Learning Disability Service Inspection (Unannounced)

Swansea Bay University Health Board, Learning Disability Service (Ref 21160)

Inspection date: 15 March 2022

Publication date: 17 June 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 978-1-80364-347-2

Contents

1. What we did 4

2. Summary of our inspection..... 6

3. What we found 7

Quality of patient experience 8

Delivery of safe and effective care 12

Quality of management and leadership 17

4. What next? 20

5. How we inspect hospitals 21

Appendix A – Summary of concerns resolved during the inspection 22

Appendix B – Immediate improvement plan 23

Appendix C – Improvement plan 27

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 the learning disability service within Swansea Bay University Health Board on 15 March 2022.

Our team, for the inspection comprised of one HIW Senior Healthcare Inspector, one HIW Healthcare Inspector and one clinical peer reviewer. The inspection was led by the HIW Senior Healthcare Inspector.

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

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

2. Summary of our inspection

We found that arrangements were in place with the intention to meet the Health and Care Standards relevant to the learning disability service.

However, we did identify improvement was needed around aspects of the service provision and asked the health board to take action to address this.

This inspection also resulted in us asking the health board to take immediate action in relation to the environment, risk assessment and checking of emergency equipment to promote the safety and wellbeing of patients.

This is what we found the service did well:

- We found good compliance with the health board's staff training programme
- All staff had received an appraisal of their work within the last year.

This is what we recommend the service could improve:

- Aspects of the environment and the arrangements to ensure estates related issues are identified and addressed in a timely manner
- The amount of information displayed for patients
- The recording of checks of emergency equipment
- Specific reviews of incidents where data indicates an increase in the use of restrictive practice, specifically the use of seclusion
- Completion of admission and initial risk assessment documentation.

3. What we found

Background of the service

At the time of our inspection, the learning disability service could provide care for up to three patients with learning disabilities. The unit forms part of the learning disability services provided within the geographical area known as Swansea Bay 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.

We saw that staff treated patients with respect and made efforts to promote their privacy and dignity. However, aspects of the environment, which may impact negatively on patient wellbeing, needed to be addressed.

Patients' care records demonstrated that patients had an assessment of their care and treatment needs. We did identify that action was required to promote the full completion of assessment documentation by staff.

We were told that patients were provided with information about their care and treatment. However, further efforts should be made to display relevant information within the unit.

Staying healthy

The unit manager described suitable arrangements for assessing patients' healthcare needs prior to their admission to the unit. We also saw evidence of assessment in the sample of care records we considered as part of the inspection.

The manager explained patients would be encouraged to make healthy lifestyle choices when appropriate to do so. The manager also confirmed that patients would be referred to other members of the multi-disciplinary team for their specialist input as necessary.

Dignified care

We saw that staff treated patients with respect and kindness, and encouraged patients to engage in positive activities according to their interests. However, we identified improvements were needed to the internal and external environment to promote dignified care for patients.

Patients had their own bedroom, own allocated bathroom and private space. However, the window within one of the three bedrooms being used for accommodation could not be opened to allow for ventilation, and another did not have suitable window blinds for privacy.

One of the bathrooms was in a poor state of repair, with an uncovered drainage hole in the floor and tap covers missing. The garden area contained items of broken furniture that needed to be removed and disposed of. As well as looking unsightly, these were potential hazards to patient and staff safety and could impact negatively of patients' wellbeing.

Improvement needed

The health board is required to provide HIW with details of the action taken to ensure the unit environment is maintained to a satisfactory standard.

Patient information / Communicating effectively

We identified that efforts were made by staff to provide patients with information about their care and treatment in a way they can understand.

The unit manager showed us a booklet providing information for patients, in an easy read format, about their stay at the unit. We saw that this contained relevant and useful information, which was clearly presented.

Staff explained that patients are asked about their language preferences when they arrive at the unit. Staff confirmed that leaflets and other written information for patients can be obtained in different language according to their needs and preferences. Staff also confirmed that Welsh speaking staff worked at the unit, which allows patients to communicate in Welsh should they choose to do so.

Staff also explained that professionals involved in patients' care would spend time with them to explain their care and treatment in ways that they can understand.

While efforts were made to provide patients with sufficient information, there was no information displayed within the unit for patients to read e.g. health promotion material, about advocacy available, COVID-19 information and how to provide feedback or complain. The health board should review this and make suitable arrangements to display relevant information that patients may find helpful.

Improvement needed

The health board is required to provide HIW with details of the action taken to display relevant information within the unit that patients may find helpful e.g. health promotion material, about advocacy available, COVID-19 information and how to provide feedback or complain.

Individual care

Planning care to promote independence

We reviewed the care records for the two patients being accommodated at the unit at the time of our inspection.

For each patient there was evidence of an assessment of their care needs on admission to the unit to identify their support needs. Relevant risk assessments had also been completed on admission. However, we did identify that these had not been fully completed for one patient.

Both patients were entitled to have a Care and Treatment Plan (CTP) under the Mental Health (Wales) Measure 2010. An up to date CTP was available for one of the patients but was not available for the other. The manager confirmed that this had already been requested and the manager was actively following this up.

Within the care records for both patients, there was evidence of patients being helped to understand their care and of the input by the multi-disciplinary team as appropriate.

People's rights

At the time of our inspection, we were informed that both patients accommodated at the unit were subject to Deprivation of Liberty Safeguards (DoLS).

We saw that urgent DoLS authorisations had been applied for by staff at the unit in respect of both patients. Standard authorisations had also been applied for at the same time in accordance with DoLS. However, the urgent authorisation for one patient had expired and confirmation of a standard authorisation had not been received. The manager confirmed this matter had been escalated in accordance with the health board's incident reporting arrangements.

The manager confirmed that patients can access advocacy and we saw information for patients was available in easy read format. However, this was not displayed within the unit.

Improvement needed

The health board is required to provide HIW with details of the action taken to promote the timely assessments of patients in accordance with the Deprivation of Liberty Safeguards (DoLS).

Listening and learning from feedback

Senior staff described suitable arrangements for seeking feedback from patients and their families about their experience of using the service. These included a designated patient experience and feedback team that used communication tools to help patients with learning disabilities share their feedback.

We saw that the health board had a current written policy and associated procedures for responding to concerns and complaints about the service. These were in keeping with 'Putting Things Right'.

Senior staff confirmed that feedback and complaints data was reported to the health board as part of the quality and safety monitoring arrangements. We also saw an example of a report.

While suitable arrangements were described and demonstrated, there was no information displayed within the unit to make patients or their representatives aware of how to provide feedback or complain.

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 identified that the arrangements for managing risk and promoting health and safety in relation to the environment required improvement.

Suitable arrangements were in place for infection prevention and control with a particular focus on preventing the spread of COVID-19.

While arrangements were in place for the safe management of medicines, we did identify improvement was needed around the recording of checks of emergency equipment.

Patients had comprehensive Positive Behaviour Plans and written policies and procedures were in place in relation to restrictive practice. One of the policies required review and we were not assured that reviews of incidents are completed in accordance with the arrangements described.

Safe care

Managing risk and promoting health and safety

The arrangements for managing risk and promoting health and safety required improvement in relation to the environment. While we saw the unit was secure against unauthorised access we identified a number of environmental hazards that posed a potential risk to the safety of staff and patients.

We saw the wooden fence immediately outside the unit had fallen over and was on the ground. Parts of the fence were broken and broken pieces of plant pots were also seen near the edge of the fence. In addition we saw broken furniture and other items in the patio area. These were not cordoned off to prevent access by patients or staff.

Apart from looking unsightly, these present hazards and pose a potential risk to patient and staff safety. Senior staff confirmed that arrangements needed to be

made to repair the fence and remove the other items, however, there was no date scheduled for this work to be completed.

Our concerns regarding these matters were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate areas for improvements we identified are provided in Appendix B.

Infection prevention and control

Senior staff confirmed that an up to date written infection prevention and control policy was in place and available to staff via the health board's intranet. Senior staff also described suitable systems for infection prevention and control.

At the time of our inspection a particular focus of these systems was to prevent the spread of COVID-19 and additional measures were in place in this regard.

Information was clearly displayed to guide staff on the correct use of personal protective equipment (PPE) depending on the tasks being performed. We saw that PPE was readily available and being used by staff.

Conversations with staff indicated that they were aware of their responsibilities around infection prevention and control.

No information was displayed specifically for patients on COVID-19 or infection prevention and control measures. However, staff confirmed that patients were provided with an easy read booklet and the information it contained was reinforced by staff verbally. Staff also described that patients are encouraged and supervised to wash their hands regularly as part of the infection prevention and control arrangements.

The environment allowed for patients to have their own bedroom, bathroom, lounge and dining space to help reduce the spread of COVID-19.

Nutrition and hydration

Staff described that patients had a choice of food and drink and confirmed that patients' specific dietary requirements were accommodated. At the time of our inspection we were told that one patient required a modified diet and saw that this was provided. Staff were available to offer support to patients to eat their meals according to their assessed needs.

Due to the arrangements in place to reduce the spread of COVID-19, patients had to eat their meals in their designated areas, away from other patients. One

of these areas had a coffee table, rather than a suitable dining table and the other had an outside picnic bench due to the previous table being broken by the patient. We were told that this was the only option available. Arrangements should be made to provide tables that are more suited to being used as dining tables.

Improvement needed

The health board is required to provide HIW with details of the action taken to provide suitable dining furniture for patients to use while accommodated at the unit.

Medicines management

A current written medicines policy was available. This set out the arrangements to promote the safe handling of medicines used at the learning disability service.

We saw that medicines were stored securely and in accordance with the manufacturers' instructions with appropriate records maintained.

We inspected a sample of three patients' medication administration records and found these had been completed fully. However, two of the records did not have details of whether the patients had any known allergies. In accordance with the policy, where there are no known allergies, this should be recorded in the allergy box on the chart.

We inspected the emergency kit and could not find evidence of recent checks being made of the emergency drugs and equipment. We were informed that there was a possibility that checklists used to record checks of the drugs and equipment may have been filed. However, these were not provided when requested on the day of the inspection. Therefore, it was not possible to establish when the emergency drugs or equipment were last checked and whether the emergency kit was complete and safe to use in the event of a patient emergency. This presents a potential risk to patient safety should the required emergency items not be available or safe to use.

Our concerns regarding this matter were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

Improvement needed

The health board is required to provide HIW with details of the action taken to promote adherence to the medication policy in relation to staff recording the allergy status of patients.

Safeguarding children and adults at risk

Senior staff confirmed that a written policy and procedures were in place for responding to safeguarding concerns. Senior staff also described suitable arrangements for reporting and referring safeguarding concerns.

Information provided by senior staff confirmed that all staff working at the learning disability service were up to date with safeguarding training.

Effective care

Safe and clinically effective care

We considered the arrangements in place to meet patients' needs in respect of their behaviour that may challenge.

We reviewed the care records for the two patients being accommodated at the unit at the time of our inspection. Both patients had written Positive Behaviour Support Plans, which set out proactive and reactive strategies that could be used by staff to manage the patients' behaviour. Staff described that a reactive strategy used for one patient was for staff to withdraw and lock the door to bathroom, while continuously observing the patient. While the plan was very detailed, it did not make reference to locking the bathroom door or where staff should record their observations.

The unit manager confirmed that staff would complete a behavioural management tool to help identify and understand reasons for behaviour that may challenge. The unit manager also confirmed advice was available from health board's Specialist Behaviour Team in this regard.

Incidents of behaviours that may challenge and the use of restrictive practice were recorded and reported by staff via the health board's DATIX incident reporting system.

We were provided with summary of incidents reported over the previous three months. We identified that staff used the least restrictive de-escalation methods with physical intervention only used where absolutely necessary. However, the

data indicated that there had been an increase in the use of seclusion during February and March and this did not appear to have triggered a specific review as described by the arrangements for monitoring and overseeing incidents of restrictive practice.

Written policies were in place for the use of restrictive practice. However, the policy Management and Aggression was dated for review in August 2017.

Improvement needed

- The health board is required to provide HIW with details of the action taken to ensure patients' Positive Behaviour Support Plans fully reflect the actions to be taken by staff and where to record observations.
- The health board is required to provide HIW with details of the action taken to ensure reviews of the use of seclusion are completed in accordance with the arrangements for monitoring and overseeing incidents of restrictive practice.
- The health board is required to provide HIW with details of the action taken to review the policy Management and Aggression.

Record keeping

We found that care records relating to patient care were being maintained and being stored appropriately.

The records demonstrated involvement by the multi-disciplinary team and how decisions relating to patient care had been made. However, we did identify some gaps within the admission and initial risk assessment documentation, where required information had not been recorded.

Improvement needed

The health board is required to provide HIW with details of the action taken to promote the full completion of admission and initial risk assessment documentation.

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.

A management structure was in place and clear processes for reporting and accountability were described and demonstrated.

We identified that the health board needs to take more proactive action in addressing estates related issues.

Our observations indicated that staffing numbers and skill mix were appropriate to meet the assessed needs of the patients. However, comments made by staff confirmed this was not always the case. We have asked the health board to take action to address the comments received by staff during our inspection.

We identified good compliance with the health board's mandatory training programme and all staff at the unit had received an appraisal of their work within the last year.

Governance, leadership and accountability

Senior staff described the management structure and the arrangements for monitoring the quality, safety and performance of the learning disability unit and the service as a whole. Clear processes for reporting and accountability were described and demonstrated.

Senior staff provided details of the governance structure for the health board's Learning Disability Delivery Unit. This clearly demonstrated the various committees, sub committees and groups making up the governance structure.

We were provided with an example of a recent Performance Dashboard presented to the health board as part of the quality and safety and performance monitoring arrangements. This included a range of pertinent data as to the operation of the health board's learning disability service. While arrangements

were described, our findings in respect of the environmental issues identified suggests that more proactive action could be taken by the health board in addressing estates related issues.

Senior staff described that in response to COVID-19, changes had been made to promote patients' safety and wellbeing when needing to access the health board's learning disability services. We were told the health board was considering plans for the modernisation of the learning disability services as a whole. At the time of our inspection, the future purpose of the learning disability unit was undecided. Until this is decided, this is likely to cause challenges to the health board with regards to future planning for staffing and creating an environment that is suitable for the intended patient group.

At the time of our inspection, an experienced unit manager, who is a registered nurse, was in charge of the unit. The manager demonstrated a clear understanding of the needs of the patients accommodated at the unit.

Improvement needed

The health board is required to provide HIW with details of the action taken to ensure where estates related issues are identified, timely remedial action is taken as necessary.

Staff and resources

Workforce

At the time of our inspection we were told that the staffing numbers and skill mix were appropriate to meet the assessed needs of the patients accommodated at the unit. Our observations also confirmed this.

However, we were also told that there have been times when the staffing numbers have been below that required to allow staff to effectively support and observe patients. Discussions with staff indicated that they felt overworked and demoralised.

Senior staff confirmed there were vacancies at the unit and recruitment was ongoing. Information provided to us showed these were equivalent to 4.22 full time staff to include both registered nurses and healthcare assistants.

Information provided to us showed that the unit's average compliance with the health board's mandatory training was 94 percent. This exceeded the health

board’s target of 90 percent with all staff having completed training in the majority of topics set.

We also found that all staff at the unit had a personal development appraisal review (PADR) within the last year.

Improvement needed

The health board is required to provide HIW with details of the action taken to address the comments received by staff during our 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
Our immediate concerns were dealt with via HIW's immediate assurance process.	-	-	-

Appendix B – Immediate improvement plan

Hospital: Learning Disability Service (Ref 21160)

Date of inspection: 15 March 2022

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
HIW requires details of the action taken by the health board to make safe the garden and patio areas.	Standard 2.1	The majority of the fencing has now been put back up, but this does need to be replaced. In the interim, service users are supervised at all times when accessing the garden to ensure their safety. There is ongoing communication with estates about the timescale for the replacement of the remaining fence. The issues identified by HIW for action will not be added retrospectively to the walk-through document, but the completion of action to address them will be monitored via this action plan.	Ward Manager / HB Estates Dept.	Part complete: to be completed by 30th April 2022

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
	Standard 2.4	Patients have not accessed the outdoor area without staff support to ensure the items / broken fence were not a risk to their safety. The broken furniture / clinical waste bin and other items have now been removed.	Ward Manager / HB Estates Dept.	Complete
HIW requires details of the action taken by the health board to make safe the bathroom located in the annex.	Standard 2.1	Drain has now been replaced.	Ward Manager / HB Estates Dept.	Complete
HIW requires details of the action taken by the health board to review the general risk assessment for the unit.	Standard 2.1	Environment assessment and anti-ligature assessment repeated on 21.3.2022. The general Health and Safety Walk-through Inspection Findings to be repeated by the Directorate Manager; action plan to be reviewed.	Directorate Manager, Learning Disabilities	30th April 2022
HIW requires details of the action taken by the	Standard	Weekly checks are undertaken by	Ward Manager	Completed 22.3.22

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
health board to show that the emergency equipment and drugs are subject to regular checks to confirm that these are available and safe to use.	2.1	ward staff. Previous sheet had been filed on 8.3.22. Shared with HIW following visit. The disposable gloves are kept at the PPE stations and the unit has a significant stock of every size, therefore no further stock needed at this time. Replacements for the eye pads have been ordered as the date had expired on the previous items. The AED (for which a check is not marked on the example checklist embedded) has since been checked. It will be ensured that AED checks are recorded on future weekly check documents.		14.04.22 AED check complete

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): Stephen Jones

Job role: Nurse Director, Mental Health & Learning Disabilities Service Group

Date: 22.3.2022 / 14.04.2022

Appendix C – Improvement plan

Hospital: Learning Disability Service (Ref 21160)

Date of inspection: 15 March 2022

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 ensure the unit environment is maintained to a satisfactory standard.	4.1 Dignified Care	Unit environment is the responsibility of Unit manager and is under constant review. Process in place for all maintenance requests to be reported to estates and follow up for outstanding work to the estates manager. Record of requests now kept on the unit and follow up request and emails sent to ensure timely follow up. Escalation of work not completed in a timely fashion is escalated by ward manager and directorate manager. This	Unit manager, Directorate Manager & Estates department	In place

Improvement needed	Standard	Service action	Responsible officer	Timescale
		is reviewed monthly. The Service Group Quality Assurance Framework includes unannounced quality checks that includes environmental issues. A formal Environmental Audit takes place annually with Health and Safety which is reported to Directorate General Manager. Immediate assurances were provided in respect of the bathroom, broken items and fence Identified by review team and this work has been completed. Of the 5 bedrooms on the unit, there are 2 bedrooms that are currently decommissioned [TEXT REDACTED FOR THE PURPOSE OF PRIVACY]. One of these decommissioned bedrooms is being used for storage and the curtains for the room are currently not in place due to COVID. The three bedrooms being used for patient's bedrooms have shutters,		

Improvement needed	Standard	Service action	Responsible officer	Timescale
		curtains currently not being used due to COVID IPC management One bedroom window has been locked due to patient's regular pattern of behaviour putting faeces through the window into a shared patient area. We are exploring alternative clinical options to provide more scope for providing increased ventilation and choice. In the meantime opportunities are taken daily for improving airflow when not using the room. The other bedroom window that could not be opened has been reported to estates and work is being followed up in accordance with process outlined above. There is no confirmed date for replacement as of yet but this is for follow up in the next monthly estate meeting in June.		July 2022 June 2022
The health board is required to provide HIW with	4.2 Patient Information	Information is provided to individuals on admission, this includes COVID	Unit Manager	17th June

Improvement needed	Standard	Service action	Responsible officer	Timescale
details of the action taken to display relevant information within the unit that patients may find helpful e.g. health promotion material, about advocacy available, COVID-19 information and how to provide feedback or complain.		information. The unit will provide accessible Information in the foyer identifying how to provide feedback or make a complaint and general health promotion information for patients and visitors. Information on the IMHA service is available for patients and is provided on an individual basis, however they will have already received this information if they have an advocate already allocated.		
The health board is required to provide HIW with details of the action taken to promote the timely assessments of patients in accordance with the Deprivation of Liberty Safeguards (DoLS).	6.2 Peoples rights	A record of DoLS status and date of authorisation is maintained in the patient's record. A renewal form is sent 6 weeks before the end date, and a reminder is sent to the DoLS team at 3 weeks to avoid any authorisations lapsing. If it transpires that the DoLS authorisation gets to the stage that it does lapse this is recorded as a Datix incident and We have ensured that this	Divisional Manager Unit Manager	Completed Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		is then reviewed and escalated. This was appropriately escalated to the DoLS Lead. The Health Board is aware of a backlog of DoLS applications. This is a National Issue and Welsh Government have provided funding for Health Boards to address this. SBUHB has employed agency Best Interest Assessors and the outstanding assessments at [TEXT REDACTED FOR THE PURPOSE OF PRIVACY] have now been processed and DoLS are in place.	Corporate Head of Nursing LPS	Completed
Delivery of safe and effective care				
The health board is required to provide HIW with details of the action taken to provide suitable dining furniture for patients to use while accommodated at the unit.	2.5 Nutrition and Hydration	The temporary dining table has been removed and table and chairs now provided.	Unit Manager	Completed
The health board is required to provide HIW with details of the action taken to promote adherence to the medication policy in relation to staff recording the allergy status of patients.	2.6 Medicines Management	Allergy status on the medication chart has been completed for all inpatients Medication audits will capture this	Unit Manager	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		information going forward.		
The health board is required to provide HIW with details if the action taken to ensure patients' Positive Behaviour Support Plans fully reflect the actions to be taken by staff and where to record observations.	3.1 Safe and Clinically Effective care	New observation policy has now been implemented, observation care plans are in place and the observation policy sets out the elements of recording patients observations. PBS management strategies are included in the PBS plans.	Unit Manager	Completed
The health board is required to provide HIW with details of the action taken to ensure reviews of the use of seclusion are completed in accordance with the arrangements for monitoring and overseeing incidents of restrictive practice.	3.1 Safe and Clinically Effective care	Datix incidents are completed for all use of seclusion, the seclusion paperwork is attached to Datix. All incidents of seclusion are reviewed in weekly ward rounds and if required any new management strategies are included in an updated PBS plan. Within the MH and LD Service Group Health and Safety group Datix information is provided on a bi monthly basis. On a monthly basis the LD performance scorecard collates and reviews incidents reported on Datix	Unit Manager, Lead Nurse and Directorate Manager	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken to review the policy Management and Aggression.	3.1 Safe and Clinically Effective care	The unit environment has been cleansed of all hard copy policies with staff reminded to access operational policies from the intranet where all most up to date policies are held. Unit staff have also been asked to ensure that they are aware of the current policy content to avoid any confusion with the erroneous copy provided to HIW. The extant Management of Violence and Aggression Policy is attached below. It is due for review in October of this year.	Head of Health & Safety	Completed
The health board is required to provide HIW with details of the action taken to promote the full completion of admission and initial risk assessment documentation.	3.5 Record keeping	All admission and initial risk assessment documentation is completed, and we incorporate the patient's individualised care plans, e.g. PBS plans as part of this initial assessment All staff have been reminded of ensuring they incorporate and refer to the patient's PBS and care plans in their	Unit Manager	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		initial risk assessment. Regular audits of record keeping are being undertaken as part of the Service Group's implementation of the Quality Assurance Framework. These bi-monthly audits are reviewed within the Directorate and reported through Divisional Governance structure to provide assurance of meeting standards.	Lead Nurse	Bi-monthly audits are in place.
Quality of management and leadership				
The health board is required to provide HIW with details of the action taken to ensure where estates related issues are identified, timely remedial action is taken as necessary.	Governance, Leadership and Accountability	We continue to liaise with estates and Senior Managers for escalation and completion of estates issues. Record of requests kept on the unit and follow up request and emails sent to ensure timely follow up. Escalation of work not completed in a timely fashion is escalated by ward manager and directorate manager Monthly meetings with estates now	Unit Manager & Estates	22nd June

Improvement needed	Standard	Service action	Responsible officer	Timescale
		being established to review works required		
The health board is required to provide HIW with details of the action taken to address the comments received by staff during our inspection.	7.1 Workforce	There is a schedule in place for monthly team meeting with ward manager and staff team, regular supervision with individual staff. This provides a forum for the discussion and sharing of issues facing the unit and Division and developing solutions. Senior nurse lead and Directorate manager liaise regularly with the unit and staff team, and meet with individual staff members as and when requested. Staff wellbeing and experience is reported within the Divisions governance structure so management are aware of and can act on developing issues. The Divisional Management team hold regular Q&A sessions for all staff across the Division to help listen to staff. There are national challenges in the training and recruitment of Registered	Unit Manager, Lead Nurse and Directorate Manager	Process in place & Newly qualified staff recruited via streamlining Sept 2022.

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Learning Disability Nurses. The Service group has Monthly Nurse Workforce meetings where issues of recruitment, retention use of flexible workforce and the patient experience are covered. The Learning Disabilities Division has a workforce plan that addresses current workforce pressures using resources across the three Health Board areas to deliver safe care. The recruitment process for newly qualified nursing staff is via the streamlining process, September 2022 is the expected start dates for staff via the streamlining process.		

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): Stephen Jones

Job role: Service Group Nurse Director

Date: 01.06.22