# Learning Disability Inspection (Unannounced)

Tan y Coed, Bryn y Neuadd Hospital

Inspection date: 19-20 October 2021

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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 receive good quality healthcare**

# Our values

**We place patients at the heart of what we do. We are:**

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

# 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 inspection of Tan y Coed Residential Unit based in Bryn y Neuadd Hospital on the 19-20 October 2021. We attended the unit briefly on the evening of the 18 October to confirm the COVID-19 status of the unit and to observe how the service delivered patient care during evening hours.

Our team for the inspection comprised of two HIW Senior Inspectors and one Clinical Peer Reviewer. The inspection was led by a HIW Senior Inspector.

HIW explored how the service met the Health and Care Standards (2015) and other relevant guidelines.

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

# 2. Summary of our inspection

Overall we found evidence that the service provided a positive patient experience, with a good level of safe and effective care delivered to its patients.

We have recommended several areas for improvement which will strengthen existing practice at the unit in line with the Health and Care Standards.

We found evidence of a well-established management team, which was supported by a committed workforce and sound local governance arrangements.

This is what we found the service did well:

- We observed kind and respectful interactions between staff and patients at all times
- There were regular and effective service user group meetings, facilitated by therapeutic support services
- There was a suitable range of standardised assessment processes in place to support patient care

This is what we recommend the service could improve:

- Develop and implement a clear service model and ethos
- Aspects of care planning, including strengthening care and treatment plans
- Aspects of risk management, particularly in relation to the environment.

Refer to Appendix C for the full improvement plan.

# 3. What we found

## Background of the service

Tan y Coed Residential Unit is based within the wider Bryn y Neuadd Hospital site and provides a rehabilitation service for people with learning disabilities. It can provide care for up to ten patients and is divided into four separate bungalows, however only three bungalows were in use at the time of our inspection due to maintenance issues.

At the time of our inspection, there were eight people staying at Tan y Coed, including one patient who was on authorised leave. This included people who had been at Tan y Coed for short and longer periods of time.

The staff team includes a unit nurse manager, deputy managers, registered nurses and healthcare support workers. Student nurses are also encouraged to work on the unit as part of their training. The unit is supported by a range of medical and therapeutic teams, including psychiatry, psychology, speech and language therapy.

The service sits in the Mental Health and Learning Disability Directorate within Betsi Cadwaladr University Health Board.

## Quality of patient experience

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

Overall we found that Tan y Coed was providing patients with a positive patient experience. We observed staff engaging with patients in a caring and respectful manner at all times.

Patients were able to provide their feedback through regular service user group meetings, with evidence of actions taken based on this feedback.

We identified a small number of improvements to further promote a quality patient experience.

We spoke to some patients and observed numerous interactions between staff and patients as part of forming a view on the quality of patient experience.

### Staying healthy

We found good evidence of standardised physical health care bundles[1] in all patient care records that we reviewed. These had been reviewed at appropriate intervals, with the exception of one plan where we noted there was confusion in relation to the frequency of blood sugar monitoring.

GP services are contracted through a local GP practice who attend the wider Bryn y Neuadd site on a weekly basis. Ward staff were complimentary about the service provided by the practice.

[1] Care bundles are used across healthcare settings with the aim of cohesively preventing and managing different health conditions

We reviewed a sample of three health passports[2] and found that these were comprehensive and up-to-date. This ensures that other health professionals are able to quickly identify the care preferences and medical needs of patients in a timely and effective manner.

Staff told us that access to other health professionals is arranged when required. For example, we confirmed patients are able to access the community dental health team based at the Bryn y Neuadd site.

Improvement needed

The Health Board must ensure that staff knowledge in relation to the frequency of individual patient blood monitoring is clarified.

## Dignified care

We observed kind and respectful interactions between staff and patients at all times throughout the course of the inspection.

The environment benefited from a small number of patients residing in each bungalow, with space across the unit maximised for individuals to all have access to their own bedrooms and smaller, shared facilities.

All patients had their own bedrooms and we found that some rooms had been personalised to provide a more homely feel. However, we noted that other rooms lacked a sense of personalisation.

We found that patients were assisted with their personal hygiene needs when required and that staff were responsive in meeting these needs. For example, we observed one patient requesting a shave, who was then promptly helped by a member of staff.

[2] The hospital passport is designed to give hospital staff helpful information that isn't only about illness and health, but likes, dislikes and preferences.

Visiting had re-started following its pause during the pandemic. Patients were able to see relatives in a designated building a short distance from the unit. We were told that this had been welcomed by patients and their relatives.

Improvement needed

The Health Board should explore creative ways to enable patients to personalise their rooms during their stay at the Unit.

## Patient information

We did not see information relating to the Putting Things Right[3] scheme or to the health boards own feedback process on display. However, we confirmed that there were suitable provision for this patient group. Patients had access to advocacy services to support them in decisions relating to the care and treatment. We also confirmed that there was an effective service user group in operation, which met the needs of the patient group in a timely and consistent manner.

## Communicating effectively

We observed staff engaging with patients at a suitable pace and communication style according to their needs. We also noted that a first language Welsh speaking patient was able to hold conversations in Welsh with a number of staff.

The patients that we spoke with told us about some of the activities that they like to participate in and we found that activity schedules had been tailored to meet these needs.

We found evidence that patients were encouraged to attend multi-disciplinary team (MDT) meetings and service user group meetings. Relatives were invited to attend where appropriate.

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## Individual care

### Planning care to promote independence

Staff we spoke with had an in-depth knowledge of the patients, which demonstrated a commitment towards providing patients with individualised care.

We found that therapeutic support services (TSS) scheduled a range of on-site activities for patients on a weekly time-tabled basis. It was positive to note that patient wishes from the service user group directly fed into the activity offering supported by TSS and the unit.

We were told that there was no dedicated occupational therapy service (OT) available on the unit, instead the resource operated across the wider Bryn y Neuadd site on a referral basis. In one patient record that we reviewed, we noted that there was a lack of sensory assessment for the patient, which highlighted a potential gap in service provision. We also noted that a lack of provision of OT services was highlighted as part of the units recent ward accreditation.

We found that there were active discharge planning arrangements in place for patients who were ready for discharge. We confirmed that decisions in relation to discharge and future placements were discussed with the patients, and relatives where appropriate, as part of their MDT reviews.

We noted that one patient had expressed dissatisfaction with their intended placement. However we were informed that proactive steps had been taken by the unit to assess the on-going suitability of the placement. In this instance unit staff had visited the intended premises. Unit management assured us that the patient would remain at the centre of the decision making process to ensure their needs and wishes were acknowledged.

We observed staff respecting patient privacy. For example, by understanding when patients preferred their own space and facilitating this whilst maintaining appropriate levels of observation.

Improvement needed

The Health Board must review the capacity of its occupational therapy service at the unit to ensure that patient needs are fully met.

## People's rights

We reviewed a sample of three patient records and found that all patients who were subject to Deprivation of Liberty Safeguards (DoLS)[4] had received timely assessments. All patients had access to advocacy services, although we were told that access to advocacy is used by some patients more than others.

Staff told us that patients are invited to be part of their MDT meetings and that the involvement of family members of advocates was encouraged where possible. One patient confirmed that they had been invited to their MDT meeting, but had declined on the most recent occasion.

## Listening and learning from feedback

It was positive to find that therapeutic support services had resumed service user group meetings, which we were told had been paused during the pandemic. We found that the group enabled patients to voice their views and opinions on a range of topics, including how safe they feel, what they would like to see improved and views on the activities provided.

The meetings had been held regularly and contained clear outcomes for patients. There were minutes written after each meeting, which made use of symbol based communication to help patients to understand.

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## Delivery of safe and effective care

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

Overall we found that Tan y Coed was providing patients with a good level of safe an effective care. We observed direct care needs being met at all times by a staff team who had an in depth knowledge of individual patient preferences and needs.

However, we identified some areas for improvement in relation to care and treatment planning, and the need to implement an audit programme to monitor these.

### Safe care

#### Managing risk and promoting health and safety

We found that the outside environment and interior of each of the bungalows was in generally good condition and met the needs of the patients.

However, we found that bungalow three was awaiting urgent remedial works. As a result, two patients had been temporarily located in bungalow two, which was co-located with the unit manager's office. We confirmed that remedial works were due to start imminently and that there were active plans in place to re-locate these two patients to a more suitable location on the unit.

The environmental risk assessment had been reviewed the month prior to the inspection, however, consideration had not been given to the risk of patients being able to access sharp items. We noted an inconsistent approach to securing these items that could potentially compromise the safety of staff and patients. Whilst we were told that this risk was mitigated by 1-1 observations, a consistent, risk assessed approach must be adopted towards the storage of these objects.

Storage of kitchen detergents must also be COSHH[5] risk assessed in all areas of the unit.

We checked up to date ligature risk assessments. Whilst these appeared to be comprehensive, we found some inconsistencies which must be reviewed. These include:

- Each assessment and action plan identified areas where a review is required of a ligature risk, and alternative arrangements are to be considered, but no dates of action were recorded

- Where reference to alternative arrangements is documented, it is not clear that any follow-up action has been taken, with the exception of maintaining observations.

We identified a fire extinguisher located in bungalow two that had not been serviced since February 2020. The need for annual servicing of fire extinguishers had not been identified as part of a recent fire risk assessment. We immediately raised this with management to ensure prompt action was taken.

We found that emergency resuscitation kit checks were undertaken using an electronic system and that these checks had been undertaken on a regular basis. We noted that the adrenalin within the resuscitation kit was expiring during the month of the inspection (October 2021). We brought this to the attention of management so that a replacement could be ordered in a timely manner.

Improvement needed

The Health Board must:

- Provide HIW with an updated schedule for the completion of the on-going remedial works at the unit.

- Review the environmental risk assessment to ensure that all risks have been identified and mitigated.

[5] Control of substances hazardous to human health

- Review the COSHH risk assessment to ensure that all risks have been identified and mitigated.
- Review the ligature risk assessments to ensure that the follow-up actions have been appropriately actioned and recorded.

## Infection prevention and control

We found a range of infection, prevention and control policies, processes and procedures were in place to protect staff, patients and visitors. In addition there were a number of audits in place to monitor and review compliance with these policies.

Overall, we found the environment to be clean and tidy. There were some minor cleanliness issues that we brought to the attention of staff who immediately remedied these. We observed domestic services staff attending and cleaning the bungalows at the time of our inspection.

We reviewed a sample of cleaning records and schedules. We found evidence that staff were not completing the schedules in full, particularly on night shifts. In response, staff told us that there are occasions when cleaning is not undertaken to protect patients sleep. We emphasised the need to maintain complete and accurate cleaning schedules and the requirememt to note in full the reasons why cleaning was not rescheduled or undertaken.

It was positive to note that there had been no patient cases of COVID-19 on the unit throughout the pandemic. We found that staff and patients had received the COVID-19 vaccination. We saw that there was access to appropriate personal protective equipment (PPE) in all bungalows and staff were observed wearing this correctly at all times.

We found that there was a dedicated visiting space, which had its own visiting policy and risk assessment. This ensures patients can receive visitors in a safe environment.

We reviewed a sample of IPC related audits, including hand hygiene, and found high levels of compliance. These were supported by regular ward manager and matron audits.

Improvement needed

The Health Board must ensure that the cleaning schedules have been completed fully, including reasons why areas may not have been cleaned.

## Nutrition and hydration

We found that patients had access to a small range of daily meal options, which catered for different dietary requirements and preferences. We saw examples of preferences being taken into account through the service user group meetings.

We observed that patients were supported in a flexible manner at meal times. This helped to meet the nutritional needs of patients, as they were able to eat in an unhurried and individualised manner.

We were informed that the family of one patient regularly provided meals that embraced the family's culture. To support this, arrangments had been made to allow the family and patient to enjoy the meals together on the Bryn y Neuadd site.

We reviewed a sample of three patient records and found that nutritional needs had been assessed, with evidence of a recent review and monitoring of weight, bowel movement and body mass index.

We confirmed that access to speech and language therapy (SALT) services was available and we saw evidence in the sample of records that we reviewed that relevant assessments had been completed.

We noted that staff provided snacks to patients in between meal times and that patients could access the on-site canteen with staff members.

## Medicines management

We reviewed three medication charts and found that these were completed appropriately, including notes and reasons where medications had been refused.

We found that there was an appropriate electronic medicines management system in place at the unit. We confirmed that nursing staff had responsibility for checking and ordering medication on a weekly basis and there was evidence of staff checking stock as it arrived at the unit.

Stock control of clonazepam, which is a controlled drug, required improvement. We identified it was not always checked and counter signed in line with controlled

drugs procedures. We also noted incomplete stock control records for the same drug.

We saw evidence that patients had individualised medications management plans and medication reviews in place. However, there was no indication that these plans had been discussed with patients to help them understand what medicines they take and their effects.

In the sample of patient records that we reviewed, we found that there were low uses of PRN medication[6] on the unit and we found no evidence of an overuse or reliance on this as required sedation.

We found evidence of an appropriate pain assessment tool being used on the unit, which assists in the management of pain for patients who may be unable clearly articulate their needs.

Improvement needed

The Health Board must ensure that:

- Standards for stock control controlled drugs are maintained in accordance with its own medications management policy
- Appropriate communication with patients regarding their medication plan is undertaken and suitably documented.

## Safeguarding children and adults at risk

The staff we spoke with were aware of how to access the local safeguarding procedure. All staff told us that they felt supported by management and confirmed they would feel comfortable to raise any concerns they had.

We saw training records that showed that the vast majority of staff had completed adult safeguarding training.

There we no open safeguarding cases at the time of the inspection.

[6] Medication that is administered when required by the patient, rather than at scheduled times.

## Effective care

### Safe and clinically effective care

We found that all patients had care and treatment plans in place, which were coherent and had been subject to MDT review. However, care planning could be strengthened by placing emphasis on the voice of the patient (and relatives where appropriate) and ensuring a person-centred approach towards goals and objectives. We noted:

- Care plan goals and objectives did not always contain a strength and independence focus, but instead were problem orientated
- In one record, the clinical review contained a review of incidents. However, the community and engagement section had been copied and pasted from a previous version. Therefore, the same goal was in place for a three month period
- In another record, there was a breadth of positive understanding and clinical formulation that gave a real sense of understanding of this patient, yet this was not translated into their care plan goals and objectives
- Staff expressed a clear understanding of patient wishes. However, there were missed opportunities to translate these into care plan goal and objectives.

The unit told us that aspects of care planning were identified as an area to strengthen in their recent ward accreditation and that they are keen to strengthen this within the staffing team.

We advised the health board to look at learning from previous audits (e.g. Welsh Government Delivery Unit All-Wales Care and Treatment Plan audit) undertaken on the site to aid and facilitate learning where applicable.

We further reviewed a sample of patient records and made the following observations regarding the documentation of evidence in relation to the management of patients care and treatment needs:

- In one record, there was no documented evidence that a sepsis screen had been undertaken, despite a high NEWS[7] score

- There was a strong urine odour in one of the bungalows on the evening of our arrival. We later found that a patient had recently became incontinent, as a result of a hernia. However, there was a lack of documented evidence on file to indicate how this had been investigated and diagnosed

- One incident involved a patient viewing sensitive material. Whilst we saw that an outcome had been documented, we considered there to be a lack of documented investigation or evidence of appropriate support or intervention following this incident.

Improvement needed

The Health Board must undertake an audit of the care and treatment plans on the unit, with a view to:

- Ensuring that plans and objectives are goal and person centred

- Ensuring evidence relating to care and treatment is appropriately and clearly documented at all times

## Safe and clinically effective care – Behaviours that challenge

Upon our arrival at the unit and throughout the course of the inspection, the environment was calm and settled. We saw no evidence to indicate patients were distressed or overly challenging.

We saw evidence that patients were supported through use of a positive behavioural support (PBS) plan. This provided consistent information to help staff understand patients' likes, dislikes and causes for behaviours that challenge.

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It was positive to note in the PBS plans we reviewed that proactive and reactive strategies had been considered, with effective formulations seen in relation to causes of identified behaviours. New staff on the unit were able to demonstrate their familiarity with the detail of these plans.

We confirmed that the strategies for managing behaviours that challenge had been considered in the sample of records that we viewed. However, in some cases there was a lack of evidence that care and treatment plans had been made accessible for patients to assist in their understanding and involvement in their care and treatment. Similarly, in two of the records, there was a lack of evidenced family involvement, despite staff confirming that there had been on-going family involvement.

We found that there was a minimal use of restrictive practice interventions (RPI's) on the unit, with staff using least restrictive de-escalation methods. Where physical interventions were deemed necessary, we found that these were documented in the patients care plans and that individual best interest decisions towards interventions were documented by the MDT.

It was positive to note that there was access to a behaviour analyst on the unit to support the MDT approach to supporting patients. We confirmed that all incidents of behaviours that challenge and interventions are recorded on behavioural charts. These are reviewed at weekly behaviour management support group (BMSG) meetings, with action plans drawn up where necessary.

We found that staffing on the unit permitted one to one care to be provided. We were told that this was used as an enabling experience for patients, whilst providing patients with the opportunity to undertake additional on and off site activities. However, through our observations, we considered the effectiveness of the one to one care whilst on the unit could be strengthened. This is to ensure that all interactions are consistently used as a positive form of engagement through an active model of care.

Improvement needed

The Health Board must ensure that care and treatment plans have been made accessible and communicated appropriately to patients (and relatives where applicable).

The Health Board must explore how one to one observations can be strengthened to ensure that they are consistently used as an active and positive form of engagement.

## Quality improvement, research and innovation

It was positive to note that the unit had recently received its bronze accreditation as part of the Health Board's quality measure accreditation scheme. The Ward Manager and staff nurse who co-ordinated the accreditation demonstrated a clear knowledge of the unit's strengths and areas to improve upon.

Members of the unit and senior management that we spoke with spoke openly and were receptive to the suggestions and recommendations put forward by the HIW inspection team.

## Record keeping

We found that patient files were structured and easy to navigate and that all members of the multi-disciplinary team recorded notes in a consistent format. This helps to ensure that there is a consistent approach to patient care.

## Quality of management and leadership

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

Overall we found a committed staff team, many of whom were long-standing members on the unit. The team was supported by a dedicated unit manager, who staff told us was supportive and visible on the unit.

We found good working relationships within the unit, other inpatient wards and the wider management structure within Bryn y Neuadd, with clear local governance arrangements in place to support this.

However, we have highlighted areas for improvement that aim to strengthen existing practice at an operational level. We also identified the need for the Health Board to support the unit at a strategic level by developing and implementing a clear service model and ethos.

### Governance, leadership and accountability

Tan y Coed provides a residential rehabilitation service to its patients. However, we found that some legacy issues had resulted in a mixed service model, which had not been reviewed for some time. As a result, there was an inconsistent approach to the care provided on the unit based on patient profile. For example, the unit provides care to some older patients who would likely stay at the unit for the foreseeable future, but also to a younger patient group who require a more comprehensive and active offer of rehabilitative care to aid their transition back into the community.

We acknowledge that ward management have a vision for the future service and that some discussions had already taken place with staff and senior management to develop ideas.

The unit is managed on a day-to-day basis by a Band 7 ward manager and supported by two deputy ward managers, all of whom are registered nurses.

On our arrival at the unit, we found that there was an experienced Band 5 nurse in charge who was overseeing that particular night shift. The nurse was able to respond to all of our queries regarding patients in a clear and comprehensive manner, and was able to escalate and communicate our arrival to senior on-call management without difficulty or delay.

During our inspection we spoke to a range of staff on the unit. Feedback received from staff was overwhelmingly positive. Without exception, all staff told us that they felt supported in their roles and that there was visible and accessible management on the unit.

All staff told us that they would feel comfortable to raise any concerns that they had, which helps to demonstrate a positive culture on the unit.

We found a clear management structure and staff we spoke with were aware of the roles and responsibilities of senior colleagues. The ward manager was complimentary of the support provided by the clinical services manager, who was enthusiastic and proactive in delivering their role.

There were appropriate governance arrangements in place in the unit and the wider structure that it is part of. We observed meetings, reviewed meeting minutes, and found that there was a suitable day-to-day flow of information between the ward and senior management:

- Team meetings on the ward included a comprehensive and relevant agenda
- Daily inpatient meetings enabled the inpatient wards and units at Bryn y Neuadd to feedback any immediate issues or concerns to the clinical site manager
- Twice daily safety huddles across the site were focused and well attended. We observed issues being raised in the morning huddle, with an effective resolution to these issues being given at the huddle prior to the night shift.

Improvement needed

The Health Board must support the unit in developing and implementing a clear service model and ethos.

## Staff and resources

### Workforce

We reviewed a sample of staffing rotas, including an analysis report, and found no indication of staffing issues on the unit. The staffing numbers and skill mix appeared to be sufficient to meet patient needs and required observation levels. The staff we spoke with expressed positive comments in relation to staffing levels and the ability to provide patents with a good level of care on the unit. We found there to be a suitable process in place for the escalation of staffing issues

We found that there were a number long-standing and committed staff at the unit, which helps to provide important continuity of care for this patient group. There were a small number of nursing and healthcare assistant vacancies on the unit, but we noted that recruitment was progressing well.

We noted that there were a number of opportunities on the unit for the training and development of new and existing staff and the unit manager expressed an enthusiasm for this. We found that students are able to undertake placements on the unit as part their nurse training and we were told that the unit had previously been able to employ some of these students following their placements.

The unit manager placed emphasis on the importance of staff development. We found that a number of healthcare support workers had completed, or were in the process of completing, their diploma certifcates which enables them to progress onto a nurse training degree.

The unit had achieved a good level of compliance regarding mandatory training, with the majority of staff having achieved the health board standard of 85%. We explored the reasons why some staff members had fallen below the required level of compliance and were provided with appropriate reasons by the ward manager, which included staff who had very recently joined the unit, long term absences and the impact of COVID-19 on the delivery of face-to-face training.

We found that 72% of staff had an up-to-date personal appraisal development review (PADR). Whilst this was below the health board target of 85%, we were provided with appropriate reasons by the ward manager and noted that appraisals were on-going at the time of the inspection.

# 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, measurable, 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 inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

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

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

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

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 |
|---|---|---|---|
| We found that the adrenalin within resuscitation kit was expiring during the month of the inspection (October 2021). | Expired medication may impact its upon effectiveness. | Whilst the adrenalin had not yet expired, we brought this to the attention of the Ward Manager so that they could re-order this ahead of its expiration. | The Ward Manager informed us that an order would be immediately placed for a replacement. |
| We identified that one of the fire extinguishers had not been serviced since February 2020 and the fire risk assessment did not identify the need to review the fire extinguishers in the bungalow concerned. | Potential risk to staff and patients in the event of a fire | We immediately brought this to the attention of ward and site management. | The issue was escalated to the health board fire safety / estates department |

## Appendix B – Immediate improvement plan

## Hospital:

## Ward/department:

## Date of inspection:

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 improvements were 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

**Hospital:** Bryn y Neuadd Hospital

**Ward/department:** Tan y Coed Unit

**Date of inspection:** 19-20 October 2021

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 must ensure that staff knowledge in relation to the frequency of individual patient blood monitoring is clarified. | 1.1 Health promotion, protection and improvement | • Weekly recording form introduced (embedded), weekly blood sugar monitoring frequency clarified with staff.<br>• Currently only required for identified patient.<br>• Process will be introduced for future patients if clinically indicated. | Ward Manager. Matron. | Completed 25/11/2021 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The Health Board should explore creative ways to enable patients to personalise their rooms during their stay at the Unit. | 4.1 Dignified Care | • The named nurse for each individual will regularly review the appropriateness of patient's room aligned to changing need and patient's wishes.<br>• This will be reviewed at Multi-Disciplinary Team (MDT) meetings as part of the Care and Treatment Plan (CTP).<br>• Other important people in a patient's life will be involved where appropriate, to support and explore ways of creating a personalised environment. | Ward Manager. Matron. | 28/02/2022 |
| The Health Board must review the capacity of its occupational therapy service at the unit to ensure that patient needs are fully met. | 6.1 Planning Care to promote independence | • Occupational Therapy (OT) capacity will be prioritised across the site to ensure timely assessment and responsive care planning.<br>• A meeting with Head of Operations and OT has been arranged to discuss capacity issues. | Head of Operations. | March 2022 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | • SBAR to be developed and presented to the Divisional Senior Leadership Team to highlight any unresolved issues. | | |
| **Delivery of safe and effective care** | | | | |
| The Health Board must provide HIW with an updated schedule for the completion of the on-going remedial works at the unit. | 2.1 Managing risk and promoting health and safety | • All works completed at Tan Y Coed and signed off on 19/11/2021. | Estates | Completed 19/11/2021 |
| The Health Board must review the environmental risk assessment to ensure that all risks have been identified and mitigated. | | • Environmental risk assessment has been reviewed.<br>• Risk identified in relation to kitchen drawers not being locked.<br>• Risk assessment completed on 25/11/2021:<br>• All drawers on Tan Y Coed are now locked.<br>• Individual risk assessments will be developed to enable access to cooking utensils when identified as a requirement. | Ward Manager.<br>Matron. | Completed<br>Completed<br>Completed<br>Completed |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
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| | | | | December 2021 |
| The Health Board must review the COSHH risk assessment to ensure that all risks have been identified and mitigated. | | • All risks identified, risk assessed and mitigated. Process in place to ensure regular review of COSHH risk assessment – reviewed on monthly ward accreditation audit. | Ward Manager. Matron | Completed 24/11/2021 |
| The Health Board must review the ligature risk assessments to ensure that the follow-up actions have been appropriately actioned and recorded. | | • Ligature Risk assessments were being reviewed at the time of the inspection. Monthly reviews in place by Ward Manager; these are sent monthly to Head of Nursing and Head of Operations for review. | Ward Manager. Matron | Completed |
| The Health Board must ensure that the cleaning schedules have been completed fully, including reasons why areas may not have been cleaned. | 2.4 Infection Prevention and Control (IPC) and Decontamination | • Monitoring and review arrangements are being introduced to ensure adherence to cleaning schedules.<br>• The cleaning schedule recording form will be redesigned to ensure reason cleaning has not been undertaken is clearly documented - this will be reviewed regularly via Ward Manager and Matron Audit. | Ward Manager. Matron | January 2022 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
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| The Health Board must ensure that:<br>• Standards for stock control controlled drugs are maintained in accordance with its own medications management policy<br>• Appropriate communication with patients regarding their medication plan is undertaken and suitably documented. | 2.6 Medicines Management | • All controlled drugs are stored in accordance with the BCUHB policy.<br>• A project will commence in January 2022 developing communication with patients regarding their medication, using resources including Books Beyond Words, and Easy Health. | Ward Manager. Matron<br>Staff across site/ Student nurses. | Completed<br>March 2022 |
| The Health Board must undertake an audit of the care and treatment plans on the unit, with a view to:<br>• Ensuring that plans and objectives are goal and person centred<br>• Ensuring evidence relating to care and treatment is appropriately and clearly documented at all times | 3.1 Safe and Clinically Effective care | • Each patient on the ward will have a CTP review led by their Care Coordinator and MDT to ensure that plans and objectives demonstrate positive goal planning and are person centred.<br>• CTPs will be reviewed monthly by the Care Coordinator to ensure evidence is provided against outcomes identified. | Ward Manager. Matron.<br>Head of Nursing. | February 2022<br>Monthly December 2021 |
| The Health Board must ensure that care and treatment plans have been made accessible and | | • Care Coordinators will ensure that patients or their representatives are part of the development of their CTP, and that accessibility and | Head of Nursing | February 2022 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
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| communicated appropriately to patients (and relatives where applicable). | | understanding are key to the implementation of care.<br>• Utilising inpatient forums, patients will support services to develop a more inclusive approach, to make care planning documentation accessible to patients across site. | | February 2022 |
| The Health Board must explore how one-to-one observations can be strengthened to ensure that they are consistently used as an active and positive form of engagement. | | • A programme of work is being undertaken across the Division to enhance positive engagement as outlined in the Therapeutic Observation Policy.<br>• Therapeutic observation documentation will be audited monthly aligned to the policy and will feed into MDT meetings to inform CTP planning and effectiveness of one-to-one support, engaging patients as part of their treatment journey.<br>• Best practice around activity scheduling and therapeutic | Ward Manager. Matron.<br>Head of Nursing LD. | February 2022 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
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| | | engagement to be used to inform CTPs. | | |
| **Quality of management and leadership** | | | | |
| The Health Board must support the unit in developing and implementing a clear service model and ethos | Governance, leadership and accountability | • Development of the model and ethos of Tan Y Coed has commenced and will continue to be developed in 2022. This is part of a wider LD transformation project. | Ward Manager. Matron.<br>Clinical Operations Manager.<br>LD Senior Leadership team | September 2022 |

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):** **CAROLE EVANSON, MIKE SMITH**

**Job role:** **Interim Director of Operations MHLD, Interim Director of Nursing MHLD**

**Date: 30/11/ 2021**