Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Follow-up Inspection (Unannounced)

Ysbyty Cwm Rhondda / Cwm Taf University Health Board / Ward B

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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 Ward B, Ysbyty Cwm Rhondda within Cwm Taf University Health Board on the 27 March 2018.

Our team, for the inspection comprised of one HIW inspection manager, one clinical peer reviewer and one lay reviewer. The inspection was led by the HIW inspection manager.

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

2. Summary of our inspection

We found that action had been taken by the health board to address the majority of the improvements needed from our last inspection[1] in 2014.

We did, however, identify that further action was needed to ensure the assessment and ongoing monitoring of patients' pain was suitably recorded within patients' care records.

Further areas for improvement were identified at this follow up inspection in relation to, ensuring care plan actions around patients' eating and drinking care needs were followed, the accuracy of information on the patient status at a glance (PSAG) board and the availability of Deprivation of Liberty Safeguards (DoLS) paperwork.

This is what we found the service did well:

- We saw an innovative approach to improving the care of patients with dementia
- Considerable efforts had been made to develop the day/dining room into a therapeutic, useable space for patients and their carers to use
- We found good compliance with the health board's mandatory training topics.

This is what we recommend the service could improve:

- The recording of both pain assessment and the ongoing monitoring of patients' pain

[1] DECI Inspection Report, Ysbyty Cwm Rhondda, 22 - 23 July 2014. http://hiw.org.uk/find-service/service-index/ysbytycwmrhondda84?lang=en

- Ensuring care plan actions around patients' eating and drinking care needs were followed
- Ensuring information on patient status at a glance (PSAG) boards is accurate
- Ensuring Deprivation of Liberty Safeguards (DoLS) paperwork is readily available for inspection.

3. What we found

Background of the service

Cwm Taf Health Board was established in October 2009 and achieved University status in July 2013. The health board provides primary, community, hospital and mental health services to people living in Merthyr Tydfil, Rhondda Cynon Taf and surrounding areas.

Ysbyty Cwm Rhondda is a community hospital located in Llwynypia. The hospital provides both inpatient and outpatient services.

Ward B has 27 patient beds which are divided to provide a mixture of multi-bedded (shared) bays and single cubicles. The ward accepts both male and female patients from other hospitals in the area who require rehabilitation care and therapy services.

HIW last inspected Ward B on 23 and 24 July 2014.

The key areas for improvement we identified included the following:

- A recognised pain assessment tool was not being used to record levels of patients' pain before and after prescribed pain relief had been given. The health board was advised of the need to ensure that patients' level of discomfort, pain or distress is assessed using a recognised assessment tool.
- The day/dining room was cluttered with equipment which meant the room was unwelcoming and rarely used by patients. The health board was advised of the need to consider the current arrangements concerning the use of this room as patients were not being provided with the opportunity to socialise with other patients, or encouraged to mobilise at mealtimes.
- Patients were not always being offered the opportunity to wash their hands prior to eating their meals. The health board was advised to ensure that patients are offered the opportunity to wash their hands

prior to eating their meals in accordance with their wishes and in-keeping with the Fundamentals of Care[2].

- Water jugs were not being routinely replenished with fresh drinking water more than once per day. The health board was advised to ensure that they provide care and support in accordance with the All-Wales Catering and Nutrition Standards.

- Some staff did not fully understand the symbols used on the patient status at a glance boards and arrangements needed to be made to ensure staff attended relevant training. The health board was advised of the need to ensure that staff are offered and provided with relevant training to ensure that they are confident and competent to meet the health, safety and welfare needs of all patients at all times. This was specifically in relation to safeguarding, dementia care, delirium and nutritional risks due to the nature of the needs associated with frail, older persons accommodated in the ward on an on-going basis.

- Most staff were not wearing identification badges. The health board was required to ensure that all staff wear visible identification for safety purposes.

- Patients were not routinely having an assessment of their mental health care needs. The health board was advised to ensure that patients' mental health and general health needs are assessed from the point of admission. This is to ensure that staff are able to plan, monitor and evaluate patient care in a more effective manner; consistent with The Fundamentals of Care.

The purpose of this inspection was to follow-up on the above improvements identified at the last inspection.

[2] The Fundamentals of Care (2003) was a Welsh Government programme which aimed to improve the quality of aspects of health and social care for adults. It contained 12 standards all relating to essential elements of care. These have been superseded by the Health and Care Standards (2015).

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 found that patients were treated with dignity and respect by a friendly, yet professional ward team.

We saw an innovative approach to improving the care of patients with dementia.

Overall, we were assured that patients' pain was well managed. Our findings identified that improvement was still needed, however, in relation to the recording of both pain assessment and the ongoing monitoring of patients' pain.

We saw that staff were wearing security (identification) passes to promote a safe environment and to help patients and their carers identify them.

Areas for improvement we identified at our last inspection

Areas for improvement identified at last inspection included the following:

- A recognised pain assessment tool was not being used to record levels of patients' pain before and after prescribed pain relief had been given. The health board was advised of the need to ensure that patients' level of discomfort, pain or distress is assessed using a recognised assessment tool.
- Most staff were not wearing identification badges. The health board was required to ensure that all staff wear visible identification for safety purposes.

What actions the service said they would take

The health board committed to take the following actions in their improvement plan dated 26 August 2014:

- The health board described it would ensure a recognised pain tool is used in assessing individual pain and that the Pain Nurse would be involved regarding the use of the pain tool. The use of the Abbey Pain Scale[3] was to be piloted for one month and if successful, rolled out to all wards in community hospitals with the health board.

- The health board described that all staff had ID badges and the requirement to wear badges was monitored. Alternative forms of identification were also being considered.

What we found on follow-up

During the inspection we distributed HIW questionnaires to patients and carers to obtain their views on the services provided. A total of four were completed and returned. We also spoke to a number of patients and their carers during the inspection.

Patient comments included the following:

> *"Completely happy when at home that my father is being well cared for and safe"*
>
> *"Plans for progression taking a long time to be put into place"*
>
> *The staff here are stretched due to lack of numbers on the ward but they are doing their best"*

Patients and/or their carers made positive comments about the care provided. Comments indicated that staff were always polite to patients and their friends/family and that care was provided in a kind and sensitive manner.

Dignified care

We saw that staff treated patients with kindness and courtesy. We also saw that patients' privacy and dignity was maintained when staff were helping them with their personal care needs. This was achieved by closing doors to single cubicles and drawing dignity curtains around beds in multi-bedded bays.

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[3] The Abbey Pain Scale is designed to assist the assessment of pain in those patients who cannot clearly express their needs.

The staff team had implemented 'natural awakening' on the ward. This approach aimed to improve the experience for those patients with dementia by allowing them to wake naturally. Senior staff described that changes to the ward routine had been made to promote a quieter and calmer ward environment to allow patients to have a more natural waking pattern.

We reviewed the care records of four patients. We saw evidence to support that nursing staff had made enquires about patients' pain. The records did not demonstrate, however, that all the key elements of a pain assessment had been considered, including the type and location of pain. A pain intensity assessment/monitoring tool was available but this was not being consistently used or always completed for those patients identified as having pain. In addition the pain intensity tool in use relied on patients being able to verbalise their pain and so, therefore, may not be suitable for those patients with impaired cognition and those unable to communicate.

We found that patients had been prescribed and were receiving analgesia (pain reliving medication). Entries within one of the patients' records also demonstrated that staff had requested a review of the patent's analgesic during an acute painful episode. We observed that the patients appeared comfortable. Comments from those patients we spoke to also confirmed this and that staff had administered analgesia when needed. This provided us with overall assurance that patients' pain was being effectively managed by the staff team. Our findings identified that improvement was still needed, however, in relation to the recording of both pain assessment and the ongoing monitoring of patients' pain.

Improvement needed

The health board is required to provide HIW with details of the action taken to demonstrate that staff are:

- completing all the key elements of a pain assessment
- consistently monitoring patients' pain.

Consideration must be given to those patients who are unable to verbalise their pain.

Patient information

Signage within the ward was clear and easy to see. Toilet and washing facilities were clearly marked. There were a number of patient/carer information leaflets readily available. There were also notice boards with the names and designation of staff on duty displayed. Information about pressure sore prevention and care, planned activity events and ward audit activity was also displayed.

During the course of our inspection we saw that staff were wearing security (identification) passes to promote safety on the ward. Staff were also wearing different coloured uniforms to assist patients and their carers to correctly identify the different grades of staff working on the ward.

Delivery of safe and effective care

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

We saw that the ward was clean, tidy and clear of clutter.

Considerable efforts had been made to develop the day/dining room into a therapeutic, useable space for patients and their carers to use.

We found that patients had been assessed for their risk of developing pressure sores and falls. Written care plans were in place to help direct staff.

Whilst, we found that patients had been assessed to identify their eating and drinking needs, care planning actions had not always been followed. We saw that staff prepared patients for their meals and provided assistance as needed. Patients confirmed that drinking water was always available and our observations supported this.

Whilst, we were assured that the Deprivation of Liberty Safeguards (DoLS) process was being used, a complete set of paperwork to demonstrate the process was not always readily available. In addition associated timescales were not always being met.

Areas for improvement we identified at our last inspection

Areas for improvement identified at last inspection included the following:

- The day/dining room was cluttered with equipment which meant the room was unwelcoming and rarely used by patients. The health board was advised of the need to consider the current arrangements concerning the use of this room as patients were not being provided with the opportunity to socialise with other patients, or encouraged to mobilise at mealtimes.

- Patients were not always being offered the opportunity to wash their hands prior to eating their meals. The health board was advised to

ensure that patients are offered the opportunity to wash their hands prior to eating their meals in accordance with their wishes and in-keeping with the Fundamentals of Care.

- Water jugs were not being routinely replenished with fresh drinking water more than once per day. The health board was advised to ensure that they provide care and support in accordance with the All-Wales Catering and Nutrition Standards.

- Patients were not routinely having an assessment of their mental health care needs. The health board was advised to ensure that patients' mental health and general health needs are assessed from the point of admission. This is to ensure that staff are able to plan, monitor and evaluate patient care in a more effective manner; consistent with The Fundamentals of Care.

What actions the service said they would take

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

- The health board described it would ensure patients are given the opportunity to eat their meals in the day/dining room. Alternative options were being trialled and going to be explored to enable patients to socialise with other patients at meals times. In addition volunteers and ward staff were to continue to arrange different events to encourage and enable patients to socialise.

- The health board described that patients are frequently encouraged to change their position and to mobilise when able. The health board also confirmed that patients' skin state was monitored on a regular basis.

- The health board described arrangements for ensuring that patients' mental health and wellbeing were considered from admission.

What we found on follow-up

Managing risk and promoting health and safety

The ward environment was clean and tidy. Patients' areas were free of obvious tripping and other hazards.

Considerable efforts had been made to develop the day/dining room into a therapeutic, useable space for patients and their carers to use. The room was appropriately furnished, brightly decorated and free from clutter. We saw evidence of therapeutic activities having taken place and information was

displayed about forthcoming events. Our findings indicated that sustained improvements had been made by the health board to provide patients with a suitable area to socialise, partake in activities and eat their meals according to their needs and wishes.

We were told that sometimes the room was used as an escalation area to accommodate an additional patient at times of increased patient demand on the service. This meant that the room could not be used during such times. Senior staff confirmed that this did not happen very often.

Preventing pressure and tissue damage

As described previously, we reviewed the care records of four patients. We found that patients had been assessed for their risk of developing pressure sores. A recognised risk assessment tool had been completed for each patient and written care plans were in place to direct nursing staff as to the care required. We also saw that monitoring records had been completed that showed staff had checked patients' skin regularly for signs of pressure and tissue damage. Specialist pressure relieving mattresses were being used and appeared to be functioning correctly.

Information about pressure sore prevention and care was displayed for patients and their carers to read. This helped them to understand the causes of pressure sores, how they can be prevented and the care patients may receive whilst in hospital.

Safety crosses[4] were clearly displayed within the ward for patients, their carers and staff to see. These included a safety cross providing information on the number of patients who had developed a pressure sore whilst on the ward. This allowed the ward team to see, via a simple system, the incidence of pressure sores with the intention of taking timely action to prevent them. This demonstrated a positive approach was being taken by the ward team in relation to pressure sore prevention and care.

[4] The Safety Cross has been adapted from industry to make highly visible the incidence of avoidable adverse events. In doing so it ensures that the whole team is aware of avoidable events and thus instils a sense of purpose in working to avoid future events.

Falls prevention

Within the sample of patients' care records we reviewed, we found that patients had been assessed for their risk of falls and written care plan plans were in place. We also saw that staff had taken action to reduce the risk of patients falling and sustaining injuries associated with falls whilst on the ward. Specialist beds were available and being used in this regard.

As mentioned previously, safety crosses were displayed. These included a safety cross for falls, which showed the number of falls that had happened. Again this demonstrated a positive approach to falls management.

Nutrition and hydration

As previously described, we reviewed the care records of four patients. These showed that patients had been screened using a recognised screening tool (MUST)[5] to identify their eating and drinking care needs. We saw that written core care plans had been implemented according to the MUST score. The care records of two patients indicated that they were being monitored and their care reviewed in accordance with their written care plan. The care plans for the other two patients instructed staff to monitor the patients' dietary intake. The monitoring charts had not been maintained, however, in accordance with the written care plan. There was also inconsistency between the information recorded on the patient status at a glance (PSAG) board and that recorded within the care records of one of the patients. We informed ward staff of our findings so that appropriate action could be taken.

We observed a meal being served and saw that patients who were able to walk were assisted to the sinks to wash their hands. Those patients who were unable to get out of bed were offered hand wipes and provided with assistance as required. We saw that meals looked appetising and were served promptly. Those patients that required help were assisted by nursing staff or family members/carers.

[5] The Malnutrition Universal Screening Tool (MUST) is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

We saw that water jugs and cups were placed on bed tables and within easy reach of patients. We also confirmed that a selection of drinks and meals were available and patients that required therapeutic diets were catered for. Comments made within questionnaires indicated that patients always had access to drinking water and that staff provided assistance at mealtimes when required.

Improvement needed

The health board is required to provide HIW with details of the action taken to ensure that actions relating to patients' nutrition and hydration care needs are completed as prescribed in their care plans.

Safeguarding children and adults at risk

We considered the arrangements for the assessment of patients' mental health care needs. Senior staff described that nursing staff would conduct an assessment when patients were transferred to the ward. Within the sample of care records we reviewed we could not find evidence to support this process.

We were able to confirm, however, that where staff felt that patients lacked capacity to make decisions about their care and treatment, relevant assessments had been completed as part of the Deprivation of Liberty Safeguards (DoLS) authorisation process. This was to ensure that patients' rights were protected. Whilst we were assured that the DoLS process was being used, a complete set of paperwork to demonstrate the process was not always readily available for inspection. In addition, timescales for authorising DoLS application were not always being met.

Improvement needed

The health board is required to provide HIW with details of the action taken to ensure that:

- mental health assessments conducted by nursing staff are evidenced within patients' care records
- relevant DoLS paperwork is complete and readily available
- timescales are adhered to in relation to DoLS authorisations.

Effective care

Safe and clinically effective care

The ward had two PSAG boards. Staff were able to describe the symbols used on the boards (see section - Quality of management and leadership). We found that one was used much more than the other as a communication tool. As described earlier, we also identified an inconsistency between the information on the board and that in a patient's care records.

Improvement needed

The health board is required to provide HIW with details of the action taken to ensure that the information on the PSAG boards is accurate.

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.

Staff were knowledgeable around the needs of the patients accommodated on the ward. They could also describe the symbols used of the patient status at a glance (PSAG) boards.

We found good compliance with the health board's mandatory training topics and staff confirmed that they had attended training on other topics relevant to their role.

Areas for improvement we identified at our last inspection

Areas for improvement identified at last inspection included the following:

- Some staff did not fully understand the symbols used on the patient status at a glance (PSAG) boards and arrangements needed to be made to ensure staff attended relevant training. The health board was advised of the need to ensure that staff are offered and provided with relevant training to ensure that they are confident and competent to meet the health, safety and welfare needs of all patients at all times. This was specifically in relation to safeguarding, dementia care, delirium and nutritional risks due to the nature of the needs associated with frail, older persons accommodated in the ward on an on-going basis.

What actions the service said they would take

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

- The health board described that arrangements would be made to explore further training around the use of the PSAG board and to ensure staff were nominated to attend other relevant training.

What we found on follow-up

Staff and resources

Workforce

During the course of our inspection, we spoke to staff who demonstrated an understanding of the patient status at a glance (PSAG) board and the symbols used. The ward had two PSAG boards and we found that one was used much more than the other as a communication tool. As described earlier, we also identified an inconsistency between the information on the board and that in a patient's care records.

Our findings indicated that staff were knowledgeable around the care needs of patients accommodated on the ward. Senior staff provided a training matrix and overall this showed good compliance with the health board's mandatory training topics. We spoke to a number of staff who confirmed that they had attended training relevant to their role. This included the care of patients with dementia and care of patients with swallowing difficulties (i.e. using thickener to allow patients to drink safely). Staff explained that they had attended this training over a year ago. The health board should explore whether a programme of ongoing refresher training would be useful for staff. As described previously, the ward had introduced natural awakening to promote the effective care of patients with dementia.

Senior staff explained that a training coordinator had previously been in post but had since had to return to clinical duties. Senior staff felt that the training coordinator was a very useful resource and that since this post had been removed, additional pressure had been placed on ward managers to oversee training.

Whilst not particular a focus of this follow-up inspection, we were made aware of some challenges around maintaining the ward's staffing skill mix. This was attributed to staff sickness and vacancies. Senior staff confirmed that when needed, bank and agency staff were used to covers shifts. We were told that it was often not possible to secure a third registered nurse to work and so a healthcare support worker was used to maintain staffing levels. Wherever possible, regular bank and agency staff were used to promote continuity of care to patients. At the time of our inspection, we were told that the level of staff sickness was reducing and that the health board was actively recruiting to the vacancies. The commitment of the staff team to cover shifts and provide patients with high quality care was evident.

Improvement needed

The health board is required to provide HIW with an update on the action taken to ensure:

- the skill mix of staff on each shift is suitable to meet the care needs of patients, and
- is in accordance with agreed staffing establishment for the ward.

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 on this inspection.	-	-	-

Appendix B – Immediate improvement plan

Service: Ysbyty Cwm Rhondda, Ward B

Date of inspection: 27 March 2018

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 improvement plan was required.				

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: Ysbyty Cwm Rhondda, Ward B

Date of inspection: 27 March 2018

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 health board is required to provide HIW with details of the action taken to demonstrate that staff are: • completing all the key elements of a pain assessment • consistently monitoring patients' pain. Consideration must be given to those patients who are unable to verbalise their pain.	4.1 Dignified Care	Review training needs in terms of use of Abby tool documentation with all team members Provide further training/ input from pain specialist nurse, including observations of patients unable to verbalise pain Undertake observations of care to identify best practice as highlighted by HIW team Audit assessment of patients to provide assurance regarding consistent	Ward Manager, Gemma Price Davies Senior Nurse , Kerry Parry	September 18

Improvement needed	Standard	Service action	Responsible officer	Timescale
		approach Provide positive observational feedback of HIW team		
Delivery of safe and effective care				
The health board is required to provide HIW with details of the action taken to ensure that actions relating to patients' nutrition and hydration care needs are completed as prescribed in their care plans.	2.5 Nutrition and Hydration	Review process of nursing input at mealtimes Audit of practice Provide HIW feedback to team and importance of linking mealtimes and nutritional assessment of patients	Ward Manager, Gemma Price Davies Senior Nurse, Kerry Parry	July 18
The health board is required to provide HIW with details of the action taken to ensure that: • mental health assessments conducted by nursing staff are evidenced within patients' care records • relevant DoLS paperwork is complete and readily available • timescales are adhered to in relation	2.7 Safeguarding children and adults at risk	Ensure all assessments and referrals are acted on same day. In the absence of ward clerk assessing clinician must forward referral to corporate team. All staff to be made aware of requirement in staff meeting and during handover Conduct audit of process June 18	Ward manager, Gemma Price Davies Senior Nurse, Kerry Parry	June 18

Improvement needed	Standard	Service action	Responsible officer	Timescale
to DoLS authorisations.				
The health board is required to provide HIW with details of the action taken to ensure that the information on the PSAG boards is accurate.	3.1 Safe and Clinically Effective care	Audit of PSAG board to provide assurance regarding accuracy of information Highlight to team during handover, ward meetings the importance of updating Review use of PSAG boards	Ward manager, Gemma Price Davies Senior nurse, Kerry Parry	July 18
Quality of management and leadership				
The health board is required to provide HIW with an update on the action taken to ensure: • the skill mix of staff on each shift is suitable to meet the care needs of patients, and • is in accordance with agreed staffing establishment for the ward.	7.1 Workforce	Skill mix 3 qualified: 3 healthcare support workers by day , ward manager supervisory 2.5 days Skill mix 2 qualified:2 health care support workers by night Bank, overtime & agency authorised through ward manager to senior nurse Enhanced care policy in use for additional staff and risk assessments in place Monitoring by senior nurse Monitoring by senior team through trend	Ward manager , Gemma Price Davies Senior Nurse, Kerry Parry	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		analysis, finance, compliments, concerns & datix		

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): **Mrs Lynda Williams / Mr Alan Lawrie**

Job role: **Director of Nursing, Midwifery and Patient Care / Director of Primary, Community and Mental Health**

Date: **25 May 2018**