Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Hywel Dda University Health Board - 21003

Activity date: 1 November 2021

Publication date: 19 January 2022

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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

Website: www.hiw.org.uk

Digital ISBN 978-1-80391-592-0

Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of a setting within Hywel Dda University Health Board as part of its programme of assurance work. The setting is a mixed gender, three-bedded, in-patient service, specialising in the care of adults (18-65), who have autism spectrum disorders or learning disabilities. At the time of the quality check there were three patients resident at the setting.

Following our quality check, the setting temporarily closed and we were told that the unit is now empty This allows the scheme of estates work to be completed before the setting once again becomes a clinically occupied space.

HIW's quality checks form part of a new tailored approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks are a snapshot of the standards of care within healthcare services. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to assurance and inspections can be found here.

We spoke to the professional lead for learning disability nursing on 1 November 2021 who provided us with information and evidence about their service. We used the following key lines of enquiry:

- How is the risk of infection assessed and managed to keep patients, visitors and staff safe?
- How do you identify and effectively manage COVID-19 outbreaks / nosocomial transmission?
- How are you ensuring that the environment is safe and suitable for the needs of patients at this time? What changes, if any, have been made as a result of COVID-19 to the following:
    - Physical environment
    - Routines, visiting arrangements and contact with loved ones
    - Behaviour management

    - Patient access to community/leave, activities and social networks (including formal leave where the Mental Health Act applies)?
- How do you meet the needs of Welsh speaking patients when accessing healthcare services in the medium of Welsh?
- How are you ensuring that there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider health and care professionals where needed?
- How do you ensure that equality and a rights based approach are embedded across the service?
- What arrangements are in place to ensure Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) discussion and decision making is undertaken appropriately and sensitively?
- Considering the impact of COVID-19, how are you discharging your duty of care against the Mental Health Act and DOLS legislation, and how are patients' rights being safeguarded?

Environment

During the quality check, we considered how the service had responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- The most recent workplace assessments relating to the environment of the setting
- Ligature Risk Assessments
- Fire safety policies/procedures, including fire safety risk assessment (if applicable).

We also questioned the service representatives on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

The lead professional nurse for learning disability nursing informed us of the measures taken since the pandemic to protect patients and staff within the environment of the setting. We were told that since the start of the pandemic patients had been supported by the staff to understand the increased restrictions in place due to COVID-19. We were told that changes to restrictions were communicated verbally to patients in a manner which they could best understand and that this information was also available to them in an easy-read format.

To ensure patients could keep in touch with friends and family, we were informed that the health board had purchased additional iPad at the start of the pandemic to allow for video

calls to take place between patients and their loved ones in lieu of physical visits. In addition, patients had open access to a ward telephone. Since restrictions had eased, visiting had been allowed to take place at the setting providing the visitors had proof of a negative lateral flow test result[1]. In addition, relatives and carers were encouraged to contact the ward, where appropriate, to check on patient well-being

We were informed that since the pandemic, access to the setting's minibus for those patients detained under the Mental Health Act[2], but granted section 17 leave[3], had been restricted with use on a patient by patient basis only. We were told that each patient would be accompanied by two members of staff and this allowed for adequate social distancing whilst on the minibus. The minibus would be cleaned with disinfectant wipes in between each use to prevent cross infection between patients. To ensure equity of use, we were informed that a weekly timetable had been formulated. This allowed for patients to attend healthcare appointments outside of the setting and also for each patient to access leisure activities, such as walking on the beach or a trip to local shops, should they wish.

Prior to restrictions easing and during the height of the pandemic, we were told that staff encouraged patients to engage in activities that they enjoyed and found worthwhile. We were told that this would include supporting patients to access online activities, to engage in baking within the setting, or very brief accompanied visits to the local shop.

We asked the setting what arrangements were in place for patients who wished to communicate through the medium of Welsh. We were told that the setting had a large percentage of Welsh speaking staff and that this meant patients could easily converse in Welsh, should they wish. We were informed posters were displayed within the setting encouraging patients to communicate through Welsh and that each patient was asked upon admission, if appropriate, in which language they preferred to communicate.

The following areas for improvement were identified:

We saw evidence that the setting had not completed a Fire Risk Assessment (FRA) since August 2020. This FRA highlighted some very serious risks to patient and staff safety and required a number of urgent improvements that were included on the Fire Action Plan attached to the FRA. These included the urgent replacement of an obsolete fire detection system, obstructed fire exits and inadequate fire doors, where there were excessive gaps allowing for smoke ingress in the event of fire. None of the actions required had been completed at the time of the quality check.

[1] Lateral flow device (LFD) tests are administered to people showing no symptoms of COVID-19 but who may still be infectious. LFD testing is a quick way to determine whether you have the virus on the day of the test. Patients typically receive results within 10 to 30 minutes.

[2] The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others

[3] Section 17 leave may be used to grant shorter periods of leave from hospital in the build up to discharging patients

We saw evidence of a recent ligature risk assessment completed in February 2021. This identified a significant number of ligature risks throughout the setting. These included window and door handles within patient bedrooms, taps within patient bathrooms and multiple ligature points within communal areas both internally and in the garden areas of the setting. However, at the time of the quality check no remedial action had yet taken place to the environment to rectify the ligature risks documented.

HIW saw evidence of a workplace assessment completed in September 2021 by the previous ward manager. This documented a very poorly maintained building with a high level of disrepair throughout internal and external areas. Areas of significant concern to the external building included poorly maintained guttering, windows and external rendering that allowed water ingress and flooding to occur during wet weather. Further, the assessment identified windows throughout the building to be missing architrave and the foam around the windows was rotting allowing for further water ingress. Additionally, doors to the outside of the building did not provide an adequate seal, again allowing water into the building in wet weather. Lighting was reported to be poor in some areas and very bright in others, with glass fittings that were filled with dead insects, without the ability to dim if necessary. General air flow through the setting was documented as poor and the setting was frequently uncomfortably hot and noisy, this was noted to be a risk for increasing the likelihood of challenging behaviour from patients.

There were further concerns identified in the workplace assessment that included windows to one patient bedroom that had been bolted shut due to the risk of the patient absconding. This meant that air flow and the ability to effectively regulate the room temperature was also affected. It was noted that patient bedrooms were only accessible via a key, increasing the risk of harm in the event of a fire or of self-harm. Another door to a patient bedroom did not contain a window, or similar, in the door, thereby preventing observation by staff should this be necessary.

The assessment further identified that the garden and outdoor areas were documented as being poorly maintained, dangerous and containing multiple items which patients could harm themselves or others. The garden areas contained rotting garden furniture with exposed rusting nails, overgrown trees that were reported as an aid to patients absconding. There were damaged polytunnels[4] that posed a significant ligature risk and areas of broken paving that were reported as a risk as they could be used as a weapon. A green algae type substance was reported as growing on the walls and the external fabric of the building and a roof area was reported as being covered in moss. The unsafe and unsuitable nature of the exterior grounds reported within the workplace assessment of the setting prevented use by the patients for therapies or to enhance their well-being.

[4] A polytunnel (also known as a polyhouse, hoop greenhouse or hoophouse, grow tunnel or high tunnel) is a tunnel typically made from steel and covered in polyethylene, usually semi-circular, square or elongated in shape. The interior heats up because incoming solar radiation from the sun warms plants, soil, and other things inside the building faster than heat can escape the structure.

During the quality check we were told by the lead professional nurse that the building was “not fit for purpose”, as the environment could not meet the needs of the changing patient population. They informed us that they felt the unit should be closed to allow full refurbishment to take place and to ensure an environment that was suitable for the patients.

As a result of the above findings HIW had significant concerns regarding the risk to immediate patient safety at the setting. These concerns were raised immediately with the health board and the fire service via our immediate assurance process, where we write to a service within two days of an inspection or quality checks requiring remedial actions to be undertaken to address the most concerning issues and tackle the areas of highest risk without delay. We have since received assurance from the health board that the areas of concern highlighted within this report and the immediate assurance document sent to the setting were being promptly addressed.

It was documented in the review evidence that patients were segregated for long periods of time. Such levels of segregation from others may inhibit personal growth and development and HIW require assurance as to the context of this long term segregation and whether any of the patients are in fact in long term seclusion. Seclusion was evidenced as a reactive response to challenging behaviours, as was the use of a low stimulus room. HIW required assurance regarding the use of low stimulus rooms in comparison to time out of seclusion, as low stimulus rooms were not referred to in the health board seclusion policy.

In relation to seclusion, HIW require assurance that these strategies are being appropriately managed within the confines of the Mental Health Act (1983) and are detailed in individual care plans alongside opportunities for personal skills development.

The health board must provide assurance that long term segregation or seclusion is appropriately managed within the confines of the Mental Health Act (1983). Additionally, this must be in keeping with individual patient care plans to ensure and allow opportunity for personal skills growth and development.

Infection prevention and control (IPC)

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- Current infection rates for any healthcare acquired infections and copies of investigation reports where there have been cases of COVID-19 outbreaks / nosocomial transmission on the ward.
- Generic infection control policies and Covid-19 specific policies
- Most recent infection control risk assessments / audits
- Cleaning schedules.

The following positive evidence was received:

The professional lead nurse for learning disabilities within the health board provided evidence of the systems in place to ensure IPC, including those measures to prevent the transmission of COVID-19 used by the setting.

We were told that each patient would be screened for COVID-19 on admission to the ward and their individual vulnerability was also assessed. Those patients who had not had a COVID-19 vaccination were offered one, where appropriate, and patients were asked to undergo a weekly Polymerase Chain Reaction (PCR) test to check for evidence of a COVID-19 infection. Patients were also encouraged to wear a facemask when necessary, if possible. Each patient would be assigned a staff team for care throughout the patient journey during the pandemic, to prevent cross infection with COVID-19. We were told that the health board had taken part in making a video for patients with learning disabilities, to help them understand the changes that had taken place within hospital settings and to inform them of what to expect when going into hospital.

Ward staff were expected to undertake a lateral flow test twice a week on set days, the results were recorded on a dedicated ward log sheet. At the height of the pandemic staff would wear personal protective equipment (PPE) over their uniforms. Dedicated donning and doffing[5] areas were allocated to allow staff to change into and out of PPE and we were told that staff had been fit tested for filtering face piece masks (FFP3)[6] in case they were required. We were told that all staff had completed mandatory COVID-19 online training, which included how to correctly don and doff PPE.

We were informed that cleaning regimes had increased within the setting. Surfaces would be

[5] Donning – putting on personal protective equipment (PPE); Doffing – taking off personal protective equipment (PPE)

[6] A Filtering Face Piece Mask (FFP3) is a particular design of mask that fits closely to the face and provides enhanced protection against moisture and aerosols

cleaned with detergent wipes three times per day and all staff were expected to wear a face mask. Hand gel was readily available throughout the ward for all patients, staff and visitors to use and we were told that the setting enjoyed strong links with the IPC team and were well supported by them.

We asked the setting the arrangements for ensuring that staff had sufficient stock of PPE. We were told that the setting had not experienced any difficulties with sourcing adequate supplies of PPE. A dedicated member of staff was responsible for checking stock levels and ordering supplies of each item of PPE. In addition, the service had a dedicated supply of PPE for mental health and learning disability settings within the health board. We were told that in addition to traditional facemasks, transparent facemasks to allow patients to see facial expressions had been purchased in order to help those who might find traditional masks a hindrance to communication. We were informed that the health board also had a PPE champion who would regularly attend the setting to ensure the correct PPE was being worn by staff.

We asked the setting how they ensured that all staff were kept informed of updates to guidance and policy relating to IPC and were told that the setting had a dedicated page on the staff intranet that would display any updates to current guidance. Additionally, important documents were printed and made available to all staff via a staff noticeboard and email.

We were provided with evidence of a comprehensive COVID-19 policy, COVID-19 risk assessments and a generic infection control policy that was in date, version controlled and adhered to national guidelines to protect patients, staff and visitors.

The following areas for improvement were identified:

During the quality check call we were told that staff at the setting were no longer wearing their healthcare uniforms at work. We were informed that this was because the restrictions surrounding COVID-19 had eased. However, personal care and housekeeping duties as well as additional environmental cleaning responsibilities due to COVID-19, were undertaken by staff members. The health board should ensure they have adequately considered the specific patient groups and care needs and whether healthcare uniforms or own clothing are the most appropriate within their settings. In this particular setting, considering the patient group has been changing, a clear policy would help staff in ensuring they are following the most up to date health board guidelines.

The health board must ensure that they have a uniform policy which has considered all patient groups, and what to do in relation to uniform when a patient group changes. This must be clearly communicated to staff so that they are clear about whether healthcare uniform or own clothes meet the needs of the patient group and setting requirements.

In addition it was documented within the workplace assessment document that the setting

had only one wet room shower unit available. As this formed part of an ensuite bathroom we were not assured that patient dignity and privacy could be respected. The sink within this single shower room had been removed due to an incident involving challenging behaviour, therefore preventing adequate handwashing after using the toilet and to brush teeth. Patients were directed to wash their hands in an alternative bathroom area after using the toilet. This bathroom contained items which patients could harm themselves or others.

The health board must provide assurance that:

- appropriate handwashing facilities are available for patients after using the toilet
- bathroom facilities must ensure that patient privacy and dignity is respected.

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they had adapted their service. We explored whether management arrangements ensured there were sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed.

The key documents we reviewed included:

- Informed consent policies / procedures
- Escalation policies
- The most recent audit/review of the detention paperwork for patients subject to the Mental Health Act 1983, along with an action plan of how any areas identified will be addressed
- Corporate policies/processes to ensure preparedness for future pandemic emergency
- Business continuity plans
- Mandatory training records for all staff
- The current percentage completion rates for mandatory training
- Risk assessments undertaken in relation to infection prevention and control, environment and staff health and safety
- Details of incidents and action taken to resolve
- Details of incidents; specifically incidents of challenging behaviour, restraint and seclusion
- The number of safeguarding referrals
- Patient voice data
- Parent / carer voice data

The following positive evidence was received:

We were told that all staff undergo annual appraisals and receive regular supervision from an

allocated supervisor within the service. Prior to the pandemic, regular staff meetings were held that allowed staff to voice any concerns they had.

We were told that a staff well-being service, in place prior to the pandemic, had been further developed to offer support to staff. In addition, a range of well-being clubs and activities had been implemented to promote staff satisfaction within the health board and the development of green spaces within the health board as a whole, was being encouraged. Home working was encouraged for those staff able to work remotely.

We asked the setting to describe how patient needs were met and their rights upheld while at the setting. We were told that all patients had a health profile [7] which detailed their individual needs should they need to go to another hospital department. We were also informed that the health board had an active department that monitored the legal processes and the up-holding of the rights of those detained under the Mental Health Act (1983). Patients were able to access mental health tribunals and patients were supported if they wished to challenge their legal detention. However, the tribunals and support were accessible virtually or via the telephone.

Staff at the setting informed us that this did impact on patient accessibility. However, support was available from an advocacy service should it be required. HIW were informed that legal representatives would regularly visit the setting to provide advice to patients. Literature received from the tribunal service would be explained to the patients by staff and decisions made by the tribunal service would be transferred into an easy read format by the speech and language team at the setting.

The following areas for improvement were identified:

We received evidence of staff sickness absence and vacancy data from the setting. This showed that the service did not have a permanent senior nursing team in place and had several nursing staff vacancies. We were told that this was due to recently implemented changes to the service provision and to the patient population. Closer inspection of this data revealed that the high level of sickness absence was due to staff stress and anxiety with many staff absent without a planned return date. Many staff members had been absent from their roles for some time.

We reviewed evidence provided to us of a violence and aggression assessment undertaken at the setting by the most recent senior nurse. This documented that staff at the setting felt highly stressed, unsupported and anxious in their roles and they often felt at threat of violent and aggressive behaviour from patients. During the quality check call we were told that staff felt that they did not have the skill set, knowledge or experience necessary to appropriately care for the highly complex patients at the setting, resulting in the high levels of staff sickness and absence. Following an incident of violent or aggressive behaviour from a patient, we were

[7] A health profile is a document that accompanies a patient with learning disabilities or communication difficulties into hospital to inform NHS staff of those difficulties, likes, dislikes and other important information

told that staff would be informally debriefed but may not always receive appropriate support. We were informed that senior staff within the health board were not always made aware of incidents of violent and aggressive behaviour as staff within the ward often did not report such incidents. Therefore, support and encouragement for learning on a managerial level was not always provided in a timely manner.

It was documented in the violence and aggression risk assessment, that staff did not feel supported by police when calling for assistance during a violent incident. Additionally, following review of this assessment, we were not assured that staff were confident of the correct procedures to undertake should a patient become violent and aggressive towards them. The document noted that there were not enough personal safety alarms for staff to use, that they were difficult to operate, and if needed while in the outdoor space at the setting, would require an alarm to be activated and then thrown a considerable distance towards a boundary fence in order for them to sound.

HIW requires assurance from the health board that:

- Action will be taken to provide ongoing support to staff to promote and maintain staff safety and well-being
- The skill set and knowledge of staff at the setting will be improved to ensure the patient group at the setting are cared for appropriately and in line with best practice
- Our findings are not indicative of a systemic failure to provide safe and effective care across all services
- Staffing levels within the service are appropriate to meet the needs of the patients at the setting at all times.

As a result of the above findings HIW had significant concerns regarding the risk to immediate staff safety at the setting. These concerns were raised immediately with the health board via our immediate assurance process, where we write to a service within two days of an inspection or quality checks requiring remedial actions to be undertaken to address the most concerning issues and tackle the areas of highest risk without delay. We have since received assurance from the health board that the areas of concern highlighted within this report and the immediate assurance document sent to the setting were being promptly addressed.

During the quality check process we asked to see evidence of recently collected patient voice data[8]. Although we were informed that a pilot form was being developed by specialist Speech and Language practitioners and senior staff, we were told during the quality check call that this data was not currently collected by the service as they felt that the forms were not in a suitable format to be used by the patient group. We were told that upon discharge, carers would not fill in the forms and that if they offered to help patients to fill them in at the setting, patients would acquiesce. Therefore data would not be reflective of the patient's voice and thoughts on the service provided at the setting. We saw evidence of a feedback form

[8] Patient voice data relates patient experience whilst on the ward or at the setting and is a means of allowing patients and carers to feedback to the service about their experience of their care

provided to patients after they had been subject to physical restraint. However incident logs did not collect data from these forms and did not specify if a patient had received the form after undergoing a physical restraint. Without collecting patient voice data, the quality of the service and patient experience cannot be known and improvements cannot be made.

HIW requires assurance from the health board that:

- Every effort is made to gather patient voice data on their views of the service provided by the setting
- Patients are able to provide feedback on their experiences of physical restraint.

HIW asked the setting to describe the arrangements for ensuring that staff completed mandatory training. We were told that staff training records were kept electronically on a central database. Due to the pandemic, most mandatory training was accessible online for staff to complete. Whilst this demonstrated an overall satisfactory rate of compliance, there were several key areas where compliance was low and inadequate for the setting. This included fire safety training, adult basic and immediate life support and safeguarding children and adults.

HIW requires assurance from the health board that staff compliance with mandatory training is completed.

We were informed that due to long term sickness absence, the patients at the setting did not have access to occupational therapy support within the unit. This meant that patients did not have targeted support in a range of therapeutic activities to encourage and develop their skills for independence and growth within the hospital setting.

HIW requires assurance from the health board that patients are provided with appropriate activities that are targeted to improve their independence, development and growth.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the areas for improvements identified will be sufficiently addressed

- Ensure required evidence against stated actions is provided to HIW within three months of the quality check.

As a result of the findings from this quality check, the service should:

- Ensure that the areas for improvements 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.

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

Improvement plan

Setting:	21003
Ward/Department/Service (delete as appropriate):	Hywel Dda University Health Board
Date of activity:	1 November 2021

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

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	HIW requires details of how the health board will assess and address all risks to fire safety within the unit.	**Standard 2.1** Managing Risk and Promoting Health and Safety	There are currently no patients on the unit. Detailed risk assessments have been undertaken, and corresponding action plans are being developed in order to address the concerns raised in the report.	Fire Safety Officer	March 2022
2	HIW requires details of how the health board will ensure that the	**Standard 4.1** Dignified Care	A capital bid was submitted to Welsh Government, this was	Director of Estates/Head	March 2022

	environment is adjusted and maintained to ensure that environmental triggers to challenging behaviours are reduced and to allow patients access to suitable outdoor space		successful, works have been approved and will commence in January. This includes a secure boundary fence to facilitate access to outside space.	of LD services	
3	HIW requires details of how the health board will ensure that appropriate access to toilets, bathrooms and handwashing facilities will be provided for patients at the service.	**Standard 2.4** Infection prevention and Control (IPC) and Decontamination	All bedrooms are en-suite and as such the bathroom is for the sole use of the patient using that bedroom. Where any situation arises that the bathroom facility is not appropriate for the individual there is an adapted bathroom available for use. All bathrooms should have a full range of handwashing and toileting facilities any defect is reported immediately for action by the estates team and an alternative bathroom for sole use offered to the individual.	Senior Nurse	March 2022
4	HIW requires details of how the health board will ensure the risk to patients from ligature within the setting will be managed and avoided to prevent harm to	**Standard 3.1** Safe and Clinically Effective Care	A capital bid was submitted to Welsh Government, this was successful, works have been approved and will commence in January. This includes a	Director of Estates	March 2022

	patients at the setting.		ligature free secure boundary fence to facilitate access to outside space. The unit is currently unoccupied however when operational, risk assessment and care planning will identify any risk on an individual basis, and reasonable adjustments made.	Senior Nurse	
5	HIW requires details of how the health board will ensure the building is property maintained in order to prevent the risk of harm to patients and staff.	**Standard 2.1** Managing Risk and Promoting Health and Safety	There are currently no patients on the unit. Detailed risk assessments have been undertaken, and corresponding action plans are being developed in order to address the concerns raised in the report.	Director of Estates/Head of LD services	March 2022
6	HIW requires details of how the health board will improve the skill set and knowledge of staff at the setting to ensure the patient group cared for at the setting are done so appropriately and in line with best practice	**Standard 2.1** Managing Risk and Promoting Health and Safety	A full training needs analysis will be completed once the inpatient model has been developed and approved. This work is currently ongoing. All staff will update their mandatory training and be given experience of other	Head of Learning Disability Service Senior Nurse	February 2022 March 2022

			services to inform future practice.		
7	HIW requires assurance from the health board that our findings are not indicative of a systemic failure to provide safe and effective care across all services	**Standard 7.1** Workforce	The MH and LD Directorate has a well-established Ward Managers forum at which quality indicators for example thematic review of incidents is undertaken, this forum reports to the MH/LD Quality Safety and experience group. Once the service is re-established with new leadership they will be attending this Ward Managers forum. As part of this process the service will be included in a healthy wards check and audits as required by the service.	Senior Nurse	December 2021
8	The health board must provide HIW with details of the action to be taken to ensure that, at all times, staffing levels are appropriate in order to meet the needs of patients at the setting.	**Standard 7.1** Workforce	Once the purpose and function of the unit is established, staffing levels will be assessed, reviewed and implemented as part of the workforce review.	Head of Learning Disability Service	February 2022

9	The health board must provide HIW with details of the action to be taken to provide on-going support to staff and promote and maintain staff well-being.	**Standard 7.1** Workforce	A Senior Nurse role has been established with operational responsibility for the staff from the setting. The V&A case manager for the Health Board will continue to support the staff to feedback any concerns and offer advice as required. The PBM/PAMOVA Trainer will continue to support the staff. In addition, they will provide expert advice and analysis on reducing restrictive practice. Behavioural incidents will be analysed and a monthly report provided to the unit of levels of restrictive practice which will inform individual care planning. Staff wellbeing are developing a structured programme of support for the staff ongoing, these will be in the form of reflect and act sessions. These are opportunities to listen to	Senior Nurse Head of Culture and Workforce / senior nurse	Complete February 2022

			staff and learn from their experiences be able to understand what underlying needs there are, and look at how best to support.		
10	The health board must provide assurance that long term segregation or seclusion is appropriately managed within the confines of the Mental Health Act (1983) and in keeping with individual patient care plans, to ensure and allow opportunity for personal skills growth and development.	**Standard 3.1** Safe and Clinically Effective Care			
11	The health board must ensure that they have a policy in place to specify when it is appropriate for staff to wear their own clothing or a healthcare uniform appropriate for their role and the needs of the patient group and setting requirements.	**Standard 2.4** Infection prevention and Control (IPC) and Decontamination			

12	HIW requires assurance from the health board that: • Every effort is made to gather patient voice data on their views of the service provided by the setting • Patients are able to provide feedback on their experiences of physical restraint.	**Standard 6.3** Listening and Learning from Feedback	Develop an Easy Read version of the Patient Experience Questionnaire, linked to the friends and family test An easy read feedback form has been developed and piloted with a patient on the setting, developed jointly between SALT, PBM and Senior Nurse.	Patient Experience Manager / Senior Nurse Senior Nurse	April 2022 Complete
13	HIW requires assurance from the health board that staff compliance with mandatory training is completed.	**Standard 7.1** Workforce	The current compliance for staff in work is 88.2%	Senior Nurse	Complete
14	HIW requires assurance from the health board that patients are provided with appropriate activities that are targeted to improve their independence, development and growth.	**Standard 3.1** Safe and Clinically Effective Care			

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.

Name: Melanie Evans, Head of Learning Disabilities

Date: 8th December 2021