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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: 16159)

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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 7 July 2016. Our team, for the inspection comprised of an HIW inspection manager (inspection lead), an HIW assistant inspection manager and a clinical peer reviewer.

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

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

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

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

2. Context

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

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

3. Summary

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

This is what we found the service did well:

- Patients were helped to stay healthy and take part in activities they liked to do both at the unit and within the local community.
- We saw staff treating patients with respect and kindness.
- Patients told us they enjoyed living at the unit and that staff helped them feel safe.
- All patients had a detailed care plan setting out the help and support they needed.
- The complex care package for one patient was reviewed by a clinician external to the health board to seek an independent view on the provision of care.
- Staff appeared to have a good understanding of the patients' care needs.

This is what we recommend the service could improve:

- The Extra Care Area requires development to maximise the patient experience of the individual being cared for in that area.
- The ongoing issues with patient toilets need to be investigated and remedied.
- Liaison between the local GP service and the unit need to be developed so that annual health checks can be undertaken in the community.
- Staff must be supported to undertake supervision for their professional development.
- Future care provision needs to be recorded in patient Care and Treatment Plans.
- Ensure that emergency equipment is safe to use in the event of a patient emergency (collapse).

4. Findings

Quality of the patient experience

Patients were helped to stay healthy and take part in activities they liked to do. We saw staff treating patients with respect and kindness.

All patients had detailed care plans and on the whole we saw that patients' current needs were being met in the unit by the staff team. However, future care provision was not recorded in patient Care and Treatment Plans.

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

Staying healthy

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

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

Senior nursing staff told us that patients at the unit were registered with a GP service; however we were informed that the GP service would not provide annual health checks for the patients. Annual health checks had to be undertaken by doctors within the health board which meant that delays were experienced.

Patients had hospital passports[1] in place in the event of admission to general hospital.

[1] Hospital passport is a document which contains important information about someone with a learning disability and provides hospital staff with important information about them and their health when they are admitted to hospital.

Patients were helped to see a dentist and optician according to their needs. Where necessary a dentist will attend the unit.

Improvement Needed

The health board must review the liaison between the local GP service and the unit need so that annual health checks can be undertaken in the community.

Patients had their own bedrooms that they could access throughout the day; one patient had their own area, an Extra Care Area, which included a bedroom, lounge and bathroom. There were also two lounges in the unit where patients could spend quiet time away from other patients if they wished to do so. The unit had a private garden that patients could freely access. Patients were able to access the facilities at the unit and in the local area and when required staff would assist patients. Patients we spoke to confirmed that they were helped by staff and that they enjoyed going to the community for social activities, this included swimming and shopping. Through out the inspection we observed patients going and returning from the local community.

Dignified care

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

We found that patients at the unit were treated with dignity and respect by the staff working there, and this was also reflected in patients' care documentation.

We saw staff treating patients with respect and kindness. All the patients had been living at the unit for some time and staff appeared to have a good understanding of their individual likes and dislikes.

All patients had their own bedroom which were individualised to each patient's tastes and interests. Patients could lock their bedroom doors so they could have privacy, which staff could over-ride if required for safety. We found staff respecting patients' privacy as far as possible. We saw staff knocking doors and asking patients if it was alright to go into their bedrooms before doing so. Patients also told us that members of staff were respectful and kind to them.

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

Patients we spoke to told us that they felt safe at the unit. We saw nursing staff managing patients' behaviours to promote the safety and well being of other patients and staff working at the unit.

Timely care

All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff. (Standard 5.1 – Timely Care)

We saw that patients' needs were being met in the unit by the staff team. One patient had complex needs, whilst the care team were providing appropriate care for the patient; it was evident that further improvement was required to the environment of the Extra Care Area in which the patient was predominantly cared for.

One patient did not have a community care manager; the previous community care manager had left their post over a year previous to our inspection. Despite the efforts of the staff at the residential unit no community care manager had been allocated. It is important that a community care manager is in place to assist with care provision plans, including discharge.

Improvement Needed

The health board must liaise with the Local Authority to ensure that a community care manager is allocated to the patient concerned.

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

Patients were very much engaged in the community and spent large periods of their time away from the unit. Patients we spoke to told us they liked living there and that staff helped them as needed. Staff appeared to have a good understanding of the patients' individual care needs.

Individual care

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

Independence)

We saw that patients at the unit each had their own written care plan. These showed that their needs had been assessed, their care and treatment planned and that care had been provided by those involved in their care. Patients had care and treatment plans as required under The Mental Health (Wales) Measure 2010[2] legislation.

It was positive to note that for one patient with complex care needs that the care package for the patient was reviewed by a clinician external to the health board to seek an independent view on the provision of care.

We looked at the care plans for three patients which were very detailed with evidence that patients were involved in their care planning. The care plans reflected the patient needs, strengths and abilities. There were very detailed physical health care assessments reflected in the care plans. In particular there were very detailed Positive Behaviour Support (PBS) plans and patient Pen Pictures.

However, reviewing the care and treatment plans there was little consideration for future planning documented, with regards to discharge to more independent living or older person's care. Through conversations with staff at the unit it was evidenced that consideration has been undertaken but not documented. It is important that Care and Treatment Plans reflect this.

Improvement Needed

The health board must ensure that future care provision is recorded in patient Care and Treatment Plans.

Reviewing the documentation it was positive to note that three of the Care and Treatment Plans had been signed by the patients to show that they understood and agreed with their plan.

Staff actively involved patients in their care and about daily decisions such as meals and activities. We saw patients being independent throughout the inspection. We also saw staff were very supportive and assisting patients when required based on their individual care needs.

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

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

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

We saw staff respecting patients' privacy and allowing them choice in their daily routines. We were told that patients were helped to keep in contact with their families and friends. Where patients' choices were restricted we saw that the reasons for this had been written in their individual care plans. The care records we saw also showed that where restrictions were in place, Deprivation of Liberty Safeguards[3] (DoLS) authorisations had been obtained in accordance with the DoLS arrangements or detention under the Mental Health Act had been completed. Independent advocacy was available to patients that included independent mental capacity advocate (IMCA)[4] and Independent Mental Health Advocacy (IMHA)[5].

From speaking with staff and looking at the care plans, staff appeared to have a good understating of the DoLS arrangements. Staff training records showed they had attended training on the Mental Capacity Act and DoLS. Information was displayed within the unit for pateints, including in Easy Read format.

It was positive to note that despite a number of patients having restrictions on when they could leave the unit, the door to the unit remained unlocked so that other patients' access to the community was not restricted. Appropriate

[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.

[4] The Independent Mental Capacity Advocate (IMCA) is a role created by the Mental Capacity Act 2005. An IMCA is independent and can support a vulnerable person who lacks mental capacity to make decisions, such as serious medical treatment, or accommodation.

[5] An IMHA is an independent advocate who is specially trained to work within the framework of the Mental Health Act to support people to understand their rights under the Act and participate in decisions about their care and treatment.

arrangements were in place to ensure those with restrictions to the community only accessed the community when authorised.

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

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

Senior staff described informal and ad hoc ways of receiving feedback from patients and their relatives on their experiences of the care provided. We were told that the health board were looking to introduce a more formal way to regularly obtain feedback from patients and their families.

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

Some patient family members attend meetings with the care team to discus their views on the care being provided to their family member.

Delivery of safe and effective care

Overall we found that safe and effective care was provided to patients. There were ongoing maintenance issues with two of the patient toilets at the unit, which would reduce the number of available toilets periodically.

The Extra Care Area of the unit had been developed for the patient that was predominantly cared for in that area. The health board were undertaking a review of the Extra Care Area to ensure that the patient's current and future needs can be met within this area. It is important that development of the Extra Care Area is undertaken to maximising the patient's experience.

Members of staff talked to patients to help them understand their care and treatment. Staff also used other forms of communication to help patients understand information.

Safe care

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

Overall we found that patients' health, safety and welfare were protected. The unit was secure against unauthorised access and members of staff were vigilant to ensure the patient safety was maintained. Areas were free from visible trip hazards. All patient areas were on the ground floor of the unit. Staff told us that risks to patient safety were assessed and that action wass taken to reduce these risks as far as possible. We also saw that risk assessments had been done within the care plans we looked at.

The environment was clean and reasonably well maintained, with cleaning being undertaken by the staff team and patient group. We were advised that there were two toilets at the unit that continuously block and whilst these are fixed by the health board's estates department they continue to cause problems. This means there was often a reduced number of toilets available for patients, this is not acceptable.

Improvement Needed

The health board must ensure that the ongoing toilet issues are investigated and remedied so that sufficient toilet facilities are available to the patient group.

The Extra Care Area was a specialist area for an individual patient. Whilst this provided a safe area for the patient the health board were undertaking a review of this area to ensure that the patient's current and future needs can be met within this area and the unit as a whole. There was a lack of sink for the patient to wash their face/hands or brush their teeth whilst in the Extra Care Area. The patient had to bend over the bath and use the bath taps; this is not very dignified for the patient and needs to be included in the future plans.

Whilst it was evident that the review was progressing it is important that these needs are identified and implemented as soon as possible and that the provision of care is kept under review to ensure that the service is maximising the patient's experience.

Improvement Needed

The health board must ensure that the development of the Extra Care Area is expedited to ensure that the setting can maximise the patient experience for the patient being cared for in this area.

We raised our concerns of the lack of ligature point audits at the unit, whilst the risks need to be managed for individual patients, it would be appropriate for the service to undertake regular ligature point audits.

Improvement Needed

The health board must undertake regular ligature point audits and appropriate mitigating actions to ensure that the environment is safe for patients.

Training records we saw showed high completion rates of CPR and choking management training along with manual handling training. Due to the patient group being cared for at the service it is essential that all staff have up-to-date training in these areas. For those staff who had not attended training, the health board should explore the reasons why and where needed support the staff to attend training.

There was resuscitation equipment maintained at the service in the event of a patient emergency (collapse). However, some of the resuscitation items were out-of-date and required replacing.

Improvement Needed

The health board must ensure that emergency equipment is safe to use in the event of a patient emergency (collapse).

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

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

Menus were available for patients, which included pictorial information to assist with communication. The menus were reviewed with patients to reflect their preferences. Drinks, snacks and fruit were also freely available at all times. Patients we spoke to told us they had a choice of meals and that they enjoyed the food.

Patients were supported by staff in choosing meals, shopping for ingredients and preparing meals. A kitchen was available at the unit that patients could use with the support of staff when required. However, at the time of our inspection the unit was awaiting a replacement fridge-freezer; a delivery date had been confirmed. During this time the patient kitchen had a smaller fridge to ensure that chilled food items could be stored as required. The old fridge-freezer was still awaiting collection.

Improvement Needed

The health board must ensure that the replacement fridge-freezer is installed at the unit and the old fridge freezer removed.

There were detailed nutritional assessments in place identifying whether patients had swallowing difficulties or needed assistance with dietary intake.

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

Overall, we found that patients' medication was managed safely at the unit. 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.

It was positive to note that there was a weekly medication audit in place, along with administration of medication check at each shift staff handover. There was also easy read "Looking after physical health when taking antipsychotic medication" available to patients.

We also observed the interaction between staff and patients during the administration of medication and observed good interaction between staff and patients.

The instances of administration of 'as required medicine' were detailed in the patient records. Individualised medication administration was detailed in each patient's care plan.

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

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

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

We saw training records that showed all members of 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 individualised person-centred care plans. These showed that care was planned to make sure patients were safe and protected from avoidable harm.

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

We saw that positive behaviour support plans were being used. These help staff identify when patients need help to manage behaviour that other people

may find challenging. Staff appeared to have a good understating of the patients' needs and we saw them helping patients to be safe and reduce any anxiety they were showing.

The unit was supported by the Specialist Behavioural Team (SBT) who were engaged in the planning and review of care where required. The Positive Behaviour Support (PBS) plans were written with the primary focus on the prevention of behaviours that challenge. We noted that where restraint may be required there were very detailed restraint plans in place. These were monitored regularly and the use of restraint recorded and reviewed.

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. Depending on an individual patient's needs, we also noted that staff would use Easy Read information to assist with communication.

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. Patient records were completed to very good standard, up-to-date, signed, dated and contemporaneous.

Quality of management and leadership

We saw very good management and leadership at the learning disability unit. We saw a committed staff team who had a very good understanding of the needs of the patients living at the unit.

Staff told us they could talk to their managers about their work and the unit manager had recently re-introduced supervision for members of staff. Training completion rates were high but there were elements of training that had lapsed for some members of staff.

Learning from incidents at the unit were shared with the staff team, however learning form incidents across the Learning Disability Directorate were not routinely shared more widely amongst services within the health board.

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. The nursing team was established with the majority of the staff working at the unit for a number of years and with the current patient group.

Across the Learning Disability Directorate the Unit Managers held monthly meetings which we were informed were helpful peer discussions. Within the unit the Unit Manager held monthly staff meetings, alternating each month between Registered Nurses and Health Care Support Workers.

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 told that learning form incidents was not routinely shared more widely amongst services within the health board. The health board should explore the reason for this and make arrangements to routinely share learning from patient safety incidents as appropriate.

Improvement Needed

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

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. The unit did not use agency staff or health board bank staff meaning that patients were supported by members of staff who were familiar to them.

Staff appeared to have a very good understanding of the needs of the patients, built up over many years working at the unit. Staff were very flexible with their working patterns to enable patients to undertake community activities during the day, evening and weekends. The stability of the staff team provided patients with consistent care and there was a genuine feel of a family ethos at the unit.

It was positive to note that student nurses have been working at the unit on placements.

We invited staff to provide their views on working at the unit. We did this by speaking to staff and asking them to complete a HIW questionnaire. Staff told us that communication amongst the team was good and they felt that discussions could be held openly. Overall members of staff were positive about working at the unit and the patient care provided.

Staff had completed annual appraisals and they told us that they had opportunities to discuss issues related to their work with their manager. At the time of the inspection the Unit Manager had recently re-introduced a structured programme of formal supervision meetings. We were informed that previously, supervision had ceased being undertaken due to the work capacity of staff. It is important that members of staff at all grades are supported to undertake supervision for professional development.

Improvement Needed

Arrangements should be made to ensure that members of staff are supported in formal supervision meetings with their managers at an appropriate frequency.

During the review of staff training records, there were areas where some members of staff were not up-to-date with all elements of the health board's mandatory training. For those staff who were not up-to-date with training, the health board should explore the reasons why and where needed support the staff to attend training.

Improvement Needed

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

5. Next steps

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

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

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

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

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

6. Methodology

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

Figure 1: Health and Care Standards

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

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

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

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

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

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

Appendix A

Learning Disability Service: Improvement Plan

Service: Residential Unit (Ref 16159)

Date of Inspection: 7 July 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
Quality of the patient experience					
6	The health board must review the liaison between the local GP service and the unit need so that annual health checks can be undertaken in the community.	1.1	The Learning Disabilities service will write to the local GP practice to ensure that the patients' annual health checks are completed in a timely manner.	Interim Assistant General Manager	30 Sept 2016
7	The health board must liaise with the Local Authority to ensure that a community care manager is allocated to the patient concerned.	5.1	The Learning Disabilities service will write to the local authority lead manager within the area to ensure that the patient is allocated a care manager.	Unit Manager / Lead Manager for Residential Units	30 Sept 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
8	The health board must ensure that future care provision is recorded in patient Care and Treatment Plans.	6.1	A full Multidisciplinary Team review for three of the patients within the unit is planned with a view to move on to placements from the unit. All staff will be advised to ensure that the Care and Treatment Plans for their patients are reflective of the needs for the future planning in relation to move on.	Unit Manager / Lead Manager for Residential Units Unit Manager / Lead Manager for Residential Units	30 Oct 2016 30 Sept 2016
Delivery of safe and effective care					
11	The health board must ensure that the ongoing toilet issues are investigated and remedied so that sufficient toilet facilities are available to the patient group.	2.1	The toilets are now in working order and the service will continue to monitor any further problems with the estates team.	Unit Manager	Completed
12	The health board must ensure that the development of the Extra Care Area is expedited to ensure that the setting can maximise the patient experience for the patient being cared for in this area.	2.1	The Learning Disabilities service is awaiting the completion of a specialist assessment in relation to this patient and following this will present options appraisal to their funding commissioners and family to plan a way forward.	Interim Director of Learning Disabilities/ Interim Assistant General Manager	30 Nov 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
			The service will explore the option of adding a sink into the patient's en-suite bathroom as an interim measure.	Unit Manager / Lead Manager for Residential Units	30 Oct 2016
12	The health board must undertake regular ligature point audits and appropriate mitigating actions to ensure that the environment is safe for patients.	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 patient's risk assessments who reside within the unit in relation to self harm.	Unit Manager / Lead Manager for Residential Units	30 Oct 2016
12	The health board must ensure that emergency equipment is safe to use in the event of a patient emergency (collapse).	2.1	Meeting has been held with the health board's resuscitation trainer in the 21 July 2016 to establish what is required for all units within the service. Details of the agreed specification for equipment have been sent to all unit managers to put in place.	Unit Manager / Lead Manager for Residential Units	30 Sep 2016
13	The health board must ensure that the replacement fridge-freezer is installed at the unit and the old fridge freezer removed	2.5	Action no longer outstanding		Completed

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
Quality of management and leadership					
17	The health board should explore the reasons why learning from patient safety incidents are not routinely shared amongst services within the health board and take suitable action to promote shared learning.	Governance, leadership and accountability	Review the leaning from Datix is via various appropriate forums, for example the Unit Managers monthly meetings, Performance Reviews and the Health and Safety Committee to ensure a robust process is in place. Minutes of these meetings should be circulated to all unit managers for information and review.	Interim Governance Lead / Interim Assistant General Manager	30 Oct 2016
18	Arrangements should be made to ensure that members of staff are supported in formal supervision meetings with their managers at an appropriate frequency.	7.1	Organise supervisions with unit manager and confirm that cascade arrangements for supervision for all staff will be put in place.	Lead Manager for Residential Units	30 Nov 2016
18	The health board should explore the reasons why members of staff are not up to date with mandatory training and where needed support staff to attend training required.	7.1	The Learning Disabilities service reviews the compliance with all mandatory training on a fortnightly basis in the lead managers meeting. Unit Manager will put plans in place to get all staff compliant with their training updates.	Unit Manager	30 Nov 2016

Service representative:

Name (print): **Dermot Nolan**

Title: **Interim Assistant General Manager**

Date: **25 August 2016**