Betsi Cadwaladr University Health Board
Action Plan Re: HIW Homicide Review, November 2014

Actions					
Issue	**Current Actions**	**Timescale**	**Lead**	**Intended Outcome**	**Current Status**
Ward Rounds 1. BCUHB continue to extend invitations to attend ward rounds (now known as MDT/Clinical team meetings) and that they continue to be attended by a wider, multi-disciplinary group of individuals.	The Health Board has implemented an Acute Care Operating Model with daily medical input provided by acute care consultants during the week and by on-call consultants at the weekend. Daily acute care meetings are attended by medical staff, nursing staff, from the inpatient ward and home treatment team, occupational therapists and pharmacists.	In place from August 2014	Locality Manager/ Local Clinical Lead	Daily multi-disciplinary input to decision making	Daily MDT meetings in place
2. BCUHB to provide an update regarding progress made by the CPG in agreeing a standard for timely Consultant reviews and physical examinations. Compliance with these agreed timescales should be monitored.	An Acute Care 7 day pathway has been adopted with a consistent and agreed way of working with patients when they are admitted, including standards for timely review and examination. Timeliness of reviews is recorded in the pathway documentation. A dedicated on call rota for the Unit is in place which includes planned attendance at the Unit at weekends to ensure timely Consultant reviews can be undertaken.	Pathway in place from September 2013	Locality Manager	Access to appropriate assessment within agreed timescales for all patients	Pathway in place

	A full physical examination is carried out by the Junior doctor and documented in the clinical notes within the first 12 hours of admission.				
Engagement with the family					
3. BCUHB should ensure the families of patients are involved in the planning, development and delivery of the patient's care, treatment and discharge planning to the fullest extent possible.	Engagement with families is part of the 7 day pathway. The pathway requires a family / carer meeting to be arranged by the named nurse with the aim of engaging the family in care planning, understanding the build up to the admission and their perception of care needs. Self assessment to be undertaken against best practice guidance in carer engagement in care planning. (Triangle of Care) Strategy for enhanced carer involvement to be developed.	7 day pathway is in place December 2014 March 2015	Locality Manager Unit Matron Head of Nursing	Improved involvement of families in the planning and delivery of care, treatment, discharge and follow up	Pathway in place
Clinical Records					
4. Specifically in relation to mental health clinical records, BCUHB should ensure that: a) Records are fully integrated	An agreed standard for Integrated Casenotes has been adopted, supported by a Standard Operating Procedure.	In place from March 2014	General Manager	Single integrated casenote for patients	In place

	A phased programme of conversion of notes is ongoing, prioritising patients who are admitted.				
b) Mental health clinical records are of a good standard reflecting professional guidelines for record keeping.	Good record keeping guidance is in place and staff training is available to support this. A training needs analysis will be undertaken to identify staff requiring further training, linked to audit findings (see below).	In place February 2015	Interim Director of Mental Health Services	Record keeping follows best practice and underpins safe care	Guidance in place
c) Good practice standards in record keeping are audited, and forms part of a rolling programme of audit and training	All Mental Health Measure Care and Treatment Planning documentation is subject to annual audit. This audit focuses on the quality of the care and treatment plans held in patient records. An audit programme to assess the quality of record keeping in casenotes and inform training needs is to be established with the first audit undertaken by 31st December 2014.	In place from 2013 December 2014	Interim Director of Mental Health Services	Quality of record keeping is regularly reviewed to ensure good practice standards are maintained	CTP documentation audit in place
d) Consideration is given to the use of electronic case records as a means of supporting the integration of notes and increased access to them.	The adoption of an electronic case record is being explored as part of the Community Care Information System national procurement. The Health Board will determine its preferred approach to developing electronic records by 31st March 2015.	March 2015	Interim Director of Mental Health Services	Improved availability and consistency of clinical records to support decision making, care planning and delivery	In progress

Physical Health Assessment 5. In relation to patient assessments, BCUHB should ensure that: a) Staff compliance with their standard for timely senior clinician reviews and physical examinations demonstrating continued compliance	An audit programme is underway and will provide an assessment of compliance against the standards set out in the 7 day pathway by January 2015. A programme of regular audits will be implemented thereafter.	January 2015 April 2015 onwards	Locality Manager	All patients will have senior clinical reviews and physical examinations in accordance with prescribed time limits.	In progress
b) In line with their own guidance, all patients are subject to urine drug screening within 2 hours of admission	7 day pathway identifies that within 2 hours of admission a urine drug screen is undertaken. Urine testing kits are available on the ward. Compliance will be subject to audit	In place November 2014	Locality Manager	Patients will have a drug screen within 2 hours of admission to support care planning and delivery	Pathway in place
6. In relation to training, BCUHB should: a) Provide substance misuse training for staff to ensure that patient care is not compromised on the grounds of potential and actual substance misuse problems.	A programme of training is ongoing and all staff will have received training by January 2015. Training programmes will be reviewed in light of the anticipated revised guidelines for co-occurring mental health and substance misuse needs.	January 2015 Within 3 months of publication	Head of Programme SMS	Increased staff awareness and confidence to manage substance misuse issues	Training ongoing

Clinical Leadership / Multi-Disciplinary Teamwork 7. BCUHB should promote a more collaborative and evidence based clinical leadership model and support the development of effective and collaborative multi-disciplinary teamwork.	The Acute Care model has been fully implemented within the Ablett Unit with an increase in Consultant medical staff. Effective multi-disciplinary working is central to this model. A Community Operating Framework is also in place which is based upon effective multi-disciplinary working.	In place from August 2014 In place from July 2013	Clinical Leads/ Locality Managers	Improved multi-disciplinary team working to support effective care planning and delivery	In place
Standards of Care and Practice and Clinical Audit 8. BCUHB should ensure systems are in place to support the development of clear and measurable standards of care and practice that are evidence based where possible and promote a culture of regular monitoring and clinical audit.	With regard to standards of care in the acute inpatient wards external accreditation has been sought and received through the Royal College of Psychiatrists AIMS Accreditation Service. A rolling clinical audit programme will be developed to review specific aspects of care by 31st December 2014.	AIMS accreditation received March 2014 December 2014	Unit Matron Clinical Lead	Regular assessment of standards of practice, supported by external validation and audit	Accreditation achieved

Staff and Culture 9. In relation to equality and diversity, BCUHB should ensure that: a) Equality and diversity training continues to be rolled out to all new staff and that all staff receive regular refresher training in these issues.	In 2011 an e learning package for diversity and equality was implemented with 100% compliance with this training amongst the Acute Care staff in the Ablett Unit. Selected staff undertook more detailed training A refresh programme will be undertaken by 31st December 2014	Implemented 2011 December 2014	Locality Manager	All staff are trained in Equality & Diversity to support improved care delivery	Initial training complete
10. In relation to mandatory training and a system of recording training across the Ablett Psychiatric Unit, Betsi Cadwaladr University Health Board should ensure that: a) Mandatory staff training regarding Mental Capacity Act (2005) and DoLS, is facilitated	Mental Capacity Act training will be included in the review of mandatory training being undertaken by the Health Board. E-learning packages are being developed to enable wider access for staff. Higher level training to be delivered face to face for key staff, through the recruitment of additional trainers, beginning in January 2015.	December 2014 January 2015 onwards	Interim Director of Mental Health Services	All staff are trained in MCA & DoLS to support improved care delivery	In progress

b) A comprehensive system that is used by all wards should be introduced to ensure consistency across the Ablett Psychiatric Unit and to enable an effective overall audit of training at the unit.	A training database has been developed and is used consistently in the Ablett unit to record training.	System in place from August 2014	Locality Managers	Staff training regularly recorded and monitored to ensure effective delivery	In place
Use of the Mental Health Act (MHA) 1983 11. Section 136 In relation to improvements in Section 136 practice, BCUHB should ensure that: a) Steps are taken to ensure that all staff involved with the application of Section 136, complete relevant documentation so that it is comprehensive, legible and reflects requirements of the MHA and MHA 1983 Code of Practice.	A revised s136 policy and supporting procedures have been developed with partner agencies and adopted. This reflects fully the requirements of the MHA and MHA1983 Code of Practice. North Wales Police have issue guidance to their officers regarding the s136 paperwork process. This was implemented at the same time as the s136 Mental Health Act documentation. Audit of s136 paperwork to be undertaken to assure quality of documentation.	Policy implemented 2012 Complete December 2014	General Manager MHA Manager	Consistent completion of documentation to support decision making	Revised policy and procedures in place

b) Steps are taken to inform staff of the designated area, as specified within its own protocol, for carrying out Section 136 assessments across their mental health services.	A designated s136 assessment area is in place within the Unit and is recognised by staff.	S136 area re-located in February 2014	General Manager	Assessments take place in an appropriate designated area	In place
c) Ablett Psychiatric Unit staff involved with Section 136 to ensure that they are clear about the protocol in place for discharge of individuals not deemed to require admission and that this protocol is adhered to.	The s136 pathway prompts assessors to identify the arrangements for safe return to community and any follow up arranged if the patient is not admitted. Audit of compliance to be undertaken by 31st December 2014	Policy implemented 2012 December 2014	Locality Manager MHA Manager	Individuals are supported to enable safe discharge	Revised policy and procedures in place
Medication **Medication Management Rationale** 12. The Health Board to ensure that patients on medication and who then take their own leave against medical advice are appropriately supported in their medication needs at the time of discharge.	The Discharge pathway will be reviewed and amended to reflect action required when a patient takes their own discharge. This will include arrangements in relation to medication	December 2014	Locality Manager	All patients who take their own discharge receive their agreed medication, with appropriate advice and information.	In progress

Diagnosis **Evidence for Diagnosis** 13. The Health Board should ensure that where Consultant Psychiatrists or other clinicians seek to apply such a diagnosis as malingering, that it is supported by a clear and substantial evidence base relating to an individual patient.	Guidance to be issued to Consultant staff regarding the standard of evidence required to support their clinical diagnosis	November 2014	Medical Director	Demonstrable evidence as to the basis of diagnosis which can be audited	In progress
14. The Health Board to provide an update regarding the development of a more systematic approach to clinical supervision and reflective practice groups, or forums for nurses.	The supervision policy identifies minimum standards for the managerial and clinical supervision of staff working within mental health services. It requires all employees to be supervised to a common set of principles in accordance with their own professional practice and background. Audit of supervision practice to be implemented by 31st March 2014 Options to establish reflective practice groups will considered and a system implemented	Supervision policy in place from June 2013 March 2015 March 2015	Head of Nursing	Clear supervision arrangements for nurses in place, supported by reflective practice groups to enhance the quality and safety of care	In progress

Risk Assessment 15. The Health Board should ensure that risk assessment processes are clear and robust and through appropriate training that all staff possess the appropriate skills to deliver these processes.	The Mental Health Measure and the supporting Code of Practice were implemented in late 2012. The Community and Acute Care Frameworks both include risk assessment processes. Welsh Applied Risk Research Network (WARRN) training is mandatory for all qualified nurses. WARNN training considers risk factors for low risk patients as well as medium and high risk patients and includes 'Asking Difficult Questions' (ADQs). An audit framework to assess the robustness of risk assessment practice will be developed and implemented.	Risk assessment processes in place from 2012 March 2015	Interim Director of Mental Health Services	All patients have a robust risk assessment to underpin their care and treatment plan	Framework in place
Discharge and aftercare planning 16. The Health Board should ensure that patients who have unresolved diagnostic issues, and who are not registered with a General Practitioner, should receive proactive involvement from the CMHT.	The Discharge pathway sets clear requirements for assessing ongoing care needs and ensuring effective involvement of the CMHT post discharge	Pathway implemented September 2013	General Manager	All patients receive appropriate involvement from the CMHT post discharge	Pathway in place

17. In relation to a patient's discharge, BCUHB should ensure that: a) Care Co-ordinators remain actively involved in a patient's discharge and after care and that all steps taken are detailed clearly within patient documentation	The Discharge pathway requires the identification of a Care Co-ordinator for all patients prior to discharge and that the care co-ordinator attends MDT meetings to plan for discharge and aftercare needs. Under the Mental Health Measure all patients must have a Care and Treatment Plan (CTP), agreed with them, which sets out their needs and how these will be met post discharge.	Pathway implemented September 2013 CTP implemented October 2012	Locality Manager	All patients have a safe discharge with appropriate after care	In place
b) Ablett Unit staff involved with Section 136's to ensure that they are clear of the protocol in place for discharge of individuals not deemed to require admission and that this protocol is adhered to.	The s136 pathway prompts assessors to identify the arrangements for safe return to community and any follow up arranged if the patient is not admitted. Audit of compliance to be undertaken by December 2014	Policy implemented 2012 December 2014	Locality Manager MHA Manager	All patients are supported to have a safe discharge from S136	In place

18. Betsi Cadwaladr University Health Board and Flintshire County Council should consider implementing a joint protocol addressing how VAHT concerns about the behaviour of an individual discharged from a CMHT, could be escalated back to that CMHT for further consideration.	Interim arrangements have been put in place for the VAHT to refer into services via the Single Point of Access process within the Community Mental Health Teams. The Health Board will develop a joint protocol with Flintshire County Council by March 2015.	In place from October 2014 March 2015	Locality Manager (East) Locality Manager (East) / Flintshire County Council	Effective communication and referral arrangements to meet individual needs in a timely manner	In progress
19. The Health Board should ensure that patients are aware of the right to access an Independent Mental Health Advocate (IMHA). This is in line with the Mental Health Act (1983) and the Mental Health (Wales) Measure 2010 which expands the provision of an IMHA to all patients.	Since the implementation of the Mental Health Measure in 2012, the Health Board has implemented advocacy arrangements to meet these needs.	In place from July 2012	General Manager	All patients have timely access to independent advocacy services	In place