Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Learning Disability Inspection (unannounced)

Abertawe Bro Morgannwg University Health Board,

Learning Disability Residential Unit

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1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW completed an inspection to the learning disability service on 25 May 2016. Our team for the inspection comprised of an HIW inspection manager (inspection lead), an HIW assistant inspection manager and a clinical peer reviewer.

HIW explored how the learning disability service met the standards of care set out in the Health and Care Standards (April 2015).

Inspections of learning disability services are unannounced and we consider and review the following areas:

- Quality of the patient experience - We speak to patients, their relatives, representatives and/or advocates to ensure that the patients' perspective is at the centre of our approach to how we inspect
- Delivery of safe and effective care - We consider the extent to which, services provide high quality, safe and reliable care centred on the person
- Quality of management and leadership - We consider how services are managed and led and whether the culture is conducive to providing safe and effective care. We also consider how services review and monitor their own performance against relevant standards and guidance.

More details about our methodology can be found in section 6 of this report.

2. Context

The service is a small residential unit providing care to for up to five patients with learning disabilities. The unit forms part of learning disability services provided within the geographical area known as Abertawe Bro Morgannwg University Health Board.

A unit manager, who is a registered nurse, is responsible for the day to day management of the unit. The manager is supported by a deputy and a team of staff, including registered nurses and healthcare support workers.

3. Summary

Overall, we found evidence that the service provided person centred care that was safe and effective.

This is what we found the service did well:

- Patients were helped to stay healthy and take part in activities they liked to do.
- We saw staff treating patients with respect and kindness.
- Patients told us they enjoyed living at the unit and that staff helped them feel safe.
- All patients had a written care plan setting out the help and support they needed.
- Staff appeared to have a good understanding of the patients' care needs.

This is what we recommend the service could improve:

- Repairs and maintenance around the unit must be completed in a timely way.
- The type of emergency equipment needed at the unit must be agreed as a matter of priority and checks done to ensure it remains safe to use.
- The way for obtaining some medication should be reviewed so that patients can have their medication quickly whilst maintaining their safety.
- Other ways of helping patients understand their care should be considered and used.
- Staff should be supported to attend training they are required to attend and have formal supervision meetings with their managers.

4. Findings

Quality of the patient experience

Patients were helped to stay healthy and take part in activities they liked to do. We saw staff treating patients with respect and kindness. All patients had their own care plan. Some of these needed to be more detailed around how staff could support patients to develop life skills to allow them to be as independent as possible.

The inspection team sought patients' views with regard to the care and treatment provided at the residential unit through face to face conversations with patients.

Staying healthy

People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manager their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities. (Standard 1.1)

Patients at the unit were helped to stay healthy and take part in activities to promote their wellbeing.

Senior nursing staff told us that patients at the unit were registered with a GP and were helped to see a dentist and optician according to their needs. Patients we spoke to also confirmed this. We looked at a sample of three patients' care plans and saw that all had received annual health checks[1] with their GP. One patient's health check was overdue and staff should, therefore, make arrangements to ensure this is done.

We were told staff helped patients to make use of the facilities at the unit and in the local area. The unit had a private garden that patients could use. There were also lounges in the unit where patients could spend quiet time away from

[1] The Welsh annual health check for adults with learning disabilities was specifically introduced in Wales in April 2006 to promote early detection and treatment of health problems in people with learning disabilities.

other patients if they wished to do so. Patients we spoke to confirmed that they were helped by staff and that they enjoyed going for walks and going to the gym.

Some patients had been identified as requiring weight management plans. We saw that patients had been seen by a dietician to help them make healthy food and drink choices.

Dignified care

People's experience of health care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical psychological, social, cultural, language and spiritual needs. (Standard 4.1-Dignified Care)

We found that patients at the unit were treated with dignity and respect by the staff working there.

We saw staff treating patients with respect and kindness. All the patients had been living at the unit for some time and staff appeared to have a good understanding of their individual likes and dislikes. All patients had their own bedroom, with a keypad lock, that they could use for privacy. We found staff respecting patients' privacy as far as possible. We saw staff knocking doors and asking patients if it was alright to go into their bedrooms before doing so. Patients also told us that staff were respectful and kind to them.

Patients were helped with their personal hygiene according to their needs and all patients appeared well cared for.

Patients we spoke to told us that they felt safe most of the time. They did tell us, however, that the behaviour of other patients living at the unit did unsettle them sometimes. We saw nursing staff managing patients' behaviours to promote the safety and well being of other patients and staff working at the unit.

Timely care

All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

We saw that patients' needs were being met in the unit by the staff team.

We looked at the care plans for three patients. These showed that members of the multi disciplinary health care team had been involved in the patients' care and treatment. We saw evidence of monthly multi disciplinary team (MDT) meetings. These monitor patients' care plans so that any problems can be identified early on and care planned to address these.

All of the patients had been living at the unit for many years and appeared settled there. Patients we spoke to told us they liked living there and that staff helped them as needed. Staff appeared to have a good understanding of the patients' individual care needs.

Individual care

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional well being. (Standard 6.1 Planning Care to Promote Independence)

We saw that patients at the unit each had their own written care plan. These showed that their needs had been assessed, their care and treatment planned and that care had been provided by those involved in their care.

We looked at the care plans for three patients. Some parts of the care plans were very detailed. We saw detailed risk assessments and care plans for helping patients with eating and drinking, preventing falls, preventing pressure sores, moving around safely and to be as pain free as possible. We also saw detailed plans for managing behaviour and long term health conditions.

Whilst we saw detailed care plans to prevent healthcare problems, we did not see plans to guide staff on how they could best support patients to further develop their life skills to help them be as independent as possible.

Patients had care and treatment plans as required under law (The Mental Health (Wales) Measure 2010)[2]. We saw that two plans had recently passed their review date. The health board must make arrangements to ensure these plans are reviewed.

Improvement Needed

The health board must make suitable arrangements to ensure patients with care and treatment plans required under the Mental Health (Wales) Measure 2010 have their plans reviewed at least annually.

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.(Standard 6.2 Peoples Rights)

We found that care and treatment for patients at the unit was provided in ways to ensure their human rights were upheld.

We saw staff respecting patients' privacy and allowing them choice in their daily routines. We were told that patients were helped to keep in contact with their families and friends. Where patients' choices were restricted we saw that the reasons for this had been written in their individual care plans. The care records we saw also showed that where restrictions were in place, Deprivation of Liberty Safeguards[3] (DoLS) authorisations had been obtained in accordance with the DoLS arrangements.

From speaking with staff and looking at the care plans, staff appeared to have a good understanding of the DoLS arrangements. Staff training records showed that the majority of staff had attended training on the Mental Capacity Act and DoLS. For those staff who had not attended training, the health board should explore the reasons why and where needed support the staff to attend training.

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[2] The Mental Health (Wales) Measure 2010 is a law made by the Welsh Government which will help people with mental health problems in four different ways. http://gov.wales/topics/health/nhswales/mental-health-services/measure/?lang=en

[3] The Deprivation of Liberty Safeguards is a framework of safeguards for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is nor, and they must receive and open and honest response. Health Services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback. (Standard 6.3-Listening and Learning from Feedback)

There was no formal system in place at the unit to obtain feedback from patients and their families.

Senior staff described informal and ad hoc ways of receiving feedback from patients and their relatives on their experiences of the care provided. We were told that the health board were looking to introduce a more formal way to regularly obtain feedback from patients and their families. This was to be an electronic based survey where questions could be presented in different formats, including the use of pictures and symbols. This meant that people who had difficulty reading or difficulty understanding words would be helped so they could provide their views.

The health board should progress with plans to introduce a suitable system to obtain feedback that can be used by people using the service.

Delivery of safe and effective care

Overall we found that safe and effective care was provided to patients. Improvements were needed to make sure repairs were completed without a delay. Work was also needed to improve fire safety and senior managers told us this was being done.

Emergency equipment was available but this was not being checked by staff to make sure it was safe to use. Senior managers told us they would check what equipment was needed as a matter of priority and make sure regular checks were done.

We were told that there were sometimes delays in getting medicines ordered by patients' GPs. Senior managers told us they would look at ways how this could be improved.

Staff talked to patients to help them understand their care and treatment. The use of other forms of communication to help patients understand should be considered and used by staff.

Safe care

People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented. (Standard 2.1-Managing Risk and Promoting Health and Safety)

Overall we found that patients' health, safety and welfare were protected. We did, however, find that improvement was needed to make sure repairs were completed without delay. Improvement was also needed to keep patients safe in the event of a fire. Senior managers were aware of this and we were assured that work was being done to improve fire safety at the unit.

The unit was secure against unauthorised access and staff were vigilant to ensure the patients' safety was maintained. Areas were free from visible trip hazards. Staff told us that risks to patient safety are assessed and that action is taken to reduce these risks as far as possible. We also saw that risk assessments had been done within the care plans we looked at.

We were told that it often took a long time to get things repaired. For example, we were told it had taken approximately seven months to complete repair work to one of the patient toilets. We were provided with other examples of where maintenance and repair work needed to be done. It was disappointing to see that some had been reported over three months ago and that work had not

been completed. We informed senior managers of this and they told us they were looking at ways to improve this.

Improvement Needed

The health board must make suitable arrangements to complete outstanding repairs and maintenance work at the unit. In addition any future work must be completed in a timely manner.

A recent visit by the fire safety officer had found that work was needed to be done to improve fire safety at the unit. We were assured by senior managers that work was being done to improve fire safety at the unit. This was being followed up by the fire safety officer but we have requested that the health board also provide us with an update on the work being done.

Improvement Needed

The health board must provide HIW with an update on the progress of work (as required by the fire safety officer) to improve fire safety at the unit.

Senior staff confirmed that there were two first aiders. We were also told that all staff are expected to attend cardiopulmonary resuscitation (CPR) training. Training records we saw showed that most staff had attended CPR training within the last year. For those staff who had not attended training, the health board should explore the reasons why and where needed support the staff to attend training.

We saw that staff had access to resuscitation equipment in the event of a patient emergency (collapse). We were told that in the event of a patient collapse, the emergency services would be called to attend. Whilst staff had access to emergency equipment to use before the emergency services arrived, we were told that this was not regularly checked. We could not, therefore, be assured that the equipment was safe to use. We informed senior managers of our findings. They agreed to check what equipment was needed as a matter of priority and to make sure regular checks were then being done to ensure it was safe to use.

Improvement Needed

The health board must establish what emergency equipment is needed at the unit.

Arrangements must be made so that checks are being done to make sure the equipment is safe to use in the event of a patient emergency (collapse).

People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury. (Standard 2.5 Nutrition and Hydration)

We found that patients at the unit were helped to eat and drink. We saw detailed care plans setting out the help patients needed with eating and drinking.

Staff explained that patients were supported by staff in choosing meals, shopping for ingredients and preparing meals. A kitchen was available at the unit that patients could use with the support of staff.

Staff also told us that patients could see a dietician to help them make healthy food and drink choices. The care plans we saw showed that the dietician had been involved in helping patients with their food choices. Patients we spoke to told us they had a choice of meals and that they enjoyed the food.

People receive medication for the correct reason, the right medication at the right dose and at the right time. (Standard 2.6 Medicines Management)

Overall, we found that people's medication was managed safely at the unit. Staff told us, however, that there were often delays in patients having medication that had been ordered by the GP.

A designated room was used for storing medication used at the unit. We saw that this was locked when not being used to prevent people, who were not allowed to, from entering. Medicines were stored in locked cupboards as we would expect for safety.

Whilst there was a room this was dimly lit and cramped, making it difficult for staff to prepare medicines before giving to patients. Staff told us they were waiting for a fridge to be installed to store medicines that require refrigeration. We were told that there were no medicines requiring refrigeration at the time of our inspection. The health board must, however, make arrangements to ensure a suitable working fridge is available to safely store medicines (requiring refrigeration) held at the unit.

Improvement Needed

The health board must make arrangements to ensure that a suitable working fridge is available to safely store medicines (requiring refrigeration) held at the unit.

As mentioned earlier, staff told us that there were often delays in getting medication that had been ordered by patients' GPs. These delays seemed to be caused by the health board's process staff had to follow for the safe ordering of medicines. We informed senior managers of our findings and they agreed that they would explore ways how to make the process quicker, whilst still making sure patients' medicines were managed safely.

Improvement Needed

The health board should explore ways how medication prescribed by primary healthcare services can be obtained for patients at the unit without undue delay whilst maintaining patient safety.

We saw one example where nursing and medical staff had not followed the health board's process when requesting and authorising medication to give to a patient. We informed senior managers of our findings and were assured that the circumstances would be investigated and arrangements made to ensure staff were supported to follow the health board's policy.

Improvement Needed

The health board must make suitable arrangements to ensure nursing and medical staff are supported to follow the health board's medication policy and procedures when requesting and authorising medication that needs to be given.

Patients we spoke to were able to tell us about their medication. Information leaflets were available to patients to tell them about their medicines and health conditions. These would, however, benefit from being made available in a format more suitable for people with learning disabilities to understand.

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time. (Standard 2.7- Safeguarding Children and Safeguarding Adults at Risk)

Staff had access to information on what to do to protect the welfare and safety of patients at the unit.

Senior nursing staff described the process staff would be expected to follow should they identify a safeguarding issue. This was in keeping with the All Wales Vulnerable Adult procedure. We were told that there were no safeguarding issues at the time of our inspection. Patients we spoke to told us staff helped them feel safe.

We saw training records that showed most staff were up to date with training on safeguarding adults. For those staff who had not attended training, the health board should explore the reasons why and where needed support the staff to attend training.

Effective care

Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs. (Standard 3.1-Safe and Clinically Effective Care)

We saw that patients at the unit had their own written care plans. These showed that care was planned to make sure patients were safe and protected from avoidable harm.

We were told that staff were expected to attend training arranged by the health board. The training records we saw showed that staff had attended training on topics relevant to do their jobs. For those staff who had not attended training, the health board should explore the reasons why and where needed support the staff to attend training required.

We saw that positive behaviour support plans were being used. These help staff identify when patients need help to manage behaviour that other people may find challenging. Staff appeared to have a good understanding of the patients' needs and we saw them helping patients to be safe and reduce any anxiety they were showing.

We found that patients were encouraged to use their own rooms when they needed their own space away from other patients so that their well being was maintained.

In communicating with people health services proactively meet individual language and communication needs. (Standard 3.2-Communicating Effectively)

The communication needs of patients were recorded within their individual care plans. We were told that staff talked to patients to help them understand decisions about their care. We did not find that other forms of communication were used to help patients understand what was being explained to them.

Improvement Needed

Staff should consider using other forms of communication to support verbal information given to patients. Consideration must be given to

providing information to patients in the most accessible format, taking into account individual communication needs and abilities.

Record keeping

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance. (Standard 3.5-Record Keeping)

Records used at the unit were stored securely to prevent unauthorised people from reading them.

Patients' care plans were in paper format and we saw that entries made by staff had been signed and dated. This showed which staff members had helped and supported patients and who was responsible for the care provided.

As described earlier, each patient had their own care plan and whilst some parts were very detailed, other parts needed more detail to be recorded. The care plans we saw showed that information about patients was shared with other members of the multidisciplinary team so that decisions could be made on how best to support patients to get the help they needed. We saw that patients' care plans had been reviewed regularly.

Where staff needed to share written information, such as medication administration (MAR) charts with the pharmacy department, this needed to be done via the fax machine. Staff told us that this could sometimes take a long time and could cause a delay in patients having treatment. The health board should therefore consider providing the staff with alternative and appropriate equipment for sharing information more easily. The system used must take into account the health board's responsibility to handle information in a secure way.

Improvement Needed

The health board should make arrangements to ensure staff have access to a suitable system for the timely sharing of written information with other members of the multidisciplinary team who are based in other locations.

Whilst not affecting patient care directly, the staff team did not have easy access to a working printer. This was causing unnecessary inconvenience to staff when they needed to print out documents saved on the computer. The health board should therefore make arrangements to ensure staff at the unit can access a printer easily.

Quality of management and leadership

We saw good management and leadership at the unit. Work was being done to improve audits so that areas of care could be looked at and improved where needed.

We saw a committed staff team who appeared to have a good understanding of the needs of the patients. Staff told us they could talk to their managers about their work. Arrangements for this needed to be more formal. Not all staff were up to date with training they were required to do. We have asked the health board to look at this and support staff to attend the training required.

Governance, leadership and accountability

Effective governance, leadership, and accountability in-keeping with the size and complexity of the health service are essential for the sustainable delivery of safe, effective person-centred care.

A nurse manager was responsible for the day to day management of the unit and was supported by a deputy. A team of senior managers was also in place. We were told there was good communication between the management team at the unit and the senior nurse manager.

We saw that some audits had been completed. These included audits of care plans and medication administration records (MARSs). Whilst audits had been done there was nothing recorded to show what improvements could be made and how. Senior managers told us that they were looking at how to improve the audits and supplied us with more information on this. This showed that other areas of care would be looked at and where improvements were needed added to an action plan.

Improvement Needed

The health board should progress with the arrangements for improving the system for audit and ensure that where areas for improvement are identified, action is taken to address this and relevant learning shared with other services within the health board.

Senior staff described suitable arrangements for reporting and investigating patient safety incidents. We were told that learning from incidents that had happened at the unit was shared with the staff team. We were told, however, that learning form incidents was not routinely shared more widely amongst services within the health board. The health board should explore the reason

for this and make arrangements to routinely share learning from patient safety incidents as appropriate.

Improvement Needed

The health board should explore the reasons why learning from patient safety incidents are not routinely shared amongst services within the health board and take suitable action to promote shared learning.

We were told that monthly meetings were held between the management team at the unit and the senior nurse manager. These meetings provided an opportunity for discussion and provide updates on issues affecting the service.

Staff and resources

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need. (Standard 7.1-Workforce))

There appeared to be enough staff working with the right skills to meet the needs of patients at the unit. We were told, however, that more staff would allow patients to take part in more social activities. Staff appeared to have a good understanding of the needs of the patients.

We invited staff to provide their views on working at the unit. We did this by speaking to staff and asking them to complete a HIW questionnaire. Staff told us that communication amongst the team was good and team meetings were held regularly. Staff told us that they had opportunities to discuss issues related to their work with their manager. This was on an informal basis and arrangements should be made to ensure staff have formal supervision meetings with their manager with records kept to demonstrate this process.

Improvement Needed

Arrangements should be made to ensure that staff have formal supervision meetings with their managers at an appropriate frequency and that these are recorded.

The manager confirmed that all staff have an annual appraisal of their work and we saw records showing this.

Throughout the report we have described that not all staff were up to date with training that the health board expected them to do. For those staff who were not up to date with training, the health board should explore the reasons why and where needed support the staff to attend training.

Improvement Needed

The health board should explore the reasons why staff are not up to date with mandatory training and where needed support staff to attend training required.

5. Next steps

This inspection has resulted in the need for the learning disability service to complete an improvement plan (Appendix A) to address the key findings from the inspection.

The improvement plan should clearly state when and how the findings identified at the learning disability service will be addressed, including timescales.

The action(s) taken by the service in response to the issues identified within the improvement plan need to be specific, measureable, achievable, realistic and timed. Overall, the plan should be detailed enough to provide HIW with sufficient assurance concerning the matters therein.

Where actions within the service improvement plan remain outstanding and/or in progress, the service should provide HIW with updates to confirm when these have been addressed.

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

6. Methodology

The new Health and Care Standards (see figure 1) are at the core of HIW's approach to inspections in the NHS in Wales. The seven themes are intended to work together. Collectively they describe how a service provides high quality, safe and reliable care centred on the person. The standards are key to the judgements that we make about the quality, safety and effectiveness of services provided to patients.

Figure 1: Health and Care Standards

During the inspection we reviewed documentation and information from a number of sources including:

- Information held to date by HIW
- Conversations with patients and interviews of staff including doctors, nurses and administrative staff
- Examination of a sample of patient medical records
- Scrutiny of policies and procedures

- Exploration of the arrangements in place with regard to clinical governance.

These inspections capture a *snapshot* of the standards of care within learning disability services.

We provide an overview of our main findings to representatives of the service at the feedback meeting held at the end of each of our inspections.

Any urgent concerns emerging from these inspections are brought to the attention of the service and the local health board via an immediate action letter and these findings (where they apply) are detailed within Appendix A of the inspection report.

Appendix A

Learning Disability Service: Improvement Plan

Service: Residential Unit (Ref 16013)

Date of Inspection: 25 May 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
Quality of the patient experience					
8	The health board must make suitable arrangements to ensure patients with care and treatment plans required under the Mental Health (Wales) Measure 2010 have their plans reviewed at least annually.	Standard 6.1	All managers to report monthly the compliance on reviews of Mental health Measure Care and treatment plans. All managers have been directed to set up action plans to ensure that all CTPs are updated.	Operational Leads for AATU and SRS and community teams. Interim Lead Nurse	Completed Completed
Delivery of safe and effective care					
11	The health board must make suitable arrangements to complete	Standard 2.1	Develop an escalation for all maintenance requests and	Interim Assistant	Completed

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	outstanding repairs and maintenance work at the unit. In addition any future work must be completed in a timely manner.		prioritise requests against appropriate budgets.	General Manager	
11	The health board must provide HIW with an update on the progress of work (as required by the fire safety officer) to improve fire safety at the unit.	Standard 2.1	Fire collated issues report to be presented to Fire Officer ABMU for immediate action.	Interim Assistant General Manager	Completed
11	The health board must establish what emergency equipment is needed at the unit. Arrangements must be made so that checks are being done to make sure the equipment is safe to use in the event of a patient emergency (collapse).	Standard 2.1	Action plan on training equipment and maintenance to be developed and implemented.	Interim Assistant General Manager	31st July 2016
12	The health board must make arrangements to ensure that a suitable working fridge is available to safely store medicines (requiring refrigeration) held at the unit.	Standard 2.6	Delivery and fitting of the fridge (linked to Estates to provide replacement flooring to enable fitting).	Chief Administrator	31st August 2016
13	The health board should explore ways how medication prescribed by	Standard 2.6	Consider options with pharmacist and link with the Primary Care lead	Interim Assistant	31st August

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	primary healthcare services can be obtained for patients at the unit without undue delay whilst maintaining patient safety.		to support the prescription of medication by GP's to enable GP's to prescribe and sign prescription charts used in the Units.	General Manager	2016
13	The health board must make suitable arrangements to ensure nursing and medical staff are supported to follow the health board's medication policy and procedures when requesting and authorising medication that needs to be given.	Standard 2.6	Operational leads to communicate via email key actions from the policy on medication, ordering storing and authorisation to all unit managers	Service Managers – Assessment and Treatments	Completed
14	Staff should consider using other forms of communication to support verbal information given to patients. Consideration must be given to providing information to patients in the most accessible format, taking into account individual communication needs and abilities.	Standard 3.2	Interim Lead Nurse to share good practice examples and guidance for making information accessible with all unit managers. For accessible information to be added to the framework for 15 steps audit and complete an audit for all units. Consult with the Unit head of Speech and Language Therapy to ensure best practice is adopted for making this information accessible.	Interim Lead Nurse Interim Lead Nurse Interim Lead Nurse	Completed 31st July 2016 31st July 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
15	The health board should make arrangements to ensure staff have access to a suitable system for the timely sharing of written information with other members of the multidisciplinary team who are based in other locations.	Standard 3.5	Printer to be repaired for the unit.	Chief Administrator	30th June 2016
Quality of management and leadership					
16	The health board should progress with the arrangements for improving the system for audit and ensure that where areas for improvement are identified, action is taken to address this and relevant learning shared with other services within the health board.	Governance, leadership and accountability	To complete 15 step challenge audits in all Units. Review the audits and complete an action plan from the findings.	Interim Governance Lead	31st July 2016 30th September 2016
17	The health board should explore the reasons why learning from patient safety incidents are not routinely shared with other services within the health board and take suitable action to promote shared learning.	Governance, leadership and accountability	Review the learning from Datix is via various forums, for example the Assurance and Learning Group, Performance Reviews and the Health and Safety Committee to ensure a robust process is in place	Governance Lead	31st July 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
			The interim governance lead to promote the co-production of an integrated model of organisation learning across the delivery unit and health board. This will demonstrate evidence of a continuous cycle of reflection, learning, change and improvement across the delivery unit.	Interim General Manager	30th September 2016
17	Arrangements should be made to ensure that staff have formal supervision meetings with their managers at an appropriate frequency and that these are recorded.	Standard 7.1	Operational leads for the units to organise supervisions with unit managers and confirm with each the cascade arrangements for supervisions for all staff.	Service Managers – Assessments and Treatments	31st July 2016
18	The health board should explore the reasons why staff are not up to date with mandatory training and where needed support staff to attend training required.	Standard 7.1	Operational leads to develop action plan to improve compliance with mandatory training.	Unit Service Managers	31st July 2016

Service representative:

Name (print): **Dermot Nolan**

Title: **Interim General Manager Learning Disability Services**

Date: **22/06/16**