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Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Learning Disability Inspection (unannounced)

Abertawe Bro Morgannwg University Health Board, **Learning Disability Residential Unit** (Ref 16015)

Inspection date: 8 June 2016

Publication date: 9 September 2016

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

In writing:

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

Or via

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Fax: 0300 062 8387
Website: www.hiw.org.uk

Digital ISBN 978-1-4734-7457-4

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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 8 June 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. There were four patients living there at the time of the inspection. 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 had very detailed care plans setting out the help and support they needed.
- We found effective leadership and management of the service.
- There was a committed staff team who 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.
- Staff must be supported to update their training on cardiopulmonary resuscitation (CPR) and fire safety as a matter of priority.
- The way for obtaining some medication should be reviewed so that patients can have their medication quickly whilst maintaining their safety.
- Staff should be supported to attend specific training to help support their professional development.

4. Findings

Quality of patient experience

Patients were helped to stay healthy and staff helped them take part in activities they liked to do. We saw that patients were treated respectfully and with kindness. Patients' care plans were detailed and person centred.

There was no formal system in place to obtain the views of patients and their families. Work was being done by the health board to improve this.

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 according to their needs and wishes 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. We looked at a sample of three patients' care plans and saw that patients had been helped to go to an annual health check[1] with their GP. We were also able to confirm that patients were helped to see the dentist and optician according to their needs.

Nursing staff told us that they helped patients to make use of the facilities at the unit and in the local area. Patients also told us that they were helped and supported by staff to enjoy activities to promote their wellbeing. These included bus rides, walks, the cinema, bowling, and various sporting activities.

[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.

Senior nursing staff explained that patients were encouraged and helped to follow a healthy lifestyle. We saw that patients had care plans that set out in detail the help they required to look after their own health.

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 saw that patients were treated with dignity, respect and compassion. We also found that staff respected patients' right to privacy.

All patients had their own bedroom, which were personalised with their own belongings. Patients were able to lock their bedroom doors at their own request. We observed one patient requesting staff to lock the door on a number of occasions, which staff promptly acted upon. The unit also had a large private garden that included a quiet area that patients could use.

We saw that staff had a friendly, yet professional, approach towards patients and treated them with respect and kindness. Staff appeared to have a good understanding of the patients' individual likes and dislikes and helped them according to their assessed needs. All patients appeared well cared for. We found staff respecting patients' privacy when supporting them with personal care.

We saw nursing staff managing patients' behaviours to promote the safety and wellbeing of other patients, staff and visitors to 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 (Standard 5.1)

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

There was a focus on helping patients to be as independent as possible and we saw a good example of how staff had worked with one patient to help achieve this.

Senior staff told us that they felt that changes could be made to the unit to help patients 'move on' to other environments so they could reach their full potential to be as independent as possible. Staff also felt these changes would allow patients currently cared for in larger assessment and treatment units to be cared for in this smaller residential unit. This was with a view to supporting patients to be more independent and promote their wellbeing in a smaller more homely setting.

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 found that staff had done their best to involve patients when planning their care. The care plans we saw were very detailed and had been reviewed regularly.

Each patient had their own written care plan. We looked at the care plans for three patients. These described in detail what patients could do for themselves and what help and support they needed from staff. They showed that patients had been involved in the planning of care and where patients were unable to, staff had recorded this.

Patients had care and treatment plans as required under law (The Mental Health (Wales) Measure 2010)[2]. We saw these had been reviewed and were up to date.

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)

[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

Care and treatment for patients at the unit were provided in ways to ensure their human rights were upheld.

We saw staff respecting patients' privacy and allowing them choice in their daily routines. Staff told us that patients were helped to keep in contact with their families. 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. We saw that these were up to date.

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 all staff were up to date with their training on the Mental Capacity Act and DoLS.

We did not see that independent mental capacity advocates (IMCAs) were involved in promoting patients' rights. We were told, however, that patients' families were advocates and were involved in decisions around care.

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 explained that the team had good relationships with patients' families and felt confident that they would raise any concerns or worries about their relatives with the staff team. We were told that feedback from patients and their families was generally on an ad hoc and informal basis.

[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.

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 have difficulty reading or difficulty understanding words would be helped to 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 and their families.

Delivery of safe and effective care

Overall we found that patients received safe and effective care.

Improvements were needed to make sure repairs were completed without a delay.

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 were checking what equipment was needed and would make sure regular checks were done. Improvement was also needed to ensure staff were up to date with cardiopulmonary resuscitation (CPR) training and fire safety training.

We were told that there were sometimes delays in getting medicines that had been 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. We saw good use of easy read leaflets to help patients understand their care and treatment.

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 patients' health, safety and welfare were protected. We did, however, find that improvement was needed to make sure repairs within the unit were completed without delay. Improvement was also needed around staff training on safety matters.

The unit was visibly 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 were assessed and that action was taken to reduce these risks as far as possible. We also saw that detailed risk assessments had been done within the care plans we looked at.

Audits to identify potential ligature points were not being conducted regularly. The health board should arrange for such audits to be done before any new patients move to the unit and at least annually. This will strengthen the existing system of audit and help ensure patients are safe.

Improvement Needed

The health board should make arrangements to ensure audits to identify potential ligature points are conducted before any new patients move to the unit and in any case at least annually.

We were told that it often took a long time to get things repaired and were provided with details of work that was required. We informed senior managers of this and they told us they were looking at ways to improve this, both at the unit, and across the other learning disability services within the health board.

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.

Ideas for making things better for patients had also been identified by senior staff. Examples included increasing the size of the main lounge so that patients could sit together if they wished, improving ventilation for the comfort of patients and staff and installing an additional shower to allow patients more choice. The health board should give consideration to working with the staff team to agree on what work can be done.

Improvement Needed

The health board should work with the staff team and agree on what improvement work can be practicably done at the unit.

We were told that all staff were expected to attend cardiopulmonary resuscitation (CPR) training. Training records we saw showed that over half the staff team required update CPR training. We also saw that most of the staff required update training on fire safety. The health board should explore the reasons why staff training has become out of date and, where needed, must support staff to attend training.

Improvement Needed

The health board must ensure staff attend update cardiopulmonary resuscitation training and fire safety training as a matter of priority.

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 had already taken action to check what equipment was needed 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 and ensure this is in place.

Checks must be 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 and make healthy food choices.

Staff explained that patients were supported by staff to go shopping and prepare meals as part of developing their independent life skills. We also found staff helping and encouraging patients at mealtimes as needed. A kitchen was available at the unit that patients could use with the support of staff.

There was a strong emphasis on staff helping patients to make healthy food and drink choices. We saw very detailed care plans setting out the help patients needed with eating and drinking.

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

We found that patients' medication was managed safely at the unit. Staff told us that there were sometimes delays in patients having medication that had been ordered by the GP but overall patients received medication in a timely way.

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 for safety. A lockable fridge was available should this be needed. Regular checks had been done of controlled drugs to make sure they were being managed properly.

Whilst there was a designated room for storing medication, this was cramped making it difficult for staff to prepare medicines before giving to patients.

Staff told us that there were sometimes delays in getting medication that had been ordered by patients' GPs. These delays seemed to be caused by the health board's process that 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 how medication prescribed by primary healthcare services can be obtained for patients at the unit without undue delay.

We saw easy read information leaflets were readily available within care plans to help patients understand their medicines and health conditions. Patients had detailed individual plans which showed staff how patients liked to take their medicines and the support they needed. Staff told us that patients' medicines were reviewed regularly to make sure it was still needed. We also saw detailed plans and flowcharts to help staff give 'as required' (often called PRN) medication safely to patients when they needed it.

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 showed a good knowledge of the process to follow should a safeguarding issue be identified. 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.

We saw training records that showed all staff were up to date with training on safeguarding adults.

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 were very detailed and showed that care was planned to make sure patients were safe and protected from avoidable harm.

We saw that positive behaviour support plans were being used and again these were very detailed. 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. Senior staff described an example where they had looked at ways to meet a patient's care needs based on best practice. We saw information on this within the patient's care plan that staff could read.

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.

Patients had different communication needs and we observed staff adapting their approach and effectively identifying what patients wanted.

We saw that staff had obtained some excellent easy read leaflets with pictures to help patients understand their care and treatment.

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.

A copy of the health board's record keeping policy was kept in each of the patient's notes we saw. We also saw clinical standards guidance was readily available. These showed staff how notes should be made. As described earlier, each patient had their own care plan and the ones we saw were very detailed.

The unit nurse manager showed us other records that we expect to be in place such as staff training records, health board policies and annual appraisals for staff.

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 strong 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. Staff told us they felt supported by their managers.

We saw a friendly and committed staff team who appeared to have a good understanding of the needs of the patients. We found staff working flexibly to ensure the needs of patients were being met. Staff told us they would like to have more training on looking after patients with learning disabilities.

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. We saw strong and effective leadership being provided by the nurse manager who we found led by example.

The health board's values were clearly displayed for staff to see and all staff had a code of conduct that they were expected to follow. This meant that staff had easy access to information on how the health board expected them to act and behave at work.

A team of senior managers was in place and the nurse manager had a good knowledge of who to contact with work related queries and requests. We were told there was good communication between the unit management team and the senior managers.

The nurse manager described that some audits were completed and was aware that senior managers were looking at how to improve these. Information provided by senior managers 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 also provided with an example of where learning from a recent HIW inspection at another site had been shared with the staff team so that improvement could be made at the unit.

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 to 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, although some staff told us that they felt more staff were needed at times. Staff appeared to have a good understanding of the needs of the patients.

We were told that one patient was in hospital and that members of the staff team were providing support to the patient whilst in hospital. This was causing some challenges for the management team at the unit to cover shifts, both at the unit and the hospital. We were told that the staff team had been flexible in working shifts to ensure adequate cover at the unit. On the day of our inspection the unit manager agreed to stay longer so as not to disappoint a patient who was going out for a meal that evening.

Senior managers should explore whether there is anything further that can be done to support the staff team given the situation at the time of our inspection. The unit manager told us that they were working hard with other teams involved in the patient's care to agree how best the patient could be supported when discharged from hospital.

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.

All staff told us that they had attended training and this had helped them in their day to day work. Staff also told us that they would like to attend more training

tailored to their work in looking after patients with learning disabilities. The health board should make arrangements to support staff to attend more specific training.

Improvement Needed

The health board should support staff as far as possible to attend training that is specific to their work in looking after patients with learning disabilities.

Comments from staff were mixed regarding staffing levels. Some staff told us that they felt there was usually enough staff whilst others indicated that they felt sometimes more staff were needed. All staff felt satisfied with the care they provided to patients.

Staff told us they felt able to report concerns where they felt care was unsafe and were confident that their concerns would be acted upon by managers.

When asked about their view of the health board and their managers, staff told us that they felt supported and that team work was encouraged.

Senior staff explained the process for staff supervision and confirmed that the aim was to have meetings every eight weeks. We were told that informal discussions happened on a day to day basis to share relevant information and answer work related queries. We were told that staff had an annual appraisal of their work and records we saw confirmed this.

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 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 16015)

Date of Inspection: 8 June 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
Quality of the patient experience					
	No improvement plan needed.				
Delivery of safe and effective care					
11	The health board should make arrangements to ensure audits to identify potential ligature points are conducted before any new patients move to the unit and in any case at least annually.	Standard 2.1	The unit will complete an initial ligature risk assessment of the complete environment and then an annual review. This will take into consideration the level of risk identified from individual patients risk assessments who reside within the unit in relation to self harm.	Unit Manager and Lead Manager for Residential Units	30th Aug 2016
11	The health board must make suitable arrangements to complete	Standard 2.1	Develop an escalation plan 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 should work with the staff team and agree on what improvement work can be practicably done at the unit.	Standard 2.1	The Health Board has identified additional capital funding to update the current two bathrooms which will allow patients to have more choice in relation to showering. Bids are being developed to apply to Health Boards Charitable funds for additional outside activity equipment which will allow patients to have more activities in their outside space within the grounds of the unit.	Interim Assistant General Manager Unit Manager	Work to commence in Sept 2016 after allocation of contract for upgrades. 30th Aug 2016
11	The health board must ensure staff attend update cardiopulmonary resuscitation training and fire safety training as a matter of priority.	Standards 2.1 and 7.1	To arrange for face to face fire training to be delivered by ABMU Fire Training officer at the unit. Unit Manager to support non compliant staff to complete on line resuscitation training.	Unit Manager Unit Manager	30th August 2016 30th September 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
12	The health board must establish what emergency equipment is needed at the unit and ensure this is in place. Checks must be done to make sure the equipment is safe to use in the event of a patient emergency (collapse).	Standard 2.1	Action to be taken on training equipment and the checking of this in line with recent changes to Health Board Resuscitation Strategy.	Interim Assistant General Manager and Lead Manager for Residential Units	30th Aug 2016
13	The health board should explore how medication prescribed by primary healthcare services can be obtained for patients at the unit without undue delay.	Standard 2.6	Consider options with our Learning Disabilities link pharmacist. Then link in with the Primary Care Lead to support the prescription of medication by GP's onto the All Wales Mental Health Inpatient prescription charts within the unit.	Interim Lead Nurse and Lead Manager for Residential Units	30th August 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	Governance, Leadership and accountability	To complete 15 step challenge audits in all Units.	Interim Lead Nurse and Lead Manager for Residential Units	31st July 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	board.		Review the audits and complete an action plan from the findings. Circulate the visual audit cycle to all unit managers. To develop with the Governance team a system for the collation, monitoring and reporting of all audits completed by the Unit managers	Interim Lead Nurse and Lead Manager for Residential Units Interim Lead Nurse Interim Assistant General Manager and Delivery Unit Governance Lead .	30th September 2016 Completed 1st December 2016
18	The health board should support staff as far as possible to attend training that is specific to their work in looking after patients with learning	Standard 7.1	Currently staff have access to specific nurse training relating to their area of work via the Health Boards educational contracts with	Unit Manager	Completed on annual basis as part of the

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	disabilities.		both universities used as part of their contract. This is identified by the individual staff and their manager as part of their PaDR process. To continue to review learning and development pathway for staff inpatient units.	Delivery Unit Learning and Development Lead and Clinical Lead Nurse	PaDR reviews 31st January 2017

Service representative:

Name (print): **Dermot Nolan**

Title: **Interim Assistant General Manager**

Date: **11 July 2016**