qualifications are checked.

Newly appointed staff undertook a period of induction under the supervision of the experienced ward staff. Staff showed us documentary evidence and talked us through the induction process.

We saw evidence that staff annual appraisals had been undertaken and ongoing supervision. Staff told us that supervision takes place on a regular basis.

We were provided with a range of policies, the majority of which were in in date; however, the patient observation policy was due for review in June 2022 which had not been completed.

**The health board must ensure that the patient observation policy is reviewed to ensure it is current.**

Interviews with staff highlighted that caring for patients with additional complex needs required a variety of skill sets and placed additional demands on regular staff working at the hospital. Caring for the patients had become more physically demanding, time consuming and as a result was impacting on staff morale and wellbeing.

Due to the lack of space on Suite 2, staff did not have access to quiet spaces to take meal breaks. A communal hall was available, however this was used by patients and hospital visitors and did not give staff any privacy.

Staff told us that similar services within the wider health board had more resources, activities co-ordinators, access to SALT, and more room availability for staff and patient use.

**The health board must ensure that staff and patients have equal access to the resources available in other areas of Cefn Coed hospital, appropriate to the patient groups.**

## Culture

### People engagement, feedback and learning

Suitable arrangements were in place to share information, and any lessons learnt promptly to staff, following complaints and incidents at the hospital and the wider organisation. This helped to promote patient safety and continuous improvement of the service provided.

We saw that information had been provided to staff on the Duty of Candour requirements and local documents had been amended to reflect these requirements. Staff told us that they would feel secure raising concerns about patient care or other issues at the hospital and felt confident that the health board would address their concerns. A whistleblowing policy was in place to support when raising such concerns.

## Information

### Information governance and digital technology

We considered the arrangements for maintaining patient confidentiality and adherence to Information Governance and the General Data Protection Regulations 2018 within the ward.

We were told that all staff have a personal login with password protection to access the intranet. This helps ensure prompt access to policies and procedures and to access the Datix incident reporting system. In addition, staff said they understand their roles and responsibilities in respect of accurate record keeping and maintenance of confidentiality.

The staff training compliance for information governance was 80%. Staff were also able to describe their role and responsibilities in relation to handling of personal and sensitive information.

## Learning, improvement and research

**Quality improvement activities**
At the time of our inspection there were several improvement initiatives in place, such as the 'Baywatch Scheme' as highlighted earlier, and initial findings demonstrated a reduction in patient falls.

Processes were also in place to improve patients choices at mealtimes and the times of meals being provided.

A 'Befriender' service was soon to be launched, where volunteers would come to the hospital to engage with patients. This is particularly beneficial for those who have limited visitors, such as family or friends.

## Whole-systems approach

**Partnership working and development**
Staff described how the service engaged with others to support partnership working in the interest of patient care, and to initiate and implement developments. There is ongoing engagement with outside partner agencies, such as local authorities, General Practitioners, housing departments, community health services, and care homes to ensure a whole systems approach to patient care. In addition, we were told that senior staff attend regular joint agency meetings to discuss any issues and to build stronger working relationships.

# 4. Next steps

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

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

The improvement plans should:

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

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

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

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

# Appendix A – Summary of concerns resolved during the inspection

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

| Immediate concerns Identified | Impact/potential impact on patient care and treatment | How HIW escalated the concern | How the concern was resolved |
|---|---|---|---|
| No immediate concerns were identified on the inspection. | | | |
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# Appendix B - Immediate improvement plan

## Service: Tonna Hospital - Suite 2

## Date of inspection: 30 September - 2 October 2024

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

| | Risk/finding/issue | Improvement needed | Standard / Regulation | Service action | Responsible officer | Timescale |
|---|---|---|---|---|---|---|
| 1. | The inspection team considered staff training compliance for Physical Intervention (PI) Training which should be completed annually.<br><br>Out of twenty-nine staff working on Suite 2, only two staff members are currently compliant with PI Training requirements. | The health board must ensure a significant number of staff working on Suite 2 complete physical intervention training promptly, to maintain the safety and wellbeing of patients and staff. | Governance, Leadership, and accountability. | To ensure all available staff attend two day physical intervention training (theory and practical) as a priority.<br><br>Progress update - The training department have provided the following dates: | Erin Smith - Head of Nursing Mental Health Division | 30th November 2024 |

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| | The remaining staff have not updated their training since 2022 and 2023. The two staff members who are currently up to date with training will become out of date in December 2024, therefore if not completed, there will be zero staff working on suite 2 who are compliant with up-to-date PI training.<br><br>HIW is not assured that there is enough staff working on Suite 2 who can perform effective and safe restraint techniques where required.<br><br>This poses a potential risk to the safety and wellbeing of patients and staff if there is a need for physical intervention with patients. | | | 8th October PBM Theory<br>14th October PBM Practical<br><br>17th October PBM Theory<br>22nd October PBM Practical<br><br>24th October PBM Theory<br>25th October PBM Practical<br><br>30th October PBM Theory<br>31st October PBM Practical<br><br>All Nurses and HCSW from Suite 2 (x26) have been booked onto the training except staff (x5) who | | |

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| | | | | are on maternity or long term sick leave.<br><br>The majority of staff will be trained in October, but further dates are available for November should they be required if any further staff need training or if any booked attendances need to be amended for unforeseen reasons.<br><br>The ward management team have devised an annual plan for training to be facilitated for all staff. | | |

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):** **Stephen Jones**

**Job role:** **Service Group Nurse Director**

**Date: 07.10.2024**

# Appendix C - Improvement plan

## Service: Tonna Hospital Suite 2

## Date of inspection: 30 September - 2 October 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 activities co-ordinator to support staff and patients on Suite 2. | The health board should consider an activities co-ordinator to support staff and patients with activities. | Health Promotion | Review of the directorate financial position/vacancies. | Dawn Griffin Directorate Manager | November 2024 Complete |
| | | | | Develop Business Case to demonstrate the need and benefits of a dedicated activity worker and offer an options appraisal. | Dawn Griffin Directorate Manager & Rebecca Mort Lead Nurse | January 2025 |
| | | | | Recruitment process | Sharon Pontin Ward Manager | April 2025 |
| 2. | A table containing written information | The health board must ensure the information | Health promotion | Table has been made more presentable and | Sharon Pontin Ward Manager | November 2024 |

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| | for patients and carers is located at the entrance to Suite 2. This contained relevant and appropriate information, but the area was cluttered with empty boxes and irrelevant items making it difficult to read and view the information. | table and surrounding area is made more presentable. | | written information for patients and carers can now be located easily without clutter. Empty boxes removed. Hotel services/Portering now aware not to store equipment outside the ward entrance. Ward Manager will continuously monitor. | | Complete |
| **3.** | Suite 2 still has a mix of single bedrooms and shared dormitories and bedrooms with no ensuite facilities. This does not reflect modern mental health care provision because shared bedrooms can impact on the privacy and dignity of patients. | The health board should consider how it can improve the patient experience and maintain their privacy and dignity, for those who must share a bedroom. | Dignified Care | Assessment of individual needs, patient preferences and clinical judgement is carried out to prioritise the needs of those requiring single bed spaces for example patients nearing end of life, patients requiring enhanced levels of observations or infection control purposes. | Sharon Pontin Ward Manager | October 2024 Complete |

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| | | | | Capital Prioritisation plans to submitted to relocate Suite 2 to a purpose built environment. Welsh Government colleagues are visiting the site on the 9th December providing opportunity for them to show them the environment of care and what the service group want to achieve with capital investment. | Dermot Nolan Service Group Director | April 2026 |
| **4.** | Patients do not have access to any tv or radio devices in their rooms due to lack of electrical sockets. | The health board should ensure that patients have access to tv and electronic devices and sockets in their bedrooms. | Dignified Care | Reported on Estates portal on 7/11/24. Job Ref. 733230, request made for additional sockets and aerial points in all bedrooms. | Sharon Pontin Ward Manager | November 2024 Complete |

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| | | | | Purchasing radios. | Dawn Griffin Directorate Manager | December 2024 |
| | | | | Environmental survey, quotes and procurement process will be required. | Estates Team Manager | May 2025 |
| | | | | Purchasing televisions. | Dawn Griffin Directorate Manager | May 2025 |
| **5.** | There was no information available on display on the role of HIW and how patients can contact the organisation. This is required by the Mental Health Act 1983 Code of Practice for Wales. | The health board must ensure that information is displayed on the role of HIW and how patients and family/carers can contact the organisation. | Patient Information | Information on the role of HIW is now placed on entrance doors and on information table on entrance of the ward. | Sharon Pontin Ward Manager | November 2024 Complete |
| **6.** | Some of the handrails on the corridor were broken and required replacing. | The health board must ensure that handrails are made safe at all times for the patient group. | Managing risk and promoting health and safety | All broken handrails were repaired to a high standard the day after inspection. | Estates Team Manager | October 2024 Complete |

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| **7.** | The grounds of the sensory garden were unkempt, unsafe with broken greenhouse panels and broken bird feeding ornament and was not therapeutic or welcoming for patients and visitors.<br><br>The garden courtyard area was also untidy with trip hazards such as unused pots, compost bags and parasols. The paving stones were covered in debris and when wet could become slippery for the patient group. | The health board must ensure that the sensory and courtyard garden are made safe for patients and visitors. | Managing risk and promoting health and safety | Sensory Garden was closed on the day of inspection due to safety concerns. | Estates Team Manager, Ricky Morgan Assistant Head of Operations and Dawn Griffin Directorate Manager | October 2024 Complete |
| | | | | Operations meeting due to take place on site 15/11/24 to address. Action plan will be developed following the meeting. | Ricky Morgan Assistant Head of Operations | November 2024 |
| | | | | The safety issues in the garden courtyard have been reported to Estates on 7/11/24. Job Reference:57062. | Sharon Pontin Ward Manager | November 2024 Complete |
| | | | | All patients currently wishing to access the courtyard, are supported by a staff member to manage risk. | Sharon Pontin Ward Manager | November 2024 Complete |

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| **8.** | There was no record of patient legal status on the electronic Medication Administration Records (MAR Charts) Staff working on the ward were unaware of the prompt in CO2and CO3 (Consent to Treatment) forms in the administration field of the Hospital Electronic Prescribing and Medicines Administration (HEPMA). | The health board must ensure that all staff on Suite 2 are recording a patient's legal status within clinical records. In addition, that Suite 2 staff are aware of the details highlighted in Consent to Treatment forms of the Hospital Electronic Prescribing and Medicines Administration (HEPMA).<br><br>The CO2/CO3 forms should be available / attached to the meds trolley to ensure legal administration of medication. | Record Keeping | At the time of inspection, ward had no patients detained under the MHA. No copies were found next to HEPMA machine for this reason<br><br>When a patient is detained under the MHA, the CO2 and CO3 forms are placed on a clip board attached to the medication trolley. | Sharon Pontin Ward Manager | October 2024 Complete |
| | | | | Staff have been made aware of the importance of keeping CO2/CO3 forms next to the HEPMA on a clipboard for future | Sharon Pontin Ward Manager | November 2024 Complete |

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| | | | | patient admissions detained under the MHA. | | |
| | | | | Legal status on HEPMA can be added as a prompt by the prescribers in which will allow staff to chart medication. Email sent to all ward doctor, all RN staff on ward and the clinical director in order to share this learning across the prescribing workforce. | Sharon Pontin Ward Manager | November 2024 Complete |
| | | | | Information booklet explaining CO2/CO3 process to be included in ward MHA file on ward. | Sharon Pontin Ward Manager | November 2024 Complete |
| | | | | MHA training arranged by MHA team for all | Penny Cram Mental Health | January 2025 |

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| | | | | staff on ward 15/01/25. | Act Team Manager | |
| | | | | All learning to be shared across the service group via Quality and Safety forums. | Dawn Griffin Directorate Manager & Erin Smith Head of Nurse | November 2024 |
| **9.** | Menu is not varied for patients on a ISSDI level 4 diet. | The health board must ensure consideration is given to the food menu, to ensure it is more varied to people who require a ISSDI level 4 diet. | Nutrition and Hydration | Catering team have made improvements and a varied menu choice is available to all patients on level 4 ISSDI. | Sharon Pontin Suite 2 Ward Manager & Claire Alexander Hotel Services | November 2024 Complete |
| **10.** | Family / carers told us that although fresh fruit was provided there was limited choices available for the patients. | The health board must ensure that a variety of fresh fruit is available to patients daily. | Nutrition and Hydration | Hotel Services have confirmed there is a varied range of fresh seasonal fruit on offer including, apples, pears, bananas, orange and plums.. | Sharon Pontin Suite 2 Ward Manager & Claire Alexander-Hotel Services | November 2024 Complete |
| **11.** | Access for patients to Speech and Language | The health board must ensure that patients have regular access to SALT in | Nutrition and Hydration | This is included on the Service Groups risk register, this is | Dawn Griffin Directorate Manager | November 2024 Complete |

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| | Therapy (SALT) was very limited. | line with their needs, and staff are appropriately supported by SALT. | | regularly reviewed by the directorate team | | |
| | | | | Business case to be revisited in conjunction with SALT services to propose and prioritise a pathway for inpatient services. | David West Divisional Manager, Erin Smith, Head of Nursing & Sioned Quirke SALT Lead | April 2025 |
| **12.** | There is no formal assessment, assessing patients capacity to take medication under the MHA and reason why the patient lacks capacity. | The health board must ensure that detailed capacity assessments are completed for patients' ability to consent to treatment or medication in line with the MHA. | Record Keeping | The process has been reviewed by the Mental Health Act Team Manager. There is a revised pro-forma, this is saved along with the certificate / SOAD request in the patient's notes and electronic file. | Sharon Pontin Ward Manager & Penny Cram Mental Health Act Team Manager | November 2024 Complete |
| **13.** | Case notes could have more information recorded about the rationale for discharging the MHA | The health board must ensure that a detailed rationale is documented in patient records relating to decision making on | Record Keeping | Rationale for discharging patient from MHA to DoLS is documented in detail in the patient's notes | Sharon Pontin Ward Manager & Natalie Hess Clinical Director | November 2024 Complete |

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| | and why Deprivation of Liberty Safeguards (DoLs) is necessary. | discharging patients from the MHA and onto DOLS. | | by the Responsible Clinician. | | |
| | | | | A new section will be added into the ward round checklist to capture any MHA changes. The discharge checklist is included in the clinical record. | Lauren Hoare & Sinead Morris Clinical leads | November 2024 |
| **14.** | The observation policy was due for review in June 2022. | The health board must ensure that the patient observation policy is reviewed to ensure it is current. | Managing risk and promoting health and safety | There is a bi-monthly policy review group.<br><br>The policy is under review by a working group of clinicians from across the service group. The policy has been reviewed, updated and is currently out for wider consultation with a view of sign off and ratification. | Marie Williams – Head of Nursing for Quality, Governance and Improvement | January 2025 |

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| **15.** | Due to the lack of any spare rooms on Suite 2, staff did not have any access to quiet spaces to take meal breaks. Staff also told us that similar services within the wider health board had more resources, activities co-ordinators, access to SALT and more room availability for staff and patient use. | The health board must ensure that staff and patients have equal access to the resources available in other areas of Cefn Coed hospital, appropriate to the patient groups. | Workforce | Staff have access to a separable (screens) space within the communal hall. | Assistant Head of Operations | October 2024 Complete |
| | | | | Change of access to the kitchen in the communal hall so all staff can use the facilities. This will require a change locking mechanism, i.e. fob / combination code. | Sharon Pontin Ward Manager & Estates Team Manager | December 2024 |
| | | | | Access to more activity and quiet spaces – See recommendation 3 | Service Group Director | April 2026 |
| | | | | Dedicated Activity Co-ordinator – See recommendation 1. | Dawn Griffin Directorate Manager & Sharon Pontin Ward Manager | April 2025 |
| | | | | Access to SALT services – see recommendation 11. | David West Divisional Manager, Erin Smith, Head of Nursing & | April 2025 |

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| | | | | | Sioned Quirke SALT Lead | |
| **16.** | No formal team meetings take place. | The health board must ensure that staff meetings are recorded, and minutes are produced and shared with all staff and should be available to view when requested. | Workforce | Staff meetings are now planned on a monthly basis, starting on 18th November 2024 with a detailed agenda template which will capture the minutes of the meetings. These meeting minutes will be stored in a file on ward and found on Suite 2 shared electronic folder for all staff to access and keep themselves updated. | Sharon Pontin Ward Manager | November 2024 Complete |

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):** **Janet Williams**

**Job role:** **Service Director**

**Date:** **14.11.24**