Arolygiaeth Gofal Iechyd Cymru

Healthcare Inspectorate Wales

Mental Health Act Monitoring Inspection: NHS Mental Health Service (Unannounced)

Llanfrechfa Grange/Assessment & Treatment Unit /Aneurin Bevan University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- Patient-centred: we place patients, service users and public experience at the heart of what we do
- Integrity: we are open and honest in the way we operate
- Independent: we act and make objective judgements based on what we see
- Collaborative: we build effective partnerships internally and externally
- Professional: we act efficiently, effectively and proportionately in our approach.

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care.
Promote improvement:	Encourage improvement through reporting and sharing of good practice.
Influence policy and standards:	Use what we find to influence policy, standards and practice.

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced NHS Mental Health Act monitoring inspection of Llanfrechfa Grange within Aneurin Bevan University Health Board on 24 October 2017. The following unit was visited during this inspection:

- Assessment & Treatment unit

Our team, for the inspection comprised of a HIW inspector and a Mental Health Act peer reviewer.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act. We look at how the service complies with:

- Mental Health Act 1983
- Mental Health (Wales) Measure 2010
- Mental Capacity Act 2005

HIW also explored how the service met aspects of the Health and Care Standards (2015).

Further details about how we conduct NHS Mental Health Act monitoring inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we found that improvements are needed to meet the requirements of the Mental Health Act 1983. In some cases we found the required sets of Mental Health Act documents (copies) to be incomplete and tribunal outcomes not present in patient files.

Advocacy visits, we were told had become infrequent and information was not visible on the unit, which needs to be clearly displayed.

Patient files need to be appropriately organised to ensure an overall picture of the patient's current status and needs are evident. Support and training from the Mental Health Act team is required for all staff to ensure legislation is being met.

We found the environment had received some upgrading/refurbishment but recommended that additional improvements be made to the furniture, fittings and fixtures to make the unit more comfortable and improve safety.

Through discussions with staff, and observations of care within the unit, we concluded that there was good team working taking place and staff were committed to providing a high standard of patient care. Staff had access to, and were using, personal alarms. They also ensured visitors to the unit were safe by issuing an alarm and/or accompanying them to appropriate areas.

Activities were being monitored to ensure they were carried out regularly.

This is what we found the service did well:

- Two group activities were offered daily by unit staff and senior managers monitor participation to ensure they take place

- We observed good team working and staff treating patients with dignity and respect

- The formulation meetings conducted by psychology and behaviour specialists were spoken of favourably by staff because of the relevant content and focus on the patient group

- Of the Mental Health Act paperwork we reviewed, we found that the responsible clinicians documentation interventions was concise, detailed and in accordance with the Mental Health Act

This is what we recommend the service could improve:

- Improvements to the Mental Health Act paperwork are required to ensure documentation is fully completed and files are organised appropriately so an overall picture of the patients current status and needs are clearly evident

- Further improvements to the environment are required, specifically to the furniture, fittings and fixtures to make the unit more comfortable and improve safety

- An improved advocacy attendance is required on the unit and information about the service needs to be clearly displayed

- Mental health act training and support for staff, specifically the unit's secretary needs to delivered to ensure compliance with legislation

3. What we found

Background of the service

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

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

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

The staff team included one manager, one deputy manager, one administrator and a team of registered nurses and healthcare support workers. The multi-disciplinary team included a designated consultant, occupational therapy, speech and language (SALT) service and psychology.

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

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We observed staff treating patients respectfully and with kindness during our inspection.

Regular activities were offered to patients, including community access and during our visit we observed patients engaged in activities. There was a system in place to monitor the types and frequency of patient social and leisure activities. The data is fed to senior managers to ensure sufficient activities are carried out.

Information needs to be improved on the unit for both patients and visitors. The patient notice board needs to be updated daily to reflect the correct date. Information about advocacy, feedback, complaints and other essential information needs to be displayed clearly.

We have recommended that the infrequent advocacy visits to the unit is addressed and improved inline with the Mental Health Act.

During our inspection, we offered patients, staff and visitors the opportunity to speak with us. Those that we spoke with told us that there was good care and treatment being provided for the patient group.

Staying healthy

Staff told us that patients were encouraged to maintain a healthy lifestyle and some healthy eating information was displayed next to the kitchen serving hatch. Breakfast, lunch and an evening meal is provided daily and patients are able to make their own food choices. As there were no catering services on-site, food choices were made the day before and sent to the catering team at a near-by hospital who transported the meals to the unit.

Comments from staff and patients highlighted that the food could be better. We observed the food served at lunchtime during our visit and noted the unappetising appearance. We were told that patient comments regarding the range and quality of food had been communicated to catering staff in the past.

Drinks and snacks outside of the set mealtimes were provided by staff. None of the patients we spoke to said they had any issues accessing those when required.

Patients were able to move freely within the unit and had access to their bedrooms and the open plan lounge/dining room. The unit was large enough to support any patient requiring a mobility aid.

There was an enclosed garden which had decking and grass areas as well as raised beds which we were told were used for patient activities and therapies.

Staff told us that a weekly activity timetable was devised by occupational therapy. We observed activities taking place on the unit and we were told that two activities were scheduled for every shift. This was documented on the notice board in the lounge area for patients to know what was taking place. Activities were also monitored to ensure they were taking place. This information was then fed back to senior managers so themes and patterns could be addressed if the activity quota cannot be met.

The unit was secured from unauthorised access and all visitors would need to use the intercom system to gain entry. Staff ensured the safety of patients and visitors further, by escorting them to the appropriate areas within the unit.

In the nurses' office there was a patient status board[1] displaying comprehensive and confidential information regarding each patient being cared for on the unit. The information was hidden when not in use. This meant that the staff team placed an emphasis on protecting patient confidentiality.

[1] A board that provides staff with a quick reference to essential information about the individual patients being cared for on the ward.

Dignified care

We observed staff on the unit interacting and engaging with patients appropriately and treating patients with warmth and kindness. The staff we spoke to, were enthusiastic about how they supported and cared for the patients. Patients were supported to be independent in taking care of their personal hygiene, with staff providing assistance where needed.

We heard staff speaking with patients in calm tones throughout our inspection. There was also evidence that staff addressed patients by their preferred name.

Each bedroom had an observation panel (window) in the door and we saw that these were mainly in the open position. From our examination of one of the vision panels, we were unable to operate it from inside the bedroom. We fed this back to staff at the time and also recommended that observation panels should be closed for privacy and only open for observation, or in response to patient preference. This is in support of patients' dignity and their right to privacy.

Patient information

A notice board displaying some patient information was located near the lounge. The white board contained the names of the staff on duty and listed the daily activities. However, the date displayed on the board at the time of our visit was wrong and had not been updated by the time we left the unit. Such patient information needs to be updated and current to support patients in orientating themselves.

There was no other patient information displayed regarding advocacy, visiting times and complaints. Staff told us that this was provided on admission. We therefore recommended that consideration is given to displaying additional information for patients and visitors.

Improvement needed

Information needs to be clearly displayed for patients and visitors which needs to include complaints (Putting Things Right) and advocacy as well as other relevant material.

Communicating effectively

Through our observations of staff-patient interactions, it was evident that staff ensured that they communicated with patients effectively. We heard staff

undertake discussions using words and language suitable to the individual patient and displayed compassion when patients became anxious.

Timely care

The unit had a multi-disciplinary team which included a Consultant, Occupational Therapist, Psychologist and a Speech and Language Therapist. The unit held weekly ward rounds and fortnightly multi-disciplinary meetings. These arrangements helped to embed a collaborative approach to patient centred care.

Individual care

People's rights

There were suitable places within the unit for patients to meet with visitors in private, along with arrangements to make private telephone calls.

We were told that advocacy services did not frequently visit the unit. We recommended in the feedback meeting that this is reviewed, especially when patients detained under the Act have a right to an independent mental health advocate to help support and ensure they understand the implications of the section of the Act under which they are detained.

Improvement needed

Access to and the frequency of advocacy services for the unit needs to be improved to ensure there is adequate support for the patient group in line with the Act.

Listening and learning from feedback

We were told that there was no formal process in place to obtain feedback from patients regarding the service. However, staff told us that they were currently involved in a project to develop a formal system to obtain patient feedback. This is likely to be in place in early 2018.

Staff told us that they supported patients who want to provide feedback about the service and patient meetings were held which captured any issues of concern raised.

Staff told us that they were trained in the use of the NHS complaints process 'Putting Things Right', but there was no information visible on the unit about this

process for patients or visitors. (See the recommendation under Patient Information)

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Our review of the Mental Health Act paperwork identified a number of areas that required improvement and we recommended that documentation is appropriately organised and completed fully, because the documentation was not particularly well organised and in some instances was incomplete. Staff working within the unit required support and training from the Mental Health Act team to ensure standards are met and maintained.

The hospital environment was being upgraded and we would advise that the additional improvements we have recommended, to form part of the refurbishment plan. This is to ensure that the furniture, fixtures and fittings are suitable for the patient group.

Safe care

Managing risk and promoting health and safety

There were processes in place to manage and review risks and maintain health and safety on the unit. This had resulted in improvements to the environment: for example, new windows had been installed and the kitchen upgraded with stainless steel cupboards and surfaces. Refurbishment of the bathrooms and bedrooms was taking place at the time of our visit.

On arrival at the unit, there were discarded old windows and pallets by the entrance porch. These were potential slip and trip hazards and we asked staff to ensure all debris from the refurbishment was placed in the designated secure area that had been set up. This was addressed by staff during the visit and the items were removed, allowing staff, patients and visitors safe and clear entry onto the unit.

We saw that improvements to the unit had, and were being, made, but we observed a number of areas that needed attention to make the environment less sparse, more comfortable and ensure patient safety. There was an open

plan dining/living area. The fixed seating in this area had high backs, wooden frames and pointed edges. This type of seating would create difficulties at such times when patients needed additional support or restraint as a result of behaviour that challenged. In addition, the seating was worn and stained. Staff told us that the furniture was due to be replaced and we welcomed this action to ensure that the issues that we identified could be eliminated.

On arrival, we saw fire doors wedged open in staff areas. The wedges were removed when this was pointed out to staff. In the day lounge, doors were locked despite signs above, indicating they were fire exits. Staff told us that in an emergency the key would be obtained from the office for the doors to be unlocked. However, we recommended that this procedure is reviewed to ensure the health and safety of everyone within the unit.

We saw a hoist in the bathroom that was dusty, requiring a thorough clean. We also saw that bathroom curtains needed to be reattached to hooks that were left on the windowsill. This was because they could potentially be used as self harm objects. The window blind in the arts and craft room was a potential ligature point. When the issue was brought to the attention of staff they agreed it would be addressed and gave assurance that no patient had access to the room unattended. We saw scissors left on seating in the lounge/dining room. We also observed stained flooring in some areas and damaged walls that required repair.

We therefore advised that all the issues identified above, should be considered in conjunction with the current plans for improvement. This was in order to ensure that the unit environment is suitable for the patient group and provides safe and comfortable surroundings.

Staff had access to personal alarms and we observed staff wearing these during our visit. Staff also made sure that, where applicable, visitors were given personal alarms for their safety. There were no call bell alarms seen in patient bedrooms and we recommended these are considered for all bedrooms so patients can call for assistance if required. There were pull cord alarms in the bathrooms.

The unit had a room so patients could receive visitors in private. There was also sufficient space for mobility aids to be used on the unit.

Improvement needed

In addition to the unit's current plan for refurbishment, the following areas need to be reviewed and considered to ensure the environment is improved to make it suitable, comfortable and safe for the patient group. Specifically:

- Decoration of the unit needs to be improved, specifically the damaged walls and marked flooring
- The bathroom hoist needs to be cleaned thoroughly so that it can be used when required
- The fixed seating in the lounge/dining room needs to be replaced to so it is appropriate for the patient group
- The window blind in the arts and craft room needs to reviewed/replaced because of the potential ligature risk
- Fire procedures need to be reviewed and improved by ensuring fire doors are not wedged open and the process of obtaining keys to open fire exists in an emergency is appropriate and safe.
- Nurse call bell buttons should be available in each bedroom to call for assistance if required.

Safeguarding children and adults at risk

There were processes in place to ensure that the hospital focused on safeguarding vulnerable adults and children, with referrals being made to external agencies as and when required.

Effective care

Safe and clinically effective care

Overall, we found governance arrangements in place that helped ensure that staff on the unit provided safe and clinically effective care for patients.

Record keeping

The patient records we reviewed were paper based files. There were secure storage arrangements in place to prevent unauthorised access to those records and breaches in confidentiality.

Of the two patient records we reviewed, we found they were difficult to navigate due to poor organisation of the notes contained within the file. Two files were in place for each patient; however, information was spread across both files. This meant it was difficult to determine a patients' overall/current needs without further investigation or discussion with staff.

These issues had been identified during our previous inspection (May 2016). It was therefore disappointing that such improvement had not yet taken place.

Improvement needed

Patient records need to be appropriately organised to ensure information can be easily located and the patients' legal status and contemporaneous history is evident.

Mental Health Act Monitoring

We reviewed the statutory detention documents of two patients and found that the mental health act (MHA) documents were in disarray, with copies of mental health act papers incomplete in some cases and not retained in chronological order, (with the required HO14[2] record of detention on top).

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[2] There are regulations that deal with the exercise of compulsory powers under the Mental Health Act 1983; these regulations prescribe the statutory forms to be used in the exercise of powers under the Act. Each Form carries its own specific number and title and the reference number of the regulation(s) to which it pertains, so form HO14 (regulation 4(3)) is the record of detention in hospital under sections 2, 3 and 4. The "Records Management: NHS code of practice" sets out specific rules and timescales for delivery and retention of Mental Health Act administration records. The authority for a patient's detention would no longer exist if the forms that were used to provide that authority were lost, unless copies of the original forms had been made (provided that the signatories endorsed the copies as a true copy of the original form). Paper copies of statutory forms retained in paper records should therefore be attached securely. It is recommended that they should logically reflect the steps taken during the assessment process with Form 14, the record of detention in hospital under sections 2, 3 and 4 on top.

In one file we reviewed, copies of 2016 documents had been inserted between two sets of 2017 documents. In addition, copies of Mental Health Tribunal for Wales outcomes were not present in files. We also saw a Multi Disciplinary Team communication form completed for another patient was found within the second set of records we reviewed.

Staff told us that two copies of the Code of Practice were available in the nurses' office; however, we found this was not the case. It is essential that copies of the Code of Practice (Welsh and English versions) need to be retained in a suitable area to ensure accessibility at all times for patients, their relatives and unit staff.

It was recommended that the current retention of MHA documentation on the unit is reviewed and that standards are set for the retention of Mental Health Act documents and associated paperwork on patient files.

Improved links between the unit team and the Mental Health Act Department is advised. Consideration should also be given to providing the unit secretary with training and updates in Mental Health Act at a suitable level appropriate to the role to facilitate a clearer understanding of specific documentation and important events during detention periods such as SOAD requests, Hospital Managers' hearings and the Mental Health Review Tribunal.

We found that the Responsible Clinician had completed the medical recommendations in a concise but detailed manner which was fully in accordance with the regulations. Their rationale for making a medical recommendation was also particularly well documented in the patient records.

Improvement needed

The filing of Mental Health Act documentation needs to be reviewed to ensure it is retained appropriately and specifically to the relevant patient

Copies of the Code of Practice need to be available to patients, relatives and staff on the unit in both English and Welsh.

Improved links between the mental health act team and unit staff are required to ensure support and training are provided to confirm legislation with the Act is being met

Monitoring the Mental Health (Wales) Measure 2010

Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010. We reviewed two care and treatment plans (CTPs) and found evidence that care co-ordinators had been identified for the patients and, where appropriate, family members were involved in care planning arrangements.

There was clear evidence in the CTPs we reviewed, that advocacy services were available to patients, however, staff told us that their visits were not regular to the unit and we recommended that this is reviewed.

To support patient care plans, there was an extensive range of patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them.

We found that Care and Treatment Plans reflected the domains of the Welsh Measure.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

Through discussions with staff and observations on the unit, we concluded there was good team working taking place. Staff were committed to providing patient care to high standards and said they felt supported by senior management.

Processes were in place for staff to receive an annual appraisal and complete mandatory training. We saw, from the training matrix, that some training had expired and recommended this was updated as soon as possible. Access to some classroom style training could be difficult due to the availability and this resulted in expired training for some staff, an area we recommended is reviewed and addressed.

We identified a need for staff to receive Mental Health Act training, with specific support and training provided to the administrator on the unit. This will ensure that the legal requirements of the Act are being met.

There were regular team and formulation meetings in place for staff. These were commented upon favourably due to the relevant content for the patient group.

The staff we spoke to were able to describe the process for reporting incidents and lessons learned were communicated to all staff as a means of improving patient care.

Governance, leadership and accountability

We found that there were systems and processes in place to ensure the unit focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit, the results of which are submitted to senior managers so outcomes could be monitored and clinical outcomes discussed regarding the delivery of patient care.

The unit had a manager and deputy who were supported by a committed ward and multi-disciplinary team. At the time of our visit, we met the new unit manager who was about to replace the current manager.

We found that staff were committed to providing patient care to high standards and staff commented that team working on the unit was very good. Staff working within the unit said they felt supported by senior managers and described them as approachable. They also told us that they felt valued.

It was positive that, throughout the inspection, all staff were receptive to our views, findings and recommendations.

Staff and resources

Workforce

We observed, and staff told us, that the unit had formed teams that worked well together and we saw motivated individuals providing dedicated care for patients. At the time of our visit, there were only a small number of vacancies which were being recruited for and a recent patient acuity[3] study had ensured shifts were appropriately resourced.

The unit did rely on support from bank members of staff as and when required and staff told us that they tried to ensure continuity for the benefit of the patient group. However, we were told that some bank staff did not have training in some key areas, specifically positive behaviour management (PBM). This

[3] Patient acuity is a concept commonly referenced by caregivers and the health science literature but without specificity or consistency of definition or measurement. Acuity has become a reference for estimating nurse staffing allocations and budget determinations of the intensity of care required for a patient.

meant that in the event of the need to use a form of restraint, anyone without training in PSB would not be involved. This action is correct, however, it is necessary that all staff working on the unit have the skills and knowledge specific for the patient group to ensure safety is maintained at all times.

Regular staff and formulation[4] meetings took place. The formulation meetings were conducted by psychology and behaviour specialists who staff spoke of favourably because of the relevant content and focus on the patient group.

We reviewed the mandatory staff training programme. The majority of training was completed on-line using the Electronic Staff Record (ESR) system. Staff told us that there were not enough computers on the unit to complete their on-line training. A training matrix providing an overview of staff compliance was presented and highlighted a number of areas where training had expired. We therefore recommended that staff training is reviewed; areas marked as expired to be updated as soon as possible. This is, to ensure staff have the necessary skills and knowledge to care for the patient group.

It was evident that the ESR system could not provide an overview of all staff training and their compliance level. Additional sheets (such as the training matrix) are produced and used by staff to provide this information and we recommend that a review of the system takes place so it can produce the information needed by managers and avoid duplication of work.

Staff told us they had no issues accessing additional and relevant external training with line manager approval. However, we were told that a shortage of Health Board classroom style training had resulted in training not being updated/refreshed. We recommend this is reviewed to ensure staff have sufficient time and opportunity to complete necessary classroom style training.

Discussions with staff highlighted that Mental Health Act training was not provided but would be welcomed. Specific training and support is urgently required for the administration staff to ensure the legal aspects of the act are being completed as required. We therefore recommended that this is planned and delivered as soon as possible.

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[4] Formulations are used to communicate a hypothesis and provide a framework for developing the most suitable treatment approach.

Staff were receiving annual, documented appraisals with completion dates recorded on the ESR system. A programme for staff to receive managerial supervision was in place. We reviewed the matrix for this process, which was last updated in August 2017 and found that very few staff received regular supervision with some staff not having had a session since February 2017. This exceeded the established six to eight week timescale between supervision sessions. We were provided with some reassurance at the feedback meeting that the new unit manager will be reviewing this and ensuring that staff have sufficient support methods in place.

The staff we spoke with, described the procedure of reporting incidents and there was clear understanding and knowledge provided from them regarding this process. Incidents were recorded on the Datix[5] system and lessons learned were discussed with the ward team when required, as stated by staff.

Improvement needed

A review of mandatory training is required to ensure all staff are up to date, including bank staff.

A review of the ESR system is required so managers can obtain an overview of all staff training and compliance data without the need to have to access each individual record and/or develop additional reports.

Mental Health Act training is required for all staff, with specific training and support to be put in place for the unit administrator to ensure the legal requirements of the Mental Health Act are being followed.

A review of the availability of classroom style training is required to ensure there are sufficient opportunities and spaces for staff to attend.

The programme of managerial supervision needs to be reviewed and improved

[5] Datix is an incident reporting and risk management system to report and track clinical incidents.

so staff receive a session in-line with the unit's timescales for this process.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

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

5. How we conduct NHS Mental Health Act monitoring inspections

Our NHS Mental Health Act monitoring inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

During our NHS Mental Health Act monitoring inspections will look at how services:

- Comply with the Mental Health Act 1983, Mental Health (Wales) Measure 2010 and Mental Capacity Act 2005
- Meet aspects of the Health and Care Standards 2015

We also consider other professional standards and guidance as applicable. These inspections capture a snapshot of the standards of care within NHS mental health services.

Further detail about how HIW inspects mental health and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection			

Appendix B – Immediate improvement plan

Service: Llanfrechfa Grange

Ward(s): Assessment & Treatment Unit

Date of inspection: 24 October 2017

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No immediate concerns identified				

Appendix C – Improvement plan

Service: Llanfrechfa Grange

Ward(s): Assessment & Treatment Unit

Date of inspection: 24 October 2017

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
Information needs to be clearly displayed for patients and visitors which needs to include complaints (Putting Things Right) and advocacy as well as other relevant material.	4.2 Patient Information	• The patient notice board will be routinely updated by the Night Shift for the following day. This action will be diarised to ensure that staff are reminded to do this. • Two display notice boards have been purchased to replace those that had previously been removed from the wall by a service user. These boards will be put in place and relevant information	Ward Manager Ward Manager	31st Jan 2018 31st Jan 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		will be made available including; staff photos and names, advocacy and complaints information. • Two white boards have also been purchased for use in this area and will be used for 'You said, We did' and a graffiti board for service user feedback. The feedback will be used to populate the you said, we did board in order that service users are able to see any improvements that have been made as a result of their suggestion.	Ward Manager	31st Jan 2018
Access to, and the frequency of, advocacy services for the unit needs to be improved to ensure there is adequate support for the patient group in line with the Act.	1.1 Health promotion, protection and improvement 2.7 Safeguarding children and safeguarding adults at risk 6.1 Planning care to	• Meeting with the advocacy service to be arranged and current service to be reviewed to ensure adequate support to the unit.	Lead Nurse	31st Jan 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	promote independence 6.2 People's rights Code of Practice for Wales, Revised 2016 - chapter 6			
Delivery of safe and effective care				
In addition to the unit's current plan for refurbishment, the following areas need to be reviewed and considered to ensure the environment is improved to make it suitable, comfortable and safe for the patient group. Specifically: ☐ Decoration of the unit needs to be improved, specifically the damaged walls and marked flooring ☐ The bathroom hoist needs to be cleaned thoroughly so that it can be used when required	2.1 Managing risk and promoting health and safety	The unit is due to undergo a refurbishment plan following allocation of capital funding. All components highlighted in this improvement plan will be addressed namely: • Decoration of the unit to all walls and ceilings • The replacement of all flooring • Fixed seating within lounge area will be removed • The bathroom hoist has been	Assistant Head of Specialist Services	July 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
□ The fixed seating in the lounge/dining room needs to be replaced to so it is appropriate for the patient group □ The window blind in the arts and craft room needs to reviewed/replaced because of the potential ligature risk □ Fire procedures need to be reviewed and improved by ensuring fire doors are not wedged open and the process of obtaining keys to open fire exists in an emergency is appropriate and safe. Nurse call bell buttons should be available in each bedroom to call for assistance if required.		cleaned and this has been added to the ward cleaning schedule The Window Blind has been removed. Immediate action taken to ensure that fire doors are not wedged open and fire exits are accessible. Fire Procedures to be further reviewed in-line with the recommendations. The need for nurse call buttons to be reviewed to ensure that these are available where required to meet the needs of individual service users and current legislation and guidance.	Ward Manager Assistant Head of Specialist Services Assistant Head of Specialist Services/Ward Manager Competent Person ATU Assistant Head of Specialist Services	Completed Complete Immediate Complete 31st Jan 2018 31st Jan 2018
Patient records need to be appropriately organised to ensure information can be easily located and the patients' legal status and contemporaneous history is evident.	3.5 Record keeping Code of Practice for	A review of patient records has been undertaken to ensure that information is organised in ways that allow this to be easily accessible. Staff have been	Ward Administrator / Deputy Ward Manager	Immediate Complete

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	Wales, Revised 2016 - chapter 35	reminded of this. All inpatient records will now be organised by a contents page and dividers. Information relevant to current care will be included in the file and stored in chronological order in its appropriate section. Accountability for individual health record to be assigned to the associate care coordinator on the ward with overall responsibility assigned to the Deputy Ward Manager. The Deputy Ward Manager will review files weekly to ensure that they comply with the filing process and contain the relevant information for current care needs.	Deputy Ward Manager Deputy Ward Manager Deputy Ward Manager	31st Jan 2018 31st Jan 2018 31st Jan 2018
The filing of Mental Health Act documentation needs to be reviewed to ensure it is retained appropriately and specifically to the relevant patient.	3.5 Record keeping Code of Practice for Wales, Revised 2016 -	Mental Health Act Documentation to be divided into Mental Health Act Forms, Mental Health Act Reports and Section 17 Leave.	Ward Administrator / Deputy Ward Manager	31st Jan 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	chapter 35	These documents will be stored in chronological order and checked weekly to ensure that they are correct and complete.	Deputy Ward Manager	31st Jan 2018
Copies of the Code of Practice need to be available on the unit in both English and Welsh to patients, relatives and staff.	Code of Practice for Wales, Revised 2016 - chapter 4	The code of practice for the Mental Health Act 2007 were allocated to the unit and are available in the ward office.	Head of Specialist Services	25th Oct 2017 Complete
Improved links between the Mental Health Act team and unit staff are required to ensure support and training are provided to confirm legislation with the Act is being met	7.1 Workforce Code of Practice for Wales, Revised 2016 - chapter 1	A review of the current arrangements between the Mental Health Act Administration Department and the ATU will be undertaken. Training, Audit of Filing and documentation and the creation of a link administrator will form part of the review.	Assistant Head of Specialist Services / Divisional QPS Lead	31st Jan 2018
Quality of management and leadership				
A review of mandatory training is required to ensure all staff are up to date, including bank staff	7.1 Workforce	All statutory and mandatory staff training will be reviewed for ward staff and any non-compliance will be addressed.	Ward Manager	31st Jan 2018

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		All statutory and mandatory staff training will be reviewed for bank staff and any non-compliance will be addressed.	Resource Bank	31st Jan 2018
A review of the ESR system is required so managers can obtain an overview of all staff training and compliance data without the need to have to access each individual record and/or develop additional reports.	7.1 Workforce	ESR system to be reviewed to ensure it captures the training undertaken by staff at the Assessment and Treatment Unit	Assistant Head of Specialist Services	31st Jan 2018
Mental health act training is required for all staff, with specific training and support to be put in place for the unit administrator to ensure the legal requirements of the Mental Health Act are being followed.	7.1 Workforce	Mental Health Act training to be reviewed to ensure all staff are provided with relevant knowledge pertaining to their role.	Assistant Head of Specialist Services	31st Jan 2018
A review of the availability of classroom style training is required to ensure there are sufficient opportunities and spaces for staff to attend.	7.1 Workforce	Where classroom based training is required its availability will be reviewed to ensure that this is not an issue for staff to access in a timely manner.	Assistant Head of Specialist Services	31st Jan 2018
The programme of managerial supervision	7.1 Workforce	The Managerial Supervision structure	Ward Manager	31st Jan

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
needs to be reviewed and improved so staff receive a session in-line with the unit's timescales for this process.		has been revised and made available to staff. Further work on ensuring that staff are able to access supervision at least every 8 weeks will be undertaken and built into the shift plan for each occasion.		2018

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Christopher Jones

Job role: Assistant Head of Specialist Services

Date: 21st December 2017