Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Learning Disability Inspection (unannounced)

Aneurin Bevan University Health Board, Assessment and Treatment Unit, Llanfrechfa Grange

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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 at Llanfrechfa Grange Assessment and Treatment Unit, Cwmbran, Torfaen, NP44 8YN on 26 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 Llanfrechfa Grange 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

Llanfrechfa Grange currently provides services in the Cwmbran area of Torfaen. The service forms part of learning disability services provided within the geographical area known as Aneurin Bevan University Health Board.

Llanfrechfa Grange is an assessment and treatment unit and is the only assessment and treatment unit for people with learning disabilities within the health board. The unit provides care for patients with a dual diagnosis of learning disabilities and mental health and patients with a learning disability who present with significant behaviours that challenge.

The setting is a mixed gender unit with 7 beds. There were 5 people living there at the time of the inspection.

The staff team includes one manager who is a registered nurse, one deputy manager (post vacant at the time of inspection), one administrator (post vacant at the time of inspection) and a team of registered nurses and healthcare support workers. The multi-disciplinary team includes a designated consultant, a full time occupational therapist, speech and language (SALT) service, psychology and dietician service. The team could also access specialist behaviour support from the Intensive Support Team.

Llanfrechfa Grange falls under the Learning Disabilities Directorate within Aneurin Bevan University Health Board. The Learning Disabilities Directorate sits within the Mental Health and Learning Disabilities Division of the health board.

3. Summary

HIW explored how Llanfrechfa Grange met standards of care as set out in the Health and Care Standards (April 2015).

Overall, we found evidence that Llanfrechfa Grange Assessment and Treatment Unit provided safe and effective care.

This is what we found the service did well:

- We saw staff treating patients with kindness and respect.
- There were good examples of staff upholding people's rights.
- Staff involved people, carers and advocates in decisions around their care and treatment.
- There were good examples of multidisciplinary working with the aim of achieving the best outcomes for patients.
- Improvement activities such as audits and improvement meetings were being implemented and we could see that actions happened as a result to improve the service for patients.
- Senior staff were planning for the future of the service and were passionate in engaging with patients and their carers around future plans.

This is what we recommend the service could improve:

- Allowing patients access to appropriate, sufficient and individualised activity opportunities.
- Empowering patients and carers to give feedback on the service on an ongoing basis during their stay.
- The environment needed some improvements to make it as comfortable and homely as possible for patients and to allow patients access to secure outside space.
- Improvements were needed to documentation, to ensure this was fully completed, updated and well organised to enable a holistic view of the person's needs.
- A more effective system was needed for keeping track of staff's ongoing training compliance.

- There were sometimes delays in moving people on to more long term placements due to the lack of appropriate service provision to meet people's complex needs.

We issued an immediate assurance letter in respect of this inspection. This was to seek assurance from the health board on the action taken or being taken in relation to:

- Blind spots in the alarm system which had the potential to compromise staff and patient safety.
- Ensuring all patients had up to date risk assessments in place.

At the time of this report the health board had provided HIW with sufficient assurance that these matters were being/would be resolved within appropriate timescales.

4. Findings

Quality of patient experience

In general patients told us they were satisfied with the care and treatment provided. We saw staff treating people with kindness and patients were supported to stay healthy. We saw that staff upheld people's rights and involved people, their families and advocates in decisions around their care and treatment. We saw good examples of care coordination and multidisciplinary meetings being held.

We saw that there were sometimes delays to aspects of patients' care and treatment. These were mainly in relation to updating relevant documentation and where there were challenges in finding appropriate service provision to enable people to move on.

Improvements were needed in ensuring risk assessments and other documentation were kept up to date, in ensuring patients had access to appropriate and sufficient activities and in providing a secure outside space for patients. Improvements were also needed to processes enabling patients and families to give ongoing feedback and in ensuring complaints information was sufficiently detailed and accessible.

The inspection team sought patients' views with regard to the care and treatment provided at Llanfrechfa Grange Assessment and Treatment Unit through face to face conversations with patients and/or their carers.

Overall patients told us they were happy with the care and treatment provided. One family were dissatisfied with the delays to their loved one moving on. We explored this case in depth and found that the reasons for this were complex and involved the lack of suitable service provision to meet the person's needs. We have asked the health board to ensure this continues to be prioritised so that the patient is able to move on to more appropriate and suitable provision.

Staying healthy

People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage 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)

Overall we found that patients were supported to stay healthy.

We found that patients were mainly able to be seen at their usual GP surgeries and usual dentists. Where there was a need we saw that patients had accessed community dental services.

We saw that patients were supported to manage their health conditions, for example, in one set of records we reviewed we saw that the person was being supported with weight management and healthy eating.

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 were treated with dignity and respect. We observed staff treating patients with kindness.

We saw that patients had access to their own private rooms and one patient confirmed that staff always knocked to ask permission before coming into their room.

There were private spaces available within the environment such as a meeting room and visitors' room which allowed patients to meet staff and visitors in a confidential place.

We found that patients were supported to be independent in taking care of their personal hygiene, with staff providing assistance where needed.

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 (Standard 5.1)

In general we found that patients received timely access to care and treatment whilst in the care of the unit. However, we found there had been delays to some aspects of care and treatment in the cases we reviewed. This was in relation to completion of appropriate paperwork including risk assessments and in the case of one individual in finding appropriate, bespoke service provision to facilitate them moving on from the unit.

There was a clinical pathway[1] in place, which was audited, to ensure important timescales for care and treatment were met. At a glance it was difficult to assess whether timescales were met due to the disorganisation of records. However we found that there had been some delays in completing admissions paperwork and in updating individuals' risk assessments following multidisciplinary team (MDT) meetings.

In one case, admission paperwork for the person had not yet been completed (two days after they had been admitted to the unit) and staff did not yet have access to up to date care management and risk assessment plans to guide their work with the person. The patient had been making threats which staff were recording but an overall risk assessment was not yet in place. Staff told us the assessments were in the process of being completed but as the person had been admitted as an emergency the usual pathway had not been able to be followed. In another case we were told that recent risks had been discussed at their MDT and through other means but risk assessments had not been updated as a result to guide staff.

In one case staff were working in a coordinated and multidisciplinary way to plan the future care of the patient. The patient had been admitted as an emergency and had complex needs. We were assured that appropriate care and treatment plans and assessments were in place and care coordination was taking place with all relevant individuals to help to move the person on as a priority. We heard however that there had been some delays in finalising the service specification due to awaiting a relevant party to complete their input. Staff were aware of this and were prioritising this as a matter of urgency.

Improvement needed

The health board must ensure that in the case discussed that delays are avoided and that the health board give priority to moving the person onto more appropriate accommodation as soon as possible.

The health board must ensure that the clinical pathway is followed, specifically in ensuring that assessments are completed, and updated, within specified timescales.

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[1] A **clinical pathway** is a standardised, evidence-based multidisciplinary management plan, which identifies an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a specified patient group.

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 looked at three sets of patient records in depth.

Overall we found good examples of care coordination between the multidisciplinary team, unit staff, community staff and wider health and social care professionals. Although it was not always clearly documented, on speaking with staff and patients, there were clear goals around their admission, the aim of the admission and around planning for the future. Patients had multidisciplinary assessments based on their individual needs and these were used to inform their ongoing and future care and treatment.

We saw that staff assessed people's current needs and risks, however, records were not consistently updated. In the records we saw it was difficult to get a sense of the patients' overall care and treatment needs and current risks to their safety. This was due to poor organisation of files and discussions around risk in MDT, or admissions, meetings not always leading to patients' risk assessments being updated.

In two sets of patient records we could not be assured that staff had access to up to date risk assessments in order to manage patients' risks to their safety. We asked the health board, through an immediate assurance letter, to address this as soon as possible. At the time of this report we had received sufficient assurance that this had been addressed. The health board were in the process of reviewing and auditing patients' risk assessments as a whole to ensure standards were being met.

We saw that staff involved people in their care and support and helped people to understand their rights and choices. Patients we spoke with understood their care and support, the role of the unit and were being involved around decisions for the future, sometimes with the help of family and/or an advocate.

We saw that staff supported people to be as independent as possible. For example, we saw the input of psychology and other therapy services to support one person to identify their skills and self coping strategies in terms of their mental health.

Staff told us they were working on improving patients' access to appropriate activities. We saw that some patients had completed individual activity plans.

However, it was not always clear from records how staff had supported patients to achieve their individual activity goals. We saw that the majority of patients accessed the community independently. Activity charts had intermittent recordings of how patients spent their days. We saw that there were some activities available on the ward but these were not tailored to individuals. Staff were working to access the right equipment and set up suitable opportunities in relation to one person where access to activities and the local community was more challenging due to the person's behaviours. This was particularly important for the person and their sense of wellbeing.

Patients had access to the right equipment to help them meet their needs. However, patients were unable to access the garden to help promote their sense of wellbeing or to help staff in managing incidents. We saw that in one case, the person's care plan outlined their need to access the garden so that they were able to employ mindfulness techniques. At the time of the inspection patients were unable to access the garden due to maintenance work that was required on the decking. Staff told us this had been the case for the past 5 months and a bid had been made to try to secure funding. The person was able to access outside space in other ways.

We saw good examples of preventative work between staff and patients who they knew well, to try to prevent admissions to the unit. For example we saw that there was a telephone call protocol in place for all staff to follow when one patient telephoned the unit. This was to ensure consistent support for the person and to try to prevent re-admission where possible.

We saw a person centred, full and detailed positive behaviour support plan in respect of one individual, to help manage their behaviours and provide support in an individualised way. This was updated as care and treatment progressed to ensure staff were providing support in a consistent and effective way.

Improvement needed

The health board must ensure that care plans and risk assessments are updated on an ongoing basis to guide staff in caring for patients according to their current needs. There must be processes in place to ensure that any discussions around risks and changes to care provided as a result, are clearly documented and all staff informed.

The health board should ensure that patients have access to secure outside space to help staff in managing incidents and to ensure patients' wellbeing can be promoted and individual needs can be met.

The health board must ensure that all patients have access to appropriate activities.

The health board must continue to develop appropriate methods of stimulation and activity in relation to the one individual discussed as a matter of priority, to support emotional wellbeing.

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)

Overall we found that care and treatment was provided with a view to ensuring patient's rights were upheld.

There were no Deprivation of Liberty Safeguards (DOLS)[2] authorisations in place at the time of the inspection. Through discussion with staff it became clear that they worked in line with the principles of the Mental Capacity Act. We saw that discussions around one person's best interests had happened appropriately and this was accurately documented. In regards to another patient, we suggested that staff consider whether a capacity assessment was appropriate in order to manage the risks associated with leaving the unit.

One patient was detained under the Mental Health Act. The records we reviewed indicated that people's care and treatment was planned and delivered with a view to upholding people's rights in respect of the Mental Health Act.

Staff told us there was a folder which contained accessible information about people's rights which they used with people to aid understanding.

As part of one patient's care and treatment, staff were using seclusion[3]. We saw that where withdrawal and seclusion was used, this was carried out in line with the health board's seclusion policy and closely monitored to ensure appropriate use. Staff had easy access to the seclusion policy which was held in the office. Staff had reviewed both the seclusion policy and enhanced care

[2] The **Deprivation of Liberty** Safeguards are an amendment to the Mental Capacity Act 2005. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.

[3] **Seclusion** is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others

room policy to ensure the use of this met appropriate standards. We also saw that there was evidence of staff explaining the use of seclusion to the individual concerned, that it was subject to continual audit with evidence of a reduction in previous months. This meant that staff were ensuring that the rights of the individual were upheld in relation to the use of seclusion.

We saw that there was active involvement from an advocate on the unit. The advocate met individually with patients and also held a meeting with all patients on a monthly basis. On the day of the inspection we saw that the advocate was involved in patients' multidisciplinary meetings to ensure patient's rights were taken into account in these forums.

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)

On an individual level we found that patients were involved in discussions around their care, treatment and plans for the future. We saw the active involvement of an advocate to help people to express their views. We also saw, on the day of our inspection, how patients and/or their families were helped to have an input into their multidisciplinary meetings so that their views were expressed.

Staff told us they gathered patient's views by sending out a questionnaire two weeks after the patient was discharged. They did not record informal verbal feedback given by patients or carers. We suggested that staff consider other ways to empower patients and carers to provide feedback about services, on an ongoing basis, with a view to making improvements.

The setting had a written procedure in place for patients to raise concerns and complaints and we were provided with a copy of the current leaflet for patients and carers. The written procedure was dated 2010 and was not fully compliant with 'Putting Things Right' requirements, the current arrangements for dealing with concerns (complaints) about NHS care and treatment in Wales. This was because the information did not include the 30 day timescale for resolving a complaint, did not include Community Health Council contact details for help with making a complaint and did not include information about how to escalate a complaint to the Public Services Ombudsman if the person was not happy with the outcome of the complaints investigation.

Wall displays of information had been dismantled due to risks associated with one patient who had been staying on the unit but who had since left. There was some information on how to make a complaint displayed near to the main entrance. The health board should consider how to make this information as accessible as possible to patients at all times.

Improvement needed

The health board should consider how to empower patients and carers to describe their experiences of services on an ongoing basis, with a view to listening and learning from feedback to make improvements.

The health board must review complaints information for patients and amend it to comply with 'Putting Things Right' requirements. Complaints information should be easily accessible to patients at all times.

Delivery of safe and effective care

Overall we found that care and treatment was delivered safely and effectively. Patient's safety within the environment had been appropriately considered and managed, patients' medicines were safely stored and administered and there were appropriate Protection of Vulnerable Adults (POVA) procedures in place.

Improvements were needed to ensure patient documentation met record keeping standards. There were aspects of the environment that we have asked the health board to review to ensure patients are as comfortable as possible. We saw that staff were reviewing and managing incidents in an appropriate and timely way, however there were a number of these that required signing off. We have also asked the health board to review the location of resuscitation equipment to ensure it is stored in the most accessible and central location.

We asked the health board through an immediate assurance letter to ensure blind spots in the alarm system are resolved for the protection of staff and patients. At the time of the report this issue had been resolved.

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)

We found that staff had adapted the environment to meet people's needs and to ensure that the safety of patients was maintained. In doing so, there were aspects of the environment that were sparse.

We found the environment to be accessible and staff told us that there had been a recent health and safety audit to ensure the environment was safe, including the assessment of potential ligature points[4].

[4] A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.

We found the environment to be sparse in areas and staff told us this was due to the needs of several patients who had since left the unit. We saw that staff were beginning to reattach curtains, information and displays to the walls.

We noticed a sign that prevented patients from eating meals on the sofa. We asked staff about this and they told us this was also in relation to a patient who had since left. We asked the sign to be removed so that patients were able to eat where they chose and staff agreed to do this.

We noticed that bedroom areas were cold. We brought this to the attention of staff. Staff told us this was due to heating being controlled centrally. Patients had been given extra blankets due to the weather recently changing again to be cooler. We asked staff to address this so that the environment could be as comfortable as possible for patients.

In one of the dorm areas a drain had been blocked which was causing an unpleasant smell. Patients had been moved to other bedrooms and staff told us this was a recent maintenance issue that had been reported.

Staff used an alarm system to call for immediate and urgent assistance when this is required. Staff told us that the alarm system did not always work and staff injuries had resulted. We were particularly concerned about alarm blind spots in the extracare room where the current need for this was essential. We saw that a bid had been submitted for a full upgrade of the current alarm system. We asked the health board, through an immediate assurance letter, to address this as soon as possible. At the time of this report we had received sufficient assurance that this had been addressed.

There was appropriate resuscitation equipment in place to enable staff to manage medical emergencies. We saw that this was currently stored in the clinical room which was not easily accessible to all staff.

Improvement needed

Staff should ensure that the environment is made as comfortable as possible for patients ensuring that the unit is maintained at a comfortable temperature, that there is relevant accessible information on display and that when rules are made for the environment due to one person's needs, that these are reviewed and removed when no longer applicable.

The health board must ensure there is a fully functioning alarm system in place.

Staff should review the location of resuscitation equipment to ensure that it is easily accessible to staff in the event of an emergency.

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

We saw in records that patients were supported with healthy eating. Daily intake and weight monitoring charts were in place where there was a need to support patients with this aspect of their health.

There was a kitchen which patients could use with staff to make hot drinks and access snacks and meals throughout the day and evening.

Staff told us that main meals were delivered to the unit and patients had a choice over their meals.

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

There was a medication policy in place and we found that patients' medicines were administered and recorded safely.

Patients' medicines were stored in the clinical room which was in the seclusion area. This meant staff had to carry patients' medicines across areas when administering. We suggested that staff consider how they could use the space in the environment more effectively to make the process of administering medicines easier for staff.

Due to this, patients' PRN ("as needed") medicines had been moved to the nurses' office where they were more readily accessible. We saw that PRN medicines were managed in line with best practice guidelines.

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)

There was a protection of vulnerable adults and child protection policy in place for staff to follow when they had concerns around potential abuse.

Staff talked us through the process of how they reported concerns through the Protection of Vulnerable Adults (POVA) team as the first step, then through the health board if the referral met the criteria. Staff talked us through one case and we found that suitable and appropriate action had been taken.

Staff told us, and indicated in questionnaires that they felt comfortable in raising concerns with management.

The training matrix indicated low compliance in terms of staff training in the Protection of Vulnerable Adults.

Improvement needed

Staff must be trained to recognise and act on issues and concerns in regards to POVA and POVA training must be kept up to date.

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)

Management staff talked us through the process of incidents management and we found that there were appropriate processes in place to report, review and record incidents.

Incidents were reported through DATIX (the health board's incidents management system), management staff reviewed the incident to take necessary steps and these were reviewed by senior management and other relevant parties where required, to take action, such as specialist behaviour support staff or health and safety staff. Incidents, themes and patterns were discussed at wider quality and patient safety forums within the health board.

We saw that there were a number of clinical incidents with actions outstanding. Although we were assured that management staff had reviewed these incidents and taken immediate actions where needed, management staff needed time to be allocated to allow them to go through and review them and sign off where actions were complete.

In the cases we reviewed we saw that patients had access to a range of therapies and interventions based on their individual needs such as positive behaviour support, psychology services and therapies such as dialectical

behaviour therapy (DBT)[5]. We saw good examples of staff supporting people to consider their own coping strategies.

We saw that where restraint or seclusion was used this was recorded and staff had audited the use of seclusion to ensure this was monitored, being used appropriately and to assess how effectively interventions were working for one person.

Improvement needed

Staff must ensure that all incidents with outstanding actions are reviewed, followed up and signed off where complete.

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

We found that most people on the unit were able to verbally communicate to make their needs known. Staff were using picture tools with one person to communicate as accessibly as possible in relation to the person's daily routines. We saw that speech and language therapy had successfully made a bid to the Health Technology Fund[6] for communication aids and equipment to further support patients' communication needs.

We saw that there was an accessible information leaflet about the unit that staff distributed to patients on admission. This contained a range of relevant and useful information. We saw there was an admissions checklist in place which staff were expected to complete for all patients. On the day of the inspection there was a lack of readily available accessible information. The reasons for this have been discussed and staff were in the process of reattaching displays back onto walls.

We saw that a recent audit of the unit had identified the need for the staff board to include photographs of staff to make this more accessible for patients. Staff were in the process of making this improvement.

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[5] DBT is a therapy designed to help people change patterns of behaviour that are not helpful.

[6] The **Health Technology Fund** was launched as a three year Welsh Government programme in 2013. Health boards across Wales applied for a share of £9.5m to invest in new technology and telehealth to improve patient care.

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)

Patient documentation was difficult to navigate due to the poor organisation of notes within patient files. There were two files in place for each patient, however, information was not filed according to the indexes and information was spread across both files. This meant that it was difficult to find an overall picture of the patient's current needs, without further investigation.

Patient's allergies in respect of medications was clearly indicated on their medication records, however, other allergies were not clearly flagged in files and required investigation through notes.

We found that recording of patient consent to care and treatment was not consistent. We also saw that some care plans and risk assessments had not been signed off and we saw examples of food charts, activity planners and observation charts that had not been fully completed.

Improvement needed

The health board must ensure that:

- ***Patient's documentation is appropriately organised***
- ***Patients' allergies are clearly indicated***
- ***Patients' consent to treatment is consistently recorded.***
- ***Care plans, risk assessments and all documentation is fully completed, signed and dated where this is required.***

Quality of management and leadership

Overall we found that there was effective management and leadership of the unit. Improvement activities such as audits and improvement meetings were being implemented and we could see that actions happened as a result to improve the service for patients. Senior staff were planning for the future and considering a future model of care. In the interim period we have asked the health board to provide assurance that service provision is being planned and developed to meet the current needs of people with learning disabilities.

We found that staffing levels were adjusted to meet patients' current needs on the unit. Patients were also able to access multidisciplinary team members and where there were clinical vacancies these were being suitably covered. Management staff were in the process of ensuring staff's annual appraisals were up to date. Improvements were needed so the health board could keep track of staff's ongoing training requirements.

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.

The current manager had been in place for six months and we were assured that they had identified, and were taking action, around areas of the unit that could be improved. Our discussions with staff and staff questionnaires indicated that they had faith in management, felt able to raise concerns and felt that management was effective.

We saw that staff gathered data for monitoring and audit activities and that actions were implemented as a result. For example, we saw the action plan resulting from a recent audit and management staff were able to provide an update on actions outstanding. We also saw that there had been recent audits around seclusion and speech and language therapy services. This meant that there was active monitoring with a view to make improvements to the service delivery for patients.

Staff told us that they did not currently meet as a team but changes were communicated to staff through notices and a folder in the office. Clinical practice meetings were in place and sufficient time allocated for staff handovers

throughout the day. We suggested that management could consider holding team meetings to further improve communication.

We saw minutes from the monthly Assessment and Treatment Unit Development Meetings which were attended by management staff and members of the multidisciplinary team. We saw that a number of relevant topics were discussed and that staff followed up and implemented any actions arising from these meetings.

Senior staff were aware of the challenges that faced the current model of care across Gwent For example, the isolation of the Assessment and Treatment Unit and lack of availability of low secure beds. This meant that with the current model, it was difficult to be flexible in terms of meeting people's fluctuating learning disability and mental health needs. Senior staff had started to plan for the future based on the assessment of current patient groups and their potential future needs.

We spoke with senior staff about the vision for the future of the service. We found that they were active in reviewing residential services and the model of service delivery as a whole in terms of the Assessment and Treatment Unit.

Staff were in the early stages of researching options for a possible integrated model for inpatient care. Senior management were passionate about engaging with patients and carers about their views for the future model. They were clear about the positive aspects of service delivery they wanted to take forward and the areas where improvements could be made. We were therefore assured that future planning was happening in terms of improving services for patients.

One of the cases we reviewed in depth was an individual with complex needs and where there were difficulties in finding appropriate service provision for the individual. The health board must ensure that in the interim period before future plans come to fruition, that there are appropriate processes in place to enable future planning for the population of people with learning disabilities, to allow for service provision to be developed to meet people's needs.

Improvement needed

The health board must ensure that there is planning around the current and future needs of people with learning disabilities within the area so that service provision can be developed to meet people's needs.

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))

We saw an appropriate skill mix of staff dedicated to the unit to support patients' individual needs. There was a team of registered nurses and healthcare support workers. Patients had access to a designated consultant, psychologist, psychologist assistant, occupational therapist, clinical behaviour specialist, drama therapist, speech and language therapy and could access services from dieticians and the Intensive Support Team. We saw that staff had discussed the need for clinical attendance at patients' MDT meetings to further improve these and work was happening around this. We attended one patient's MDT meeting on the day of the inspection. We found this to be effective in facilitating discussions with all parties involved around future plans for the person's care and treatment.

There were a number of staff vacancies at the time of the inspection including a deputy manager and an administrator. Staff had been appointed to these posts and were due to start imminently. There were also clinical vacancies in occupational therapy and psychology and a new consultant had just started. Where there were shortfalls in clinical posts, cover was being provided in the interim by the Intensive Support Team and resources from the community team.

Staff told us they reviewed staffing levels on an ongoing basis according to patients' needs. On the day of the inspection, the manager had been included in the numbers as a registered nurse. Staff told us this happened rarely. We saw that bank staff and occasionally agency staff were used on the unit. However, senior staff had focussed on the recruitment of more unit staff as a priority and overall numbers had increased. We were assured that with the current patient group on the unit, staffing levels were appropriate to meet patients' needs.

Our discussions with staff, and comments in staff questionnaires, indicated that there was a good process of induction in place to ensure staff were sufficiently supported to begin their roles. The unit offered places to student nurses and staff told us there were good mentoring and shadowing processes in place.

Staff told us they had access to professional development and a range of training opportunities. We saw staff training certificates which confirmed this. Staff told us there was a focus on training in positive behaviour support and two healthcare support workers had additional responsibilities as trainers for this. Staff told us there was a development need as a team to have training in

personality disorder due to an increasing number of patients being admitted to the unit with this condition.

The training matrix indicated that there was low training compliance on the unit in topics such as administration of medicines, mental capacity and infection control. Management staff had identified the need for a central log to be kept of staff training and had begun work on this, to be continued once the new administrator was in post.

We looked at a small sample of staff files and found that appropriate checks were carried out in the recruitment of staff to ensure suitability for the role and to safeguard patients.

Management staff told us they had identified the need for staff appraisals to be brought up to date and we saw that this was now being implemented and monitored. This gave staff the opportunity to receive feedback on their performance, to discuss training needs and indicate if any additional support was needed

Improvement needed

The health board should ensure there is a system to enable monitoring of all staff's training so that they can be assured of staff compliance with ongoing training requirements.

The health board must support staff to stay up to date on their training.

The health board should review the training needs of staff in regards to supporting people with personality disorder.

The health board must ensure that all staff have annual appraisals.

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 Llanfrechfa Grange 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: Llanfrechfa Grange (Ref 16030)

Date of Inspection: 26 May 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
Quality of the patient experience					
8	The health board must ensure that in the case discussed that delays are avoided and that the health board give priority to moving the person onto more appropriate accommodation as soon as possible.	5.1	The Health Board is consulting with care providers on the suitability of their services to provide care for individual. Procurement of such services has proved difficult since it is the service provider who assesses if the Service User's needs will be met by the accommodation offered. An options appraisal meeting took place on 13th July 2016 to review current placement options. This has included the family.	Chris Jones Assistant Head of Specialist Services	13th July 2016 ongoing

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
8	The health board must ensure that the clinical pathway is followed, specifically in ensuring that assessments are completed, and updated, within specified timescales.	5.1	The care pathway is being reviewed and updated to reflect current accepted practice by the Assessment and Treatment unit. The process will be monitored by the key nurse (associate care co-ordinator) A process of Audit will be undertaken to ensure that the components of the pathway are embedded into practice. Management supervision is being rolled out onto the unit. A part of this supervision will be the review of records and assessments completed by staff to ensure completeness and compliance with policy.	Chris Jones Assistant Head of Specialist Services Chris Jones Assistant Head of Specialist Services Chris Jones Assistant head of Specialist Services	15th July 2016 Annually within 3 months of implementation To all staff by 13th October 2016
10	The health board must ensure that care plans and risk assessments are updated on an ongoing basis to guide staff in caring for patients according	6.1	A tasks checklists has been completed for qualified staff to ensure that any changes to risk management plans are discussed in	Chris Jones Assistant head of	8th June Completed

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	to their current needs. There must be processes in place to ensure that any discussions around risks and changes to care provided as a result, are clearly documented and all staff informed.		every handover. WARRN risk assessment will at a minimum be checked and updated every night by qualified staff on night duty. Amendments will be discussed through the handover process. Management supervision is being rolled out onto the unit. A part of this supervision will be the review of risk assessments undertaken by the reviewee. The assessments will be checked for compliance against policy and against records to ensure all risks are identified and have a management plan.	Specialist Services Chris Jones Assistant head of Specialist Services Chris Jones Assistant head of Specialist Services	Commenced 6th June 2016 To all staff by 13th October 2016
10	The health board should ensure that patients have access to secure	6.1	At the time of the inspection the outside garden space had been	Chris Jones Assistant	Completed 6th June

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	outside space to help staff in managing incidents and to ensure patients' wellbeing can be promoted and individual needs can be met.		closed due to health and safety problems with the decking area. The decking has now been replaced and service users are able to access the garden area.	head of Specialist Services	2016
10	The health board must ensure that all patients have access to appropriate activities.	6.1	The Assessment and Treatment Unit have reviewed patient's care plans to ensure that activities offered are appropriate to their need. A band 5 Occupational Therapist post has gone to advert to support the assessment and structure of proposed activities for individuals. This role is currently being managed by a senior OT from within the directorate.	Chris Jones Assistant head of Specialist Services Chris Jones Assistant head of Specialist Services	Complete 6th June 2016 Advertised 19th July 2016
11	The health board must continue to develop appropriate methods of stimulation and activity in relation to the one individual discussed as a matter of priority, to support emotional wellbeing.	6.1	The individual referred to in the report has a specific activity plan suitable to his needs. The service user has now begun to engage more in the social aspects of the plan.	Chris Jones Assistant head of Specialist Services	20th July 2016 ongoing

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
13	The health board should consider how to empower patients and carers to describe their experiences of services on an ongoing basis, with a view to listening and learning from feedback to make improvements.	6.3	The Health Board uses the Health and Care Standards monitoring system to gather and collate patient, carer and relatives' feedback. An annual Performance and Service Review will include a review of service user stories and feedback from relatives, carers and service users. Relatives and carers of service users will be encouraged to attend the review to provide feedback if they wish. A patients meeting will be developed along with the advocacy service to obtain service user feedback and also provide information.	Chris Jones Assistant head of Specialist Services Chris Jones Assistant head of Specialist Services Chris Jones Assistant head of Specialist Services	13th July 2016 Annually December 2016 By October 2016
13	The health board must review complaints information for patients and amend it to comply with 'Putting Things Right' requirements.	6.3	An easy read version of the Putting Things Right leaflet has been developed. This will be made available in leaflet form on the	Chris Jones Assistant head of	13th July 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	Complaints information should be easily accessible to patients at all times.		Assessment and Treatment Unit and also on the Putting Things Right information page on the Health Board's website. An Independent Mental Health Act Advocate attends the unit regularly under Part 4 of the Mental Health (Wales) Measure 2010 in order to support and provide information for service users who wish to escalate concerns.	Specialist Services Chris Jones Assistant Head of Specialist Services	June 2012 as required and weekly
Delivery of safe and effective care					
15	Staff should ensure that the environment is made as comfortable as possible for patients ensuring that the unit is maintained at a comfortable temperature, that there is relevant accessible information on display and that when rules are made for the environment due to one person's needs, that these are reviewed and removed when no longer applicable.	2.1	Works and estates have been contacted to review and amend the unit's heating system to ensure that it maintains a comfortable temperature throughout unit. A display cabinet has been purchased to ensure that relevant accessible information is displayed at all times.	Chris Jones Assistant head of Specialist Services Chris Jones Assistant head of Specialist Services	8th June 2016 12th July 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
15	The health board must ensure there is a fully functioning alarm system in place.	2.1	The Alarm System was upgraded as a matter of urgency and is now fully functional with no 'blind spots'	Chris Jones Assistant head of Specialist Services	31st May 2016
15	Staff should review the location of resuscitation equipment to ensure that it is in a central, easily accessible location.	2.1	A review of the clinic area is being undertaken to see if this can be moved to another more central room on the unit. The resuscitation equipment will be located in the clinic.	Chris Jones Assistant head of Specialist Services	15th July 2016.Currently in costing process review to be complete by October 2016
17	Staff must be trained to recognise and act on issues and concerns in regards to POVA and POVA training must be kept up to date.	2.7	POVA training is mandated for all care and this will be provided to all staff at induction to new roles. All staff currently in role who have not undertaken POVA training will complete this to the required level.	Chris Jones Assistant head of Specialist Services Chris Jones Assistant head of Specialist Services	31st July 2016 onwards 31st October 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
18	Staff must ensure that all incidents with outstanding actions are reviewed, followed up and signed off where complete.	2.1	The Health Board uses the Datix Incident Management System to review, follow up and sign off incidents. The management supervision process will check and provide assurance to the Health Board that all incidents are being reviewed, followed up and signed off. The unit manager will be provided supervision by the Assistant Head of Specialist Services.	Chris Jones Assistant head of Specialist Services	13th July 2016 every 4 weeks
19	The health board must ensure that: • Patient's documentation is appropriately organised • Patients' allergies are clearly indicated • Patients' consent to treatment is consistently recorded. • Care plans, risk assessments and all documentation is fully	3.5	Management supervision is being rolled out onto the unit. A part of this supervision will be the review of the documentation completed by individual members of staff. Documentation will be checked for compliance against policy and procedures and action plans developed with staff where there is poor compliance. A rolling audit programme is	Chris Jones Assistant head of Specialist Services Chris Jones	By October 13th 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	completed, signed and dated where this is required.		underway in relation to the health records, care plans and risk assessments.	Assistant head of Specialist Services	Bi Annually
Quality of management and leadership					
21	The health board must ensure that there is planning around the current and future needs of people with learning disabilities within the area so that service provision can be developed to meet people's needs.	Governance Leadership and Accountability Standard	The Mental Health and Learning Disabilities Division have began developing plans for an integrated service model that include high dependency care, psychiatric intensive care, and low secure services. An interim scheme to manage the needs of service users requiring such services is now being developed and a professional practice group is meeting to develop training, skill mix and staffing requirements. The Health Board is collaborating with Local Authorities, Housing and third party service providers to develop bespoke solutions to service users' needs.	Chris Jones Assistant head of Specialist Services Chris Jones Assistant head of Specialist Services	July 2016 ongoing. 15th July 2016 ongoing

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
23	The health board should ensure there is a system to enable monitoring of all staff's training so that they can be assured of staff compliance with ongoing training requirements.	7.1	The Learning Disabilities monitors its staff training compliance via a Microsoft excel training matrix stored on a local network and the electronic staff record.	Chris Jones Assistant head of Specialist Services	Ongoing
			Management supervision is being rolled out onto the unit. A part of this supervision will be the review of statutory training and a review of staff learning needs to ensure that staff possess the necessary training to work within the Assessment and Treatment Unit. Any training compliance issues will be rectified through this process by the unit manager.	Chris Jones Assistant head of Specialist Services	By 13th October 2016 at least every 8 weeks
			A Continuing Professional Development file will be kept on the unit for each member of staff. A record of current training will be recorded in this by staff in readiness for supervision and Performance and Development Reviews.	Chris Jones Assistant head of Specialist Services	By October 13th 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
23	The health board must support staff to stay up to date on their training.	7.1	Management supervision is being rolled out onto the unit. A part of this supervision will be the review of statutory training and a review of staff learning needs to ensure that staff possess the necessary training to work within the Assessment and Treatment Unit. Any training compliance issues will be rectified through this process by the unit manager. A Continuing Professional Development file will be kept on the unit for each member of staff. A record of current training will be recorded in this by staff in readiness for supervision and Performance and Development Reviews	Chris Jones Assistant head of Specialist Services Chris Jones Assistant head of Specialist Services	By 13th October 2016 at least every 8 weeks By October 13th 2016
23	The health board should review the training needs of staff in regards to supporting people with personality disorder.	7.1	A bespoke training package in regards to supporting people with personality disorder is being developed for staff on the unit. This will be delivered in 3 sessions so that all staff will be able to attend.	Chris Jones Assistant head of Specialist Services	By November 30th 2016
23	The health board must ensure that all	7.1	The PADR compliance as at 31st	Chris Jones	By 30th

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	staff have annual appraisals.		June 2016 of the unit is 53% the Health Board target is 85%. An improvement plan has been developed at the Assessment and Treatment Unit with all staff having allocated reviewers. All staff will be reviewed.	Assistant head of Specialist Services	September 2016

Service representative:

Name (print): **Chris Jones**

Title: **Assistant Head of Specialist Services**

Date: **15th July 2016**