Arolygiaeth Gofal Iechyd Cymru

Healthcare Inspectorate Wales

Learning Disability Follow-up Inspection (Unannounced)

Hywel Dda University Health Board, NHS

Residential service 17069

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@gov.wales**

Fax: **0300 062 8387**
Website: **www.hiw.org.uk**

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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 follow-up inspection of a residential service (17069) within Hywel Dda University Health Board on the 9 November 2017.

Our team, for the inspection comprised of one HIW Inspector, and one clinical peer reviewer.

Further details about how we conduct follow-up inspections can be found in Section 5.

2. Summary of our inspection

Overall, we found evidence that the service had improved since the initial inspection in June 2016 and the follow up inspection in February 2017.

We were satisfied that the service provided safe and effective care and had either completed the requirements of the previous reports or were in the process of finalising individual improvements.

However, whilst some of the previous improvement plan had been completed, further work is required to complete other areas.

We also identified some improvements which were additional to those already outstanding. However we acknowledge that the service is changing and there are new and improved ways of working in place..

This is what we found the service did well:

- Staff treated patients and each other, with respect, patience and kindness. There was a committed staff team.
- The unit hade a new manager who was well supported by senior staff. We were able to see that there was a commitment to improve the service for the benefit of the patients

This is what we recommend the service could improve:

- Fire officers need to be contacted for advice regarding a specific bedroom door
- Re -establish regular meetings with the estates department of the health board
- Senior managers attend staff meetings to discuss on going service changes
- Observation panels on bedroom doors need to be set to closed as the default position

- Documentation regarding the use of least restrictive holds needs to be improved
- Staff need training in active support / person centred planning.

3. What we found

Background of the service

The unit forms part of learning disability services provided within the geographical area served by Hywel Dda University Health Board.

The unit provides residential placements for a maximum of six people with severe learning disabilities, autism and challenging behaviours, some of whom may be detained under the Mental Health Act[1]. One of the single rooms has been converted to a quiet communal area and a small office space has been converted into an occupational therapy room. There were five male patients living at the unit, at the time of this inspection.

The service employs a staff team which includes a new unit manager together with a team of registered nurses and support workers. A consultant psychiatrist works between this unit and another learning disabilities service nearby. There is a part time occupational therapist and a visiting psychology team.

The service is managed and operated overall, by the combined Mental Health/Learning Disabilities Directorate within Hywel Dda University Health Board.

HIW last inspected 17069 on 13 February 2017,.which was a follow up from the original inspection on 7 June 2016. Due to the slow progress on improvements HIW considered another follow up inspection was required.

The key areas for improvement we identified included the following:

- Remedial building work
- Patient care including appropriateness of placement, well being, human rights, partnership working

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[1] The Mental Health Act is the law which sets out when you can be admitted, detained and treated in hospital against your wishes. It is also known as being 'sectioned'. For this to happen, certain people must agree that you have a mental disorder that requires a stay in hospital.

- Record keeping
- Health and safety including medicines management
- Governance, management and leadership in areas such as supporting staff.

The purpose of this inspection was to follow-up on the improvements which had not been addressed at the last inspection.

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 were able to confirm that progress had been made in relation to improving the unit environment which enhanced patients' dignity and privacy.

In addition, assessments had been undertaken to ensure patients were receiving the most appropriate care and support from an integrated multi disciplinary team of professionals.

However, there were some outstanding improvements with regard to aspects of the initial and subsequent inspections.

What improvements we identified

Areas for improvement identified at last inspection included the following:

- The health board is required to inform HIW how it will ensure that remedial work at the unit (now and in the future), will be completed as soon as possible to ensure the health, safety and welfare of patients and staff. This was an area of service provision identified for improvement during the HIW 2016 inspection and remains unresolved

- The health board is required to inform HIW of the action to be taken to review whether patients' placements at the unit remain appropriate and alternative accommodation explored for long term care purposes. This issue remains outstanding from the HIW 2016 inspection

- The health board is required to provide HIW with details of how it will ensure that patients' physical and emotional well-being and independence is maximised now, and in the future

- The health board is required to provide HIW with a comprehensive description of how it will ensure that equality and human rights is embedded across the functions and delivery of learning disability services in accordance with statutory requirements and Mental Capacity Act legislation

- The health board is required to inform HIW of the action to be taken to ensure that staff are provided with appropriate support following incidents recorded via DATIX. This is in order that lessons can be learned with a view to minimising the risk of repeated patient incidents.

What actions the service said they would take

The service committed to take the following actions in their updated improvement plan dated 20 April 2017:

- A Capital funding bid for 3 areas of work has been submitted and prioritised, awaiting feedback from Estate Colleagues for Commencement date. Remedial works to the doorway, bath and decoration. To ensure ongoing maintenance issues are addressed in a timely manner, monthly site meetings will be held with Estates colleagues, any unresolved concerns will be escalated via the Head of Service and Director as appropriate.
- 2 Community Team Learning Disability Managers identified to lead on the progression of 2 individuals immediately. Head of Service will contact Director of Social Services Pembrokeshire to ensure a social worker is allocated to help progress discharge. Documentation will be improved to record discussions and rationale for decision making with regard to all clients' medium and long term accommodation needs. Multi Disciplinary Team (MDT) meetings scheduled over next 3 months. Deprivation of Liberty Safeguards (DoLS) Care Plans will be developed to specifically address the restrictions in place for all clients subject to DoLS including long term accommodation requirements.
- Occupational therapist to address the overcrowded activity room available to clients on the unit and remove any surplus equipment. If storage opportunities are limited within the unit, appropriate storage equipment will be purchased to facilitate this. Active support training being planned and resource pack has been ordered. Activity plans will be amended to clearly show dates of activities being commenced and reviewed as well as the author of the plan. To be developed as part of the Active Support process. Administrative support will be provided to the unit manager to specifically develop a File Referencing / Location System for all five clients' records. Related paper documents will be kept together in a minimal number of files to avoid confusion and minimise risk. Administrative support will also ensure that all word documents printed out are clearly marked with the author's name and date of creation. Priority will be given to

permanent recruitment of the vacant ward clerk post, which will go out to advert by the end of April 2017.

- The unit manager has now recently received the Deprivation of Liberty Safeguards (DoLS) Care Plans and is developing for all three clients subject to DoLS. These Care Plans will explicitly set out the rationale for restrictions on each client. DoLS review and documentation should be person centred and be subject to authorisation and sign off. The head of nursing is undertaking a review of the DoLS documentation in collaboration with DoLS Coordinator, meeting date set for 6th April 2017. Analysing of behaviour baseline data to be completed, this analysis will inform the development of bespoke recording mechanisms for ongoing monitoring. Date scheduled for ongoing monitoring design April 11th 2017. Review ongoing requirements for ongoing behavioural support and develop a model that will support the progression of patients from the unit. Templates for keyworker meetings will be amended to explicitly record discussions around need for Best Interest Meetings to be held. This will be replicated for MDT and ward round meetings. Subsequent Best Interest Meetings will be clearly identified as such in the record keeping / documentation.

- Keyworker meetings will explore learning from events which is then shared with the wider team and discussions at ward round, through using behaviour monitoring tools which will identify proactive measures required. It is acknowledged that this detail will also be included in the Investigation conclusions on DATIX. Health and Care Standards, Fundamentals of Care: A dedicated meeting with the staff team will be arranged for April 2017 to provide feedback from the staff survey, and to explore further the comments taken from the suggestions box provided for staff. Service manager will request that the professional lead nurse for learning disabilities is given access to the Fundamentals of Care data.

- Review the existing Draft Operational Policy and Equality Impact Assessment. Introduce a clinical governance meeting for the unit. Restructure of learning disability and older adult mental health management includes specific capacity for one service manager to take a lead on the in-patient unit. A who’s who pictorial guide to the senior management structure is being developed and will be cascaded to all staff. Senior staff will continue to visit the unit. Shift work impacts on people’s experience of seeing senior managers so the Directorate is giving more thought to how this can be addressed.

- A substantive manager for the unit had been appointed, but has been unable to take up the post due to an urgent health issue; the manager is due to commence phased return from the 17th April 2017. Two Band 5 registered nurses recruited. One Band 5 registered nurse recruited to the bank. The longer term recruitment challenge in relation to learning disability nurses is on the Directorate's Risk Register and the service has developed a recruitment and retention plan.

What we found on follow-up

Staying healthy

We saw in patient records and were told by managers and staff that the local GP visits the service twice a month on a Tuesday morning. Should patients require a GP in between these visits an alternative appointment will be made. We saw that consultations and heath reviews had been undertaken by consultant psychiatrist, who now visits the unit every Wednesday.

Psychologists had commenced work with patients and all assessments had been undertaken. We saw that the Brief Behavioural Assessment Tool (BBAT)[2] and Behavioural Anchored Rating Scores. (BARS)[3] assessments had been completed. Observation of patients by professionals has been ongoing, which

[2] The Brief Behavioural Assessment Tool (BBAT) is an informant based assessment tool to use in functional analysis. It explores key areas that are usually assessed using multiple tools and makes a brief overall assessment. It is not to be used instead but with other standardised tools.

[3] BARS are rating scales that add behavioural scale anchors to traditional rating scales (e.g., graphic rating scales). In comparison to other rating scales, BARS are intended to facilitate more accurate ratings of the person's behaviour or performance.

will inform the Positive Behaviour Intervention Plans (PBIS)[4] that have either been developed or are in the process of being developed. They were due to be completed by June 2017 but at least one was outstanding at the time of this inspection.

The occupational therapist has been working with the speech and language team and they have jointly developed sensory activities tailored to meet individual needs. We saw that the occupational therapy room had been de-cluttered and was now a functional activity room twice weekly.

General nursing records had been reviewed and updated. This evidenced that there was a more multi disciplinary approach to providing holistic care and support to the patients living at the unit.

Dignified care

We saw that there was a staff identification board (including senior staff) available in the staff room and it was explained that there were plans to replicate this to display in the communal living area which would assist patients to recognise people who were either visiting the service (in a managerial position) or helping to support them with their daily living routines.

We saw that observation panels in the bedroom doors were still set to open as a default position. This is not dignified for the patient and doesn't allow privacy in their own rooms.

Improvement needed

The manager must ensure that bedroom door observation panels are set to closed as a default position to maintain dignity and privacy.

[4] Positive Behaviour Intervention Support (PBIS) is an approach that can be used to improve individuals' safety and promote positive behaviour.

Communicating effectively

HIW had previously identified that the patients living at the unit needed the assistance of communication aids to help them express themselves and enhance their understanding of aspects of their daily care. At the last inspection, we were able to confirm the use of a Go Talk[5] device and Widgit[6] health products, the use of which had been approved by the speech and language therapist. We also saw that the staff team had access to picture cards to assist patients in identifying what they wished to do and what was about to happen next in their day. We did not see the use of any of these communication aids during our latest visit.

We were also told in the last inspection that an iPad was due to be purchased to enable one particular patient to communicate; an assessment having been requested with the electronic assistive technology department at Rookwood Hospital Cardiff. We did not see an assessment for, nor an iPad being used as a communication tool during this visit.

We were told that Total Communication[7] was being promoted although we did not see anything other than verbal communication on the day. We did not see individual communication passports[8] in the patient records.

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[5] A ‘Go Talk’ is a battery powered communication device that can be used by people who cannot communicate well by speaking. Another person (a carer or friend, for example) records messages – any messages the person will likely need, in any language, dialect or accent which enables them to “say” what they want with the push of a button.

[6] Widgit Health products and symbols have been designed in partnership with healthcare professionals to meet the communication needs of service users. In routine health care, clear communication improves the effectiveness of diagnosis and treatment, leading to quicker and more effective recovery. By providing communication support, Widgit products aim to improve the inclusion of, and outcomes for, patients, especially those who have a communication need.

[7] The total communication approach is about using the right combination of communication methods for an individual to ensure the most successful forms of contact, information exchange and conversation.

Since our last inspection, the large crack in a wall above a bedroom door (which was no longer occupied by a patient) that extended almost across the entire length of the same wall and required structural repair had been temporarily repaired. However the door frame having been subject to temporary strengthening to prevent further damage was no longer suitable to hold a fire door. We were told that this now required a considerable amount of structural work and a capitol funding bid had been successful to finance the work. In the meantime there was no door to the room and it was now used as a quiet communal area. We requested that the Fire Authority and health board fire officer be notified to ensure that the room was safe for use.

We were told during the last inspection that monthly meeting had been scheduled between the acting manager of the unit and the estates manager. This was to ensure that repairs were undertaken in a timely manner. On discussion at this inspection, it was clear that these meetings had ceased due to a lack of commitment from the estates department. This meant that there was a delay in discussing how the structural repairs could be undertaken in a timely manner.

Improvement needed

The service needs to review the many different means of communication available and ensure each patient has access to the most appropriate for their individual needs. These need to be recorded in their communication passports.

The service needs to ensure that the room used as a quiet communal area is safe for use without a fire door.

The manager needs to re-instate regular meetings with the estates department to ensure repairs are undertaken in a timely manner.

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[8] Person-centred booklet for those who cannot easily speak for themselves.

Individual care

Planning care to promote independence

We had previously found (during 2016 and 2017) that the staff team were considerate and showed genuine care towards the patients. Although this was still the same we were encouraged to hear that staff were proactively encouraging and supporting patients to become as independent as possible, in accordance with their identified abilities and skills.

There were now active plans in place to consider whether the residential unit remained the most appropriate environment for patients to receive long term care. Four of the five patients have now been assessed as able to move on to supported independent living and plans were already in place for one to move in the near future.

Two members of local authority staff had been identified to move these placements forward but had been on sick leave for some time. Nevertheless two expressions of interest have been considered and there was a multidisciplinary team meeting arranged to discuss a third. The local authority had employed a temporary social worker to oversee the work.

At the last inspection, we found that the range of social and leisure activities available to patients had improved. We also saw that the one room at the unit had been converted to an activities area. At the time the room was full of equipment and would not comfortably seat more than two people. Additionally we did not see that the room was used during our visit. However during this visit we saw that the room had been emptied of clutter and there was evidence of painting, arts and crafts and photographs of outdoor activities on the walls.

Patient risk assessments had been developed and activities that patients engaged with had written outcomes and future plans to assist staff on a day to day basis.

Generally, paper documentation relating to individual patients, were in the process of being transferred to an electronic system and although staff told us there had been an issue with accessing the system, this seems to be

improving. There is an expectation by staff that a new suite of electronic learning disability tools will be in place by January 2018.

People's rights

We saw that DoLS[9] assessments had been reviewed and an analysis of individual behaviour had been assessed and incorporated into the conditions of the assessments. The review of specific behavioural support was on-going and the psychology team were planning to develop a model to support patient progression. We saw that a template had been developed to be used at keyworkers meetings to record any Best Interest decisions.[10]

We discussed DATIX forms again at this inspection, specifically; recorded evidence of outcome of pro-active measures taken to minimise the repeat of such events and confirmation that staff were provided with feedback/debriefing, or the opportunity to learn from patient incidents. We were told that there were now keyworker meetings (minutes of these were evidenced) where there was an opportunity to explore learning from events and discussion around improved practice. The service manager confirmed that the professional lead nurse and the unit manager now had access to any reported data. This will enable improved and transparent communication to the manager and team members.

We were shown the staff suggestions box and told that there was a dedicated meeting planned to review the Fundamentals of Care audit. The service manager also confirmed that the results of the staff survey are considered when deciding service improvement.

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[9] DoLS are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. They refer to the extra safeguards needed if restrictions and restraint used in the care of a person, will deprive them of their liberty. The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital.

[10] If a person has been assessed as lacking capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interest. it is vital that you record your best interests decision. Not only is this good professional practice, but given the evidence-based approach required, you will have an objective record should your decision or decision-making processes later be challenged.

Delivery of safe and effective care

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

Staff working at the unit continued to make every effort to provide patients with safe and effective care, and we found that the improvements to service which required senior management action had generally been resolved.

An establish extended multidisciplinary team was in place to regularly assess, plan and monitor the delivery of care and treatment to patients living at the unit. However some matters, which included seclusion arrangements, required further improvement.

The issues identified in the last report relating to aspects of medicines management had been resolved.

What improvements we identified

- The health board is required to provide HIW with a full description of the action to be taken to ensure that people's health, safety and welfare are actively promoted and protected at times when seclusion arrangements are adopted in response to patient behaviours that challenge.
- The health board is required to provide HIW with full details about how it will ensure that up to date and relevant patient information is readily available to staff to identify, prioritise and manage real risks that may cause serious harm.
- The health board is required to inform HIW of the action taken/to be taken to ensure that arrangements for access and exit from the unit in respect of all who visit, are in keeping with health and safety and fire safety legislation.
- The health board is required to inform HIW of the action taken to ensure that there are appropriate organisational structure and management systems in place for IPC and decontamination in place. This is to ensure that the physical environment is maintained and

cleaned to a standard that facilitates IPC and releases staff to spend more time with Patients.

- The health board is required to provide HIW with a description of the action taken to ensure that there is compliance with legislation, professional and local guidance for all aspects of medicines management.

- The health board is required to provide HIW with a full description of the action taken to ensure that health care professionals in the form of extended MDT work in partnership with each other to record and improve the health and wellbeing of patients in receipt of care and treatment. This matter was raised at the previous inspection and therefore remains unresolved.

What actions the service said they would take

The service committed to take the following actions in their improvement plan:

- MDT meeting on Wednesday 15th March, it was agreed that re-sectioning of the patient would not resolve the longer term element of care, or the questions relating to his segregation, and on that basis it was agreed to complete an application to the Court of Protection on the patient's behalf before the end of the current authorisation. We have no control over how quickly this would be seen by a judge, so a short authorisation is being put in place. Behaviour baseline data is currently being analysed in order to inform future plans. The draft seclusion Policy will be finalised and agreed through the MH and LD Quality, Safety and Experience Assurance Sub Committee, for ratification at the Clinical Policy Review group, for the Health Board.

- Face risk profiles have been reviewed and updated for all clients at the unit which is evidenced on care plans; this was undertaken in October 2016. The Directorate Business Manager will continue to meet regularly with the Health Boards' Informatics Team in order to progress the uploading of Learning Disability Tools to FACE/Care Partner, in order to maximise the use on the electronic system. In the interim, a File Referencing / Location System will be developed for each Learning Disability Team to enable all staff to be able to locate specific records swiftly and easily.

- A Protocol has now been written and issued and a sign in/out book adopted. Replacement keys for the filing cabinets have been ordered. The arrangement whereby staff from the Hafan Derwen site accessed

the keys for Pool Cars from the unit was adding to unnecessary 'foot fall'. This arrangement will cease with effect from 30th April 2017.

- The Infection Prevention and Control (IPC) lead for the Health Board has been asked to undertake a follow up visit and provide a report around any concerns and actions. Infection Control Audits take place on a 2 year cycle across the in-patient units - the next audit is due 2017.

- As required medication (PRN) is used infrequently on the unit. When it is utilised there are clear guidelines in place for rationale, the use of one medication in preference to another and minimal intervals before second PRN does can be repeated. Daily activity records show where medication has been administered with rationale explained and outcome / effect of its use on the client. This is also documented clearly on DATIX if a reportable incident has occurred indicating its use. Medicine charts also show clear prescribing and administration of PRN medication. The clinical room has received a deep clean and expired items have been removed.

- The team has ensured that all five clients receive reassessment of their needs. Some of this work, in particular the sensory assessments are lengthy given such a complex client group, and as such are not complete yet. However, all assessments required have commenced and Network Training Days have either occurred or been planned to bring together the assessments and develop a full analysis for each individual client. MDTs for all clients will be finalised by the end of June 2017. MDT meetings have taken place for all five clients since the inspection in June 2016 and dates have been set for 2017 to occur every three months for each client. The Medical Lead for Learning Disabilities will reaffirm with the Consultant Psychiatrist and Specialist Registrar the need to ensure regular attendance at the Ward Round. Consultant Psychiatrist Job Plan review to take place to review Responsible Clinician duties with respect to the two In-patient units.

What we found on follow-up

Safe care

Managing risk and promoting health and safety

During our 2016 inspection, we found that there was a lack of understanding among staff working at the unit about what constituted the practice of seclusion to manage patients' behaviours that challenged. However, this inspection

evidenced that staff had received training from both the psychology team and the Positive Behavioural Intervention and Support team. Formulation days with staff had been undertaken where individual plans were developed to manage and support patients. Not every patient had completed plans in place but we were assured this was on-going.

During our previous visits, we found issues relating to the 'seclusion' of patients at the unit. A DoLS review had resulted in a referral to the local adult protection team by a relevant person's representative. The outcome of the referral was an application to the Court of Protection[11]. A Court hearing was held and it was decided that the individual was being lawfully cared for in an appropriate environment.

At the time of the last inspection, there was a draft seclusion policy in place, and we were told that the staff team had been engaged in its development and use to date. The policy still had not been finalised at this inspection.

Visitors are still expected to use the side entrance of the premises where there is no means of alerting staff to arrival, although there is a signing in book there still is no bell.

The filing cabinets containing confidential files have been moved to the unit manager's office and are now locked. We are therefore satisfied that files are stored in a safe environment.

The computers are still used in the kitchen area so caution is required when people are accessing through this room.

Improvement needed

The health board needs to be timely in its finalisation of the seclusion policy.

The health board needs to review the security of the premises.

[11] The Court of Protection makes decisions on financial or welfare matters for people who can't make decisions at the time they need to be made (they 'lack mental capacity').

Infection prevention and control

During the previous HIW inspections, we found there were no dedicated, regular housekeeping staff linked to the unit. We were told that there was now a cook and an administration support officer which reduced the housekeeping tasks for the nurses and care staff. There are also arrangements in place for the IPC team to visit for advice and support with any issues arising.

Medicines management

During the last follow up inspection, we looked at patients' medication charts to determine whether medicines were being prescribed and administered in accordance with Mental Health Act (MHA) 1983 legislation and current professional guidelines. We also looked at the arrangements for the storage and handling of medications. The following issues were identified for improvement:

- There was limited evidence for the use of ‘as and when needed’ medication. This meant that we were unable to determine whether such ad hoc medication was administered at appropriate times and what effect it had on the patients concerned

- The medicines room was overstocked with items such as sharps containers

- A number of items stored in cupboards in the medicines room had passed their expiry date and needed to be appropriately disposed of.

What we found on this occasion was that the clinical room had been cleaned and any expired items removed. We looked at the medication administration charts and found that they had been completed correctly. Additionally there was a process in place to ensure safe administration and storage of all medication such as, audits completed by nurse on night shifts and weekly pharmacy reviews.

Effective care

Record keeping

We discussed and reviewed the content of a sample of patients' records. As a result, we found there had been a substantial improvement. There were fully completed Brief Behavioural Assessment Tool (BBAT), DoLS assessments and a range of required patient risk assessments. Although there were some Positive Behaviour Support Plans (PBSPs) in place, some were still in the

process of being developed. The service was also using the 13 Step Management Plan[12] with some patients.

The electronic FACE system continued to be in the process of being updated with patient records. The service was expecting a new learning disability suit of tools on the electronic system by January 2018. In the meantime they were developing an interim file to store records.

Improvement needed

Documentation regarding the use of least restrictive holds needs to be improved.

[12] This is a plan developed with support from a clinician with behavioural expertise following a comprehensive assessment and functional analysis of the challenging behaviour. All staff implementing this plan should be supported via appropriate levels of training and supervision.

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 services review and monitor their own performance against the Health and Care Standards.

We found that there was still no up to date final operational policy or similar guide in place to set out the direction of this particular service. We were told that some work had commenced on the individual role specifications however this was still at a senior evel and had not been cascaded to all members of staff.

We found that collaboration between senior health board managers and the unit staff team had improved significantly. There was a new unit manager in post and on the day of the unannounced inspection two senior managers were also present. Staff told us that this was a regular occurrence.

The numbers of registered nursing staff had improved and there was a full complement working within the unit at the time of this inspection.

There were still some outstanding areas of staff training.

What improvements we identified

Areas for improvement identified at last inspection included the following:

- The health board is required to provide HIW with a clear description as to how it will ensure that there are effective governance, leadership and accountability arrangements in place to guide and support the staff working at the service. This is in accordance with the Standards which state that such arrangements are essential for the sustainable delivery of safe, effective person centred care.
- The health board is required to provide HIW with full details of how it will ensure that there are always enough staff in place to work at the

service at the right time to meet patients' needs. The health board is also required to inform HIW about how it intends to reduce staff overtime hours and create a shift pattern that is more consistent with optimising individuals' health and well-being

What actions the service said they would take

- To revise and update the existing Draft Operational Policy and Equality Impact Assessment. Introduce a Clinical Governance meeting for the unit. Restructure of Learning Disability and Older Adult MH Management includes specific capacity for one service manager to take a lead on the in-patient unit. A who's who pictorial guide to the Senior Management structure is being developed and will be cascaded to all staff.

What we found on follow-up

Governance, leadership and accountability

During this follow-up inspection, we found the service to be managed and run by a staff team who demonstrated a commitment to provide safe and effective care. Conversations with staff also revealed that they were becoming clearer about their roles and responsibilities and described how they supported each other at work on a day to day basis.

However, there was still no up to date operational policy, or similar guide in place to set out the direction of this particular service. This meant that although there were new systems in place there was still a lack of strategic clarity regarding service delivery.

We found that the collaboration between senior health board managers and the staff team at the unit had improved and the visibility of senior staff was evident on the day, with the new service manager for inpatient services and the professional lead nurse on the premises when we arrived. Staff told us that communication was improving and leadership was clearer and more approachable. There was a new manager in post, who also arrived during the inspection. We saw that regular minuted staff meetings had been re-instated, and senior staff indicated that they were also available for ad-hoc meetings when they were on the premises, whether that be one-to one or in a group.

To date Clinical Governance meetings for the unit had not been established. Going forward the unit manager has taken responsibility for arranging these on a regular basis given that there is now a Head of Service in post. These should offer a more transparent and direct means of disseminating information.

As stated previously in the report we saw a who's who pictorial guide to the senior management structure which was available to all staff. This will help to identify lines of management and accountability.

Staff and resources

Workforce

There had been changes to the senior management and day to day management of the unit. This seemed to have been challenging at the beginning however, positive work changes and a more supportive atmosphere seems to have prevailed. Most staff spoke optimistically regarding the direction of change for the service.

We found that two registered nurses had been appointed to the staff team and one other had been recruited to the internal bank system. The learning disability directorate remains on the risk register with the health board regarding recruitment and retention and a plan had been developed to address the staffing deficits health board wide.

Staff had received training in many of the areas which would improve patient care however training on active support and person centred planning had still not been undertaken.

Improvement needed

The unit manager needs to ensure Governance meetings are developed.

Staff must access training which will develop the care delivered to patients namely; active support and person centred planning.

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 follow-up inspections

Follow-up inspections can be announced or 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. In some circumstances, we will decide to undertake an announced inspection, meaning that the service will be given up to 12 weeks' notice of the inspection.

The purpose of our follow-up inspections is to see what improvements the service has made since our last inspection.

Our follow-up inspections will focus on the specific areas for improvement we identified at the last inspection. This means we will only focus on the Health and Care Standards 2015 relevant to these areas.

During our follow-up inspections we will consider relevant aspects of:

- Quality of patient experience
- Delivery of safe and effective care
- Management and leadership

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. We will also highlight any outstanding areas of improvement that need to be made.

Further detail about how HIW inspects 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.			

Appendix B – Immediate improvement plan

Service: 17069

Date of inspection: 9 November 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 assurance issues identified.				

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):

Job role:

Date:

Appendix C – Improvement plan

Service: 17069

Date of inspection: 9 November 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	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The manager must ensure that bedroom door observation panels are set to closed as a default position to maintain dignity and privacy.	4.1 Dignified Care	The manager has set the observation panels to closed as the default setting. All staff informed via internal communications (handover, team meetings and supervision). Standard Operating Procedure to be written to include observation panels to remain closed as default position	Team Manager Isla McEwan	Completed 28/12/17 28/01/18

Improvement needed	Standard	Service action	Responsible officer	Timescale
The service needs to review the many different means of communication available and ensure each patient has access to the most appropriate for their individual needs. These need to be recorded in their communication passports.	3.2 Communicating effectively	Speech and Language Therapist to review means of communication available within the local setting/area. Any 'gaps' in communication provision to be identified and raised through the directorate governance structure via operational management.	Kate Richardson Specialist Speech and Language Therapist	11/04/18
		Speech and Language Therapist to ensure that communication passports are up to date and available in the patient records	Kate Richardson Specialist Speech and Language Therapist	11/04/18
The service needs to ensure that the room used as a quiet communal area is safe for use without a fire door.		The manager to organise a meeting with the HB Fire Officer to ensure the area is safe for use	Team Manager Isla McEwan	Completed
The manager needs to re-instate regular meetings with the estates department to ensure repairs are undertaken in a timely manner.		Escalation of incomplete works to be escalated through Business Performance Assurance Governance framework via operational line	Team Manager Isla McEwan	Every quarter

Improvement needed	Standard	Service action	Responsible officer	Timescale
		management structure. Service Managers to diarise attendance at staff meetings on a regular basis and provide these dates to staff teams.		
Delivery of safe and effective care				
The health board needs to be timely in its finalisation of the seclusion policy.	2.1 Managing risk and promoting health and safety	The Seclusion Policy to be ratified by the Health Board Clinical Policy review Group.	Interim Head of Nursing Nadine Morgan	28/01/18
The health board needs to review the security of the premises and the impact on privacy and confidentiality.		Manager to review access to the building for visitors and provide recommendations to the Service Manager/Head of Service. .	Isla McEwan Team Manager	01/01/18
Documentation regarding the use of least restrictive holds needs to be improved	3.5 Record keeping	Quality of documentation for least restrictive holds to be audited on a regular basis.	Service Manager Guto Davies	28/02/18 Monthly plus spot checks

Improvement needed	Standard	Service action	Responsible officer	Timescale
				thereafter
		All team members to attend a workshop session to ensure consistency of understanding of what is required.	Service Manager Guto Davies	28/02/18
Quality of management and leadership				
The unit manager needs to ensure Governance meetings are developed.	Governance, Leadership and Accountability	Manager to establish a quarterly Governance meeting which will report to the Service's Clinical Advisory Group (service wide Governance group).	Isla McEwan Team Manager	28/02/18
Senior managers attend staff meetings to discuss on going service changes.		Service Managers to diarise attendance at staff meetings on a regular basis and provide these dates to staff teams.	Service Manager Guto Davies	28/12/17
Staff must access training which will develop the care delivered to patients namely; active training and person centred planning.	7.1 Workforce	Manager to ensure staff receive active support and person centred planning training	Isla McEwan Team Manager	20/06/18

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): Nadine Morgan

Job role: Interim Head of Nursing, Mental Health & Learning Disabilities

Date: 13th December 2017