

Learning Disability Inspection (unannounced)

**Abertawe Bro Morgannwg
University Health Board,
Llwyneryr Assessment and
Treatment Unit**

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1. Introduction

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

HIW's primary focus is on:

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

HIW completed an inspection to Llwyneryr Assessment and Treatment Unit on 18 & 19 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 Learning Disability Assessment and Treatment Unit providing care to for up to seven 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, healthcare support workers and domestic housekeeping staff.

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:

- There was clear and strong leadership of the unit, providing patient focused care.
- All patients had very detailed care plan setting out the individual help and support they needed.
- The provision of food for the patient group was exceptional, patients and staff spoke very favourably of the meals.
- The liaison between the learning disability unit and physical health care services was commendable and greatly beneficial to the patient group.
- Patients were helped to take part in activities they liked to do both at the unit and within the local community.

This is what we recommend the service could improve:

- The bathroom and shower facilities at the unit required refurbishment to ensure that staff could effectively support patients to maintain their personal hygiene as required.
- Personal protective equipment that is commonly required for the care of patients should readily available to staff.
- Patients should be able to access the internet at the health board's Learning Disability services.

4. Findings

Quality of the patient experience

Patients were helped to stay healthy and take part in activities they liked to do. Overall, we saw staff treating patients with respect and kindness. During our observations of staff-patient interactions, however, we witnessed one member of staff who could have interacted with patients more respectfully.

All patients had very detailed care plans and patients' current needs were being met in the unit by the staff team. The nursing team had developed key documentation that provided great detail on the individual patients and how to care and support them as individuals.

The inspection team sought patients' views with regard to the care and treatment provided at the 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. There were extensive detailed physical assessments and information relating to individual patient needs. Patients had up-to-date hospital passports¹ in place in the event of admission to general hospital. It was positive to note that where required, in addition to hospital passports, staff had developed enhanced health information titled 'My Health Needs'. This provided extra detail

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.

to assist staff to understand the complex physical health requirements of some of the patients.

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

Patients had their own bedrooms that they could access throughout the day; one patient also had access to a 'soft room' in which staff could manage the patient's behaviours in a managed environment.

There was a large communal lounge/dining-room where patients could spend time as a group or sufficient space to undertake activities by themselves. There was also a 'quiet room' where patients could go to be away from other patients if they wished to do so. Along with these areas there was a sensory room and a computer room. However, there was no access to the internet for patients via the health board's computer network.

Improvement Needed

The health board must review the provision of internet access to patients resident in Learning Disability services.

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. 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. Throughout 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. However, during our time in the patient areas we observed one member of staff who could have engaged with patients more respectfully. It was evident that other members of staff were able to interact in a more respectful manner with the patients displaying similar behaviours. We brought this to the attention of the Unit

Manager at the time of the inspection who assured us that they would address this with the staff concerned.

Improvement Needed

The health board must ensure that members of staff interact with patients in a respectful manner.

Staff appeared to have a good understanding of patients' individual likes and dislikes, their behaviours and how to support and manage these.

All patients had their own bedrooms which were individualised to each patient's tastes and interests. Due to some patients' behaviours their bedrooms were required to remain bare for the safety of the patient. 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. The unit had shower and bathroom facilities for patients to use, some patients were assisted by members of staff according to their needs. However, the facilities and the layout of these rooms did not lend themselves to supporting patients appropriately. The bathroom and shower facilities require to be reviewed to ensure that they are appropriate for patient use with or without staff support.

Improvement Needed

The health board must review the bathroom and shower facilities to ensure that they met the needs of the patient group, including when support from members of staff when required.

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 and had been resident at the unit for a number of years. Whilst the care team were providing appropriate care for the patient; it was evident that the care needs of this patient needed to be further explored to ensure a service is developed and available to maximise the patient experience for this individual.

Improvement Needed

The health board must review the current and future care provision of this patient to ensure that a service is developed and available to maximise the patient experience for this individual.

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 multi-disciplinary team (MDT) meetings taking place at least monthly. These monitor patients' care plans so that any problems can be identified early on and care planned to address these.

Patients were engaged in the community and with one patient who 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.

It was positive to note that on patient discharge from the unit, the care team develop an 'Assessment and Treatment Outcome Report' (ATOR) which summarised all detail required to provide care for the patient at the next residential placement or on discharge.

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 2010² legislation.

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.

One set of notes were for a patient recently admitted. Despite the short period of time since admission these had an extensive amount of detailed information pertaining to the individual care for this patient. Whilst the assessment was ongoing for this patient, the care documentation was completed with the most salient and important information. Whilst the inpatient documentation was comprehensive the unit were still awaiting the patient's Care and Treatment Plan from the community team that had previously been involved with the patient's care, this means the inpatient service did not have the most up-to-date patient information on their admission.

Improvement Needed

The health board must ensure that there is a process for community Care and Treatment Plans to be readily available at inpatient settings as required.

We noted that in addition to Disability Distress Assessment Tool (DisDAT) that was in use; where required, the care team used an enhanced pain tool which was reflected in individual patients' 'My Health Needs' plan.

Whilst were observed very detailed patient documentation we also noted that there were a number of omissions in recordkeeping, these included:

- A recent change in a patient's legal status under the Mental Health Act had not been reflected through the patient's care documentation. It was positive to note that this omission had been identified during the unit manager's recent audit and was in the process of being rectified.

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>

- We noticed that one patient's Positive Behaviour Management (PBM) plan had been under review for four months. The delay had been due to multidisciplinary team availability; however there was no record of a new review date and therefore it appeared that the review had been overlooked. We were assured by the Unit Manager that the review will be undertaken shortly as all members of multidisciplinary team are available.

Improvement Needed

The health board must remind staff of the importance of ensuring patient documentation accurately reflects the individual's legal status.

The health board must ensure the Positive Behaviour Management plan referred to is up-dated.

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 staff were very supportive and assisting patients when required based on their individual care needs.

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. 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. Apart from the one recent change in patient legal status under the Mental Health Act, the care records we saw also showed that where restrictions were in place.

Deprivation of Liberty Safeguards³ (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 that all staff had attended training on the Mental Capacity Act and DoLS. Information was displayed for patients within the unit, 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 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 not, 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)

The health board's system for obtaining feedback from patients and their families was in use at the unit, this included Easy Read versions. However, staff reported that these were not often completed. Senior staff described informal

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.

and ad hoc ways of receiving feedback from patients and their relatives on their experiences of the care provided.

Some patient family members attend meetings with the care team to discuss their view's on the care being provided to their family member.

Advocacy representatives from the IMCA and IMHA services also provided feedback to the service.

Delivery of safe and effective care

Overall we found that safe and effective care was provided to patients.

We found that the nutrition and dietary needs of the patient group were catered for and that the provision of the food provision at the service provided by the housekeeping staff was exceptional.

There was extensive level of monitoring and audit of clinic rooms and clinical practices to safeguard patients and members of staff. The extensive liaison with the local general hospital specialities was commendable.

Members of staff talked to patients to help them understand their care and treatment. Staff also used other forms of communication and technology 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 is taken to reduce these risks as far as possible. We also saw that risk assessments had been done within the care plans we looked at.

The environment was clean and reasonably well maintained, with cleaning being undertaken by dedicated domestic staff at the unit. The unit undertake monthly environment audits to review any outstanding estate works which are feedback to the health board's estate department.

As detailed earlier the bathroom and shower areas require refurbishment. We also identified that there was damage to the plaster around some of the doorframes. These areas need repairing as a priority to prevent further damage to the areas.

The window in the 'soft room' required replacing after a patient had damaged it. This had been reported to the health board's estates department and being actioned, however at the time of the inspection this work had not been completed.

The outside windows of the unit required cleaning. We were informed that this had been undertaken regularly by a contractor; however they had not been cleaned for over a year.

Improvement Needed

The health board must ensure that the repair work to damaged doorframes is completed.

The health board must ensure that the window in the 'soft room' is replaced.

The health board must ensure the external windows to the unit are cleaned regularly.

It was noted that the unit were awaiting the delivery of personal protective equipment. The order for this equipment had been authorised by senior management, however it had not been provided at the time of our inspection. The lack of personal protective equipment for staff was causing a delay in staff meeting an important aspect of the patient's care which was inappropriate.

The potential behaviours of the patient were not uncommon for patients being cared for at the unit. The health board should have personal protective equipment readily available that can be immediately provided to units for behaviours that are common to patients that are cared for within the learning disability directorate.

Improvement Needed

The health board must review the behaviours that are common to patients that are cared for within the learning disability directorate to ensure that personal protective equipment readily available to staff.

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 that all staff had completed CPR and choking management training, however eight (40%) members of staff training had elapsed. Due to the patient group being cared for at the service it is essential

that all staff have up-to-date training in this area. For those staff who had not attended refresher 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.

Patients had individual nutrition and hydration risk assessments along with further specialist assessments and guidance such as Speech and Language Therapy (SALT) e.g. for patients at risk of dysphagia (difficulty or discomfort in swallowing).

There was comprehensive understanding by staff members of specialist diet requirements, supported from within the health board by a specialist nurse.

The domestic housekeeping staff served the food for the patients at the unit. The food was supplied from a neighbouring general hospital and we observed the presentation of food to be of exceptional standard. To supplement the food supplied by the hospital the housekeeping staff would buy additional food from local shops such as bakeries and supermarkets. This provided patients with a greater variety of options which met their dietary needs and personal preferences.

During the inspection we observed the one housekeeper discussing food options with the patients individually at the unit, listening to the patient views and providing options to the patient to ensure that the patient was satisfied with what meal they'd be having. Staff at the unit commented very favourably on the housekeeping staff and stated that they provided a valuable service to patient care at the unit.

The onsite kitchen area of the unit was appropriate for the housekeeping staff to prepare food and drink to the patients at the unit. However, it was evident that there was a lack of storage available in the kitchen area for dried goods and tins.

Improvement Needed

The health board must review the kitchen storage at the unit.

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

Overall, we found that people's medication was managed safely at the unit. 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, including Controlled Drugs being stored and monitored as required by law.

It was positive to note that there was extensive level of monitoring and audit of clinic rooms and clinical practices to safeguard patients and members of staff. There were several regular medication audits in place, such as weekly medicine chart audit, as per Nursing and Midwifery Council (NMC) guidelines.

There were much individualised medication plans in place for each patient, including 'as required medicine'. The administration of 'as required medicine' was detailed in the patient records. Where required, covert medication details were also included in individual care plans and alongside the medication charts.

All medication charts were reviewed weekly during ward rounds to ensure that medicines were still appropriate for the patient. Use of antipsychotic / sedation medication was discussed by the multidisciplinary team at ward rounds and the use was monitored. This was also documented in patient care plans.

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-but-one member of staff had completed training on safeguarding adults; however the training for another three members of staff had elapsed. It is essential for patient safety that all staff have up-to-date training in this area.

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, however as already highlighted a number of members of staff require refresher training in some training areas. For those staff whose training is out-of-date the health board should explore the reasons why and where needed support the staff to attend training required.

There was an excellent example of preventing further deterioration of physical ill health; with extensive liaison with the local general hospital specialities, such as orthopaedics, microbiology and coronary care.

We saw that Positive Behaviour Support (PBS) 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 PBS plans were written with the primary focus on the prevention of behaviours that challenge, with the philosophy of least restrictive intervention at all times. 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.

It is commendable that the unit contributed to a recent publication 'Positive behavioural support as a clinical model within acute assessment and treatment services'.

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. We observed staff signing with patients to assist with communication and we also noted that one patient used 'ProTalk', an electronic communication aid, 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 a very good standard, up-to-date, signed, dated and contemporaneous.

Daily entries in individual patients' files were regular throughout the day and detailed so that it was easily understandable of the patient's activity and presentation. However, members of staff were not always recording their daily entries to the health board's recordkeeping guidance, whilst staff members were signing and dating entries, they were not printing their name or their grade as per health board guidance.

Improvement Needed

The health board must ensure that staff follow the health board's their record keeping guidance.

Quality of management and leadership

We saw very good management and leadership at the learning disability unit. We saw a committed staff team who appeared to have 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 staff supervision was being undertaken. 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 from 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. It was positive to see student nurse placements at the unit.

Across the learning disability directorate the Unit Managers held monthly meetings which we were informed were helpful peer discussions.

Throughout the inspection it was evident that the Unit Manager provided clear and strong leadership at the unit, that they were very patient focused with in-depth knowledge of each patient. The team focused leadership provided by the Unit Manager enabled the staff members to be empowered to undertake their roles and develop the service for the benefit of the patient group.

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 from 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))

At the time of the inspection there appeared to be enough staff working on each shift 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.

Due to enhanced observations required because of the behaviours of some of the patients there were additional health care support workers on shift. Some of these additional shifts were filled by health care support workers working back-to-back shifts, leading to staff working very long hours. Whilst the unit manager monitored the number of hours worked per employee, and those we spoke to chose to undertake the shift, this practice may result in members of staff not being suitably alert towards the end of their shifts, which could impact upon patient safety. We are aware that the health board will be changing from the current overtime hours arrangements to a bank staff arrangement in September 2016. In the meantime the health board need to ensure that staff members are working appropriate shift patterns for the safety of patients and the welfare of staff.

Improvement Needed

The health board must ensure that staff work appropriate shift patterns for the safety of patients and the welfare of staff.

Staff appeared to have a very good understanding of the needs of the patients. 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, particularly for those patients that had been at the unit for a number of years.

It was positive to note that where patients were due to be moving on from the unit to another setting that members of staff from the new setting would attend the unit regularly. This allowed for the staff members to get to know the patient and for the patient to get used to the new staff. The Unit Manager would ensure

that any new staff or visitors entering on the unit would not disrupt the patient group and would manage the situation with consideration for the patient group as a whole.

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. There was a structured programme of formal supervision for members of staff at all grades for professional development.

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.

It was positive to note that there was an infection control lead nurse for the unit. As part of their role they provided information and support to members of staff at the unit. Whilst there were eight members of staff who did not have a completion date for Infection Control eLearning, the majority of staff members had been provided with training by the infection control lead nurse. Whilst this provides some reassurance that staff are aware of infection control, the figures held by the health board do not reflect the knowledge of the staff working at the unit.

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.

Common feedback from members of staff on the provision of mandatory training was that the modules were generic and not specific to learning disability care. Staff stated that previously the training provided was focused on learning disabilities and therefore more beneficial to staff.

Improvement Needed

The health board must review the provision of mandatory training to ensure it specifically meets the requirements of the staff working at Learning Disability services.

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: Llwyneryr Assessment and Treatment Unit

Date of Inspection: 18 & 19 July 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
Quality of the patient experience					
6	The health board must review the provision of internet access to patients resident in Learning Disability services.	1.1	The service will explore with the IT Department how internet access can be achieved for the patient activity room.	Interim Assistant General Manager	30 Oct 2016
7	The health board must ensure that members of staff interact with patients in a respectful manner.	4.1	The unit manager met with the individual member of staff to make them aware of their interaction with the patient and allow them the opportunity to reflect on this. Also to make it clear what is the appropriate interaction that is expected from all members of the team.	Unit Manager	Completed

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
7	The health board must review the bathroom and shower facilities to ensure that they met the needs of the patient group, including when support from members of staff when required.	4.1	Review of the bathrooms within the unit will be completed and prioritised for improvements in line with the other areas across the service and the limited allocated capital funding for this financial year.	Interim Assistant General Manager / Lead Manager for Assessment Units	30 Nov 2016
8	The health board must review the current and future care provision of this patient to ensure that a service is developed and available to maximise the patient experience for this individual.	5.1	Ongoing review of this patient and their complex level of needs will continue with the Multidisciplinary Team to ensure the appropriate level of care is being provided and try to plan for future move on when appropriate.	Unit Manager / Lead Manager for Assessment Units	30 Sept 2016
9	The health board must ensure that there is a process for community Care and Treatment Plans to be readily available at inpatient settings as required.	6.1	The service will inform all the Health Team Managers within the community to remind their staff that if one of their patients is being admitted to our inpatient setting their up-to-date Care and Treatment Plan must be shared with the unit on admission day.	Interim Assistant General Manager	30 Sept 2016
10	The health board must remind staff of the importance of ensuring patient documentation accurately	6.1	All staff within the unit will have the recent manager's audit shared with them and have also been	Unit Manger	Completed

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	reflects the individual's legal status.		informed about the importance of up-to-date recordkeeping in line with their NMC Code.		
10	The health board must ensure the Positive Behaviour Management plan referred to is up-dated.	6.1	All staff within the unit have been informed of the finding in relation to the positive behavioural plan being out-of-date, instructed to review their own current plans and for all future plans being developed to have clearly defined dates of structured reviews in place.	Unit Manager / Lead Manager for Assessment Units	30 Oct 2016
Delivery of safe and effective care					
14	The health board must ensure that the repair work to damaged doorframes is completed.	2.1	Develop an escalation plan for all maintenance requests and prioritise requests against appropriate budgets. Monthly meetings are now in place with estate managers and it will be escalated via this forum.	Interim Assistant General Manager	30 Oct 2016
14	The health board must ensure that the window in the 'soft room' is replaced.	2.1	Develop an escalation plan for all maintenance requests and prioritise requests against appropriate budgets. Monthly	Interim Assistant General Manager	30 Oct 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
			meetings are now in place with estate managers and it will be escalated via this forum.		
14	The health board must ensure the external windows to the unit are cleaned regularly.	2.1	Will raise the issue with the Head of Hotel Services to establish what contract is in place to ensure these windows are cleaned.	Interim Assistant General Manager	30 Oct 2016
14	The health board must review the behaviours that are common to patients that are cared for within the learning disability directorate to ensure that personal protective equipment readily available to staff.	2.1	Appropriate protective equipment identified by the Unit Manager has been ordered	Unit Manager	Completed
14	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 Assessment Units	30 Oct 2016
15	The health board must ensure that emergency equipment is safe	2.1	Meeting has been held with the health board's resuscitation	Unit Manager / Lead Manager	30 Oct 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	to use in the event of a patient emergency (collapse).		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.	for Assessment Units	
16	The health board must review the kitchen storage at the unit.	2.5	The service will review what is currently required for the unit in relation to storage of dried food and tins.	Unit Manager / Lead Manager for Assessment Units	30 Oct 2016
18	The health board must ensure that staff follow the health board's their record keeping guidance.	3.5	All staff will be advised about the requirement to ensure that all entries in patients notes are signed, dated and also have the printed name and designation of the nurse against them in line with policy.	Unit Manager / Lead Manager for Assessment Units	30 Oct 2016
Quality of management and leadership					
20	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	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	Interim Governance Lead / Interim Assistant General Manager	30 Oct 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	promote shared learning.		robust process is in place. Minutes of these meetings should be circulated to all unit managers for information and review.		
20	The health board must ensure that staff work appropriate shift patterns for the safety of patients and the welfare of staff.	7.1	Individual working patterns will continue to be reviewed by managers to ensure that staff are not working excessively. The introduction of the bank system into the Learning Disabilities will increase the pool of Health Care Support Workers available to our service.	Unit Manager / Lead Manager for Assessment Units	30 Oct 2016
21	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
22	The health board must review the provision of mandatory training to ensure it specifically meets the requirements of the staff working	7.1	Certain mandatory training is generic across the health board which its staff required to complete. Where training allows	Interim Assistant General Manager	Complete

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
	at Learning Disability services.		<p>itself to become more specific to a particular service this will always tried to be achieved.</p> <p>Without having the specific details of what training is being referred to then it is difficult to change.</p>		

Service representative:

Name (print): Dermot Nolan

Title: Interim Assistant General Manager

Date: 25 August 2016