Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Learning Disability Inspection Report (Unannounced)

Swansea Bay University Health Board

NHS Hospital Setting

Inspection date: 24 and 25 January 2023

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced learning disability inspection of a hospital setting at Swansea University Health Board on 24 and 25 January 2023.

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

The hospital is a small residential hospital providing care for up to five patients with learning disabilities.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
The environment had significantly improved since the last inspection and met all the needs of the patients. We observed that staff interacted and engaged with patients appropriately and treated patients with respect and dignity.

There was a range of suitable activities at the hospital and within the community for patients to access.

The range of information at the hospital could be improved for patients and families.

This is what we recommend the service can improve:

- Patient menus need to be reviewed and improved to ensure that the menu choices are meeting the nutritional requirements of the patients
- Food temperature checks need to be consistently taken and recorded
- Health information should be provided for patients and visitors.

This is what the service did well:

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff.

Delivery of Safe and Effective Care

Overall summary:

The hospital environment was equipped with suitable furniture, fixtures, and fittings for the patient group.

We found that staff were completing clinical processes and documentation as required.

There were established processes and audits in place to manage risk, health and safety and infection control. This enabled staff to continue to provide safe and clinically effective care.

This is what we recommend the service can improve:

- COSHH equipment is stored correctly

- Protect patient confidentiality.

This is what the service did well:

- Care plans were detailed, individualised, and easy to navigate
- Safe and effective medicine management.

Quality of Management and Leadership

Overall summary:

There was an established staff team with strong teamworking ethos. The staff team had a good understanding of the needs of the patients at the hospital.

This is what we recommend the service can improve:

- Regular staff meetings should take place and be minuted
- Review rotas to ensure staff have sufficient rest days between shifts
- Review and update policies
- Improve DoLS training figures.

This is what the service did well:

- Motivated and patient focussed team
- Staff team were cohesive and were positive about the support and leadership they received.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Staying Healthy

Health Protection and Improvement
Patients were able to access GP, dental services and other physical health professionals as required. Patient records evidenced detailed and appropriate physical assessments and monitoring.

We saw evidence to support and improve patient health with regular review of goals and patient progress being considered at MDT meetings.

Patients had up-to-date hospital passports in place in the event of admission to a general hospital. It was positive to note that where required, in addition to hospital passports, staff had developed enhanced health information on how the patients liked to be cared for. This provided extra detail to assist staff to understand the complex physical health requirements and how to treat patients fairly and in accordance with their specific individual needs.

Dignified care

Dignified care
We noted that all employees, including ward staff, senior management and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients.

We observed staff taking time to speak with patients and address any needs or concerns the patients raised; this demonstrated that staff had responsive and caring attitudes towards the patients.

The hospital had suitable rooms for patients to meet staff and other healthcare professionals in private. There were suitable arrangements for telephone access so that patients were able to make and receive calls in private. Depending on individual risk assessments, patients were able to have access to their mobile phones and electronic devices.

Bedroom doors had viewing panels so that staff could undertake observations without opening the door and potentially disturbing the patient. It was positive to note that viewing panels were in the closed position, opened to undertake observations and then returned to the closed position. This helped maintain patient privacy and dignity.

It was also positive to note that staff had documented and understood individual patient preferences for interventions to manage their challenging behaviours. Patient information forms were printed out and kept in the nurse's office to help any unfamiliar staff understand the needs and patient's personal preferences. These forms were very detailed and comprehensive and written in the patient's voice. Patients and staff we spoke to told us that, where possible, these advanced preferences were followed which helped maintain patient dignity and wellbeing.

Patients were able to use their own mobile phones to maintain contact with family and friends, in addition to having access to the office phones if required.

Communicating effectively

Staff explained individual needs of patients and how best to deal with communication needs for each patient. Staff were familiar with patient's individual needs and expectations.

All patients we spoke to stated that they felt safe and able to speak with a staff member should they need to. Patients told us they were happy at the hospital and that staff were kind and helpful. There was clear mutual respect and strong relational security between staff and patients.

The patients that we spoke to 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.

Patient information

We noted there was limited information displayed in the hospital to help patients and their families understand their care. There were no details about organisations that can provide help and support to patients and families affected by mental health conditions.

There was no information available on either ward on the role of HIW and how patients can contact the organisation. This is required by the Mental Health Act 1983 Code of Practice for Wales.

The health board must review the notice boards on the ward and ensure that information is up to date and relevant. The health board must make sure that

particular attention is paid to what information is displayed. Information displayed must be relevant to patients and visitors.

Timely care

Timely Access
The health board held adequate bed status management meetings to establish bed occupancy levels, and to discuss progress of patients who were awaiting discharge and community placements.

Individual care

Planning care to promote independence
Patients had their own individual weekly activity planner including individual and group sessions based within the hospital and the community (when required authorisation was in place). During the inspection we observed staff and patients engaging in activities in the hospital and in the community.

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.

Patients were fully involved in monthly multidisciplinary reviews. We saw evidence that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals. Our findings showed clear evidence of multidisciplinary involvement in the care plans, this helped support the hospital in being able to deliver comprehensive care to the patients.

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.

Some patients were waiting to leave the hospital, however, community placements were not quite ready. There was evidence that the health board was closely monitoring this and providing patients with regular updates on the status of their placements.

People's rights
We reviewed a sample of four patient records and found that all patients who were subject to Deprivation of Liberty Safeguards (DoLS) 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 or advocates was encouraged where possible.

Listening and learning from feedback
Ward staff confirmed that wherever possible they would try and resolve complaints immediately. The health board also had a process in place where patients could escalate concerns via the health board Putting Things Right complaints procedure.

Senior staff confirmed that feedback and complaints data was reported to the health board as part of the quality and safety monitoring arrangements.

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. There were currently no ongoing complaints from patients at the hospital.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety

The hospital had processes in place to manage and review risks and maintain health and safety at the hospital. The hospital provided individualised patient care that was supported by least restrictive practices, both in care planning and hospital or ward practices.

We noted that staff were not wearing alarms and there was no policy or risk assessment in place to indicate why staff were not given alarms. Given that there is no psychiatric emergency response available, this presents a risk to staff and patient safety and the health board should review this and consider implementing a policy on the use of alarms.

During interviews with staff, they highlighted that the main hospital phone was not operating correctly when staff attempted to make a 999 call. The health board must ensure maintenance checks are undertaken to ensure that staff can use the 999 facilities in an emergency.

The furniture, fixtures and fittings at the hospital were appropriate for the patient group. This area had significantly improved since our last inspection, where we identified that the environment did not meet all patients needs. The health board had recently undertaken a full refurbishment of the hospital and the environment was meeting the needs of the current patients.

There were up-to-date ligature point risk assessments in place. These identified potential ligature points and what action had been taken to remove or manage these. There were weekly audits of resuscitation equipment and staff had documented when these had occurred to ensure that the equipment was present and in date.

The hospital had a business continuity plan in place that included the service's responses to such things as adverse weather, utility failures and outbreak of infectious disease.

Infection prevention and control (IPC) and Decontamination

A system of regular audit of infection control arrangements was described. This was completed with the aim of identifying areas for improvement so that appropriate action could be taken where necessary. Staff confirmed that cleaning schedules were in place to promote regular and effective cleaning of the hospital. Staff were aware of their responsibilities around infection prevention and control and staff were observed undertaking cleaning duties effectively.

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

The hospital was very clean, tidy, and organised. Throughout the inspection, the inspection team was impressed by the level of cleanliness of the hospital, which contributed to the patients having a better experience whilst staying at the hospital.

There were hospital laundry facilities available so that patients could undertake their own laundry with appropriate level of support from staff based on individual needs.

Cleaning equipment was not always stored and organised appropriately. COSHH materials such as laundry detergents were not stored in a locked cupboard. This was brought to the attention of staff and was immediately resolved.

We also noted that the orange clinical bags were being stored in a wired basket in the clinical room and not being stored in the correct way.

Appropriate bins were available to dispose of medical sharp items and these were not over filled.

Nutrition and hydration

Patients nutritional and hydration needs are considered and recorded in files kept in the kitchen. Although there are set mealtimes staff told us that there is flexibility around timing of meals based on patient's activities and health appointments.

There is no dietician or chef oversight at the hospital, so menus are not as nutritionally well balanced as they could be, however, staff told us that the menu reflected patient preferences. The health board should review the menu plans and ensure that the dietician has some input to ensure that the meals meet the nutritional requirements of patients.

Food temperature checks were not being taken consistently, and it was unclear if the thermometers were calibrated. The health board must ensure that food temperature checks are always undertaken, and that the equipment used has been tested.

Medicines management

Medicines management was safe and effective. Medication was stored securely with cupboards and medication fridges locked. Temperature checks of the fridge

were being recorded, however, the fridge was currently not at the recommended temperature setting. This was brought to the attention of senior management to ensure that all medication is stored at the manufactures advised temperature. In addition, the clinical room was hot and the temperature of this room was not being recorded.

There was limited pharmacy input and audit activity undertaken that assisted the management, prescribing, and storage of medication at the hospital. The hospital would benefit from more frequent pharmacy support and input. We noted current medication is well overstocked and some medications also did not have dates of opening endorsed on packaging or bottles. A process was in place if emergency medication orders were required.

There were appropriate arrangements in place on the ward for the storage and use of Controlled Drugs and Drugs Liable to Misuse. However, none were currently prescribed to the patient group or being used at the time of the inspection.

We observed several medication rounds, and saw that staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately. Staff were very confident and knowledgeable when administering medication.

The current medication management policy in the clinical room expired in 2014, the inspection team were provided with a more up to date policy which is due for review in 2023, it is important that the most up to date copy is available for staff in the clinical area.

The Medication Administration Records (MAR Charts) reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages, their Mental Health Act legal status and all consent to treatment forms were present with the charts.

Safeguarding children and safeguarding adults at risk

There were established health board policies and processes in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Ward staff had access to the health board safeguarding procedures via its intranet. Senior ward staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff, they were able to show knowledge of the process of making a safeguarding referral.

Medical devices, equipment and diagnostic systems

There were regular clinical audits undertaken at the hospital and we saw evidence of regular auditing of resuscitation equipment. Staff had documented when these had occurred to ensure that the equipment was present and in date.

We identified that there were no ligature cutters at the hospital. This was immediately brought to the attention of senior management who promptly arranged for ligature cutters to be available at the hospital and we were assured that all staff would be briefed on the location of ligature cutters.

Effective care

Safe and clinically effective care

Overall, we found that systems and governance arrangements were in place, which helped ensure that staff provided safe and clinically effective care for patients. There was an established electronic system in place for recording, reviewing, and monitoring patient safety incidents. Staff confirmed that debriefs take place following incidents.

All staff participate in ward round and MDT meetings for patients, all staff stated that their views and opinions are acknowledged and welcomed within these meetings and all staff felt able to contribute their thoughts and views on patient care.

Safe and clinically effective care – Behaviours that challenge

Evidence obtained during the inspection confirmed that incidents and use of physical interventions are rarely used. This demonstrated that the use of least restrictive model of care was being used effectively at the hospital focusing on therapeutic engagement between staff and patients which created a relaxed ward atmosphere. When a restraint does take place, all completed paperwork is checked and robustly supervised and any lessons learnt are disseminated to staff.

Management of patients' behaviours were reflected in their care plans and risk management profile, along with staff training to use skills to manage and defuse difficult situations.

During interviews with staff, we were told that necessary information regarding patients care needs and risks are not always passed onto staff prior to the patients admission to ensure they receive safe and appropriate care. The health board must ensure that all relevant information is provided to staff to ensure the safety of staff and patients at the hospital.

Information governance and communications technology
We found that patient records and identifiable patient data was not always kept securely to ensure that confidentiality was maintained. The Patient Status at a Glance board was in the nursing office; however, the board was visible to patients and visitors who passed the office. The health board must make every effort to consistently protect patient confidentiality.

Record keeping
We reviewed the care plans of four patients. We reviewed a sample of care files and found that they were kept to a good standard.

Entries were comprehensive and recognised assessment tools were used to monitor mental and physical health.

Care plans were well detailed, individualized and reflected wide range of MDT involvement.

Management of patients' behaviours were reflected in their care plans and risk management profile, along with staff training to use skills to manage and defuse difficult situations.

It was positive to see that care files clearly showed patient involvement in care discussions, which were patient focussed and signed by the patient. Records also included evidence of the patients' voice to reflect their views.

There was good evidence of pain assessment being completed, and if there was a change in patients' presentation, risk assessments were completed. Physical health monitoring was consistently recorded in patient records. Overall, the nursing documentation viewed was good and physical assessments were comprehensive.

Quality of Management and Leadership

Governance, Leadership and Accountability
There was a clear organisational structure for the hospital, which provided clear lines of management and accountability. They defined these arrangements during the day, with senior management and on-call systems in place for the night shift.

During interviews with staff, they were fully aware of the on-call systems in place at the hospital.

The operation of the hospital was supported by the health board's governance arrangements, policies, and procedures.

We found a friendly, professional staff team who showed a commitment to providing high quality care to patients. Staff were able to describe their roles and appeared knowledgeable about the care needs of patients they were responsible for.

During our time on the ward, we observed a positive culture with good relationships between staff who we observed working well together as a team. It was clear to see that staff were striving to provide high levels of care to the patient groups.

Staff spoke positively about the leadership at the hospital and from senior managers within the health board's learning disability directorate. Staff also spoke favourably about the support from colleagues working within the hospital and reported a good team-working ethos at the hospital.

Arrangements were in place to quickly share information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the service provided.

We found improvements had been made in several areas since our previous inspections at the hospital. The health board had completed a renovation of the hospital, which ensured that the facilities met the needs of the patient group.

During the inspection we were unable to access some governance and audit documentation due to the ward manager and deputy ward manager being on leave. These documents were provided to the inspection team following the inspection. However, the health board must ensure that information can be accessed by others when staff are absent from the workplace.

Workforce

The staffing levels appeared appropriate to support the safety of patients within the hospital at the time of our inspection. 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 patients. This was due to several factors; agency staff being booked but not turning up for duties and agency staff not being familiar with the patient group complex needs, placed additional demands on regular staff working at the hospital.

Staff were also responsible for undertaking all the cleaning, shopping, and food preparation for the patients, with no additional support being provided from the wider health board. Discussions with staff indicated that at times they felt overworked because of the additional requirements placed upon them.

Some staff expressed concern regarding the allocation of shifts at the hospital, with some indicating that after working a set of night shifts, they would only have one rest day allocated before returning to work, which did not give them adequate time to fully recover. Staff indicated that this occurred when there were staff shortages. Some staff told us that they would work three to four twelve-hour night shifts, where they would finish work in the morning and then be rostered to be back in work the following day. The health board must ensure that allocation of staff shifts encompass sufficient rest days between shifts and that staff are recruited into the current vacancies.

We saw evidence of staff annual appraisals in staff files and there was evidence of regular staff meetings, however there were limited formal minutes of meetings being recorded.

The inspection team considered the staff training compliance and provided with a list of staff mandatory training compliance. Training figures provided to us on the inspection indicated that compliance was overall very good, however improvements are required in DOLS training as current rates were shown as 28%.

We were provided with a range of policies, however, upon review most of the versions we received had passed their review date. The following policies were found to be out of date:

- Infection prevention and control Due for review December 2022
- Health and safety Policy due for review December 2022
- Safe and supportive engagement and observation policy due for review February 2022.

The health board must make sure that all policies are updated and reviewed.

It was positive that, throughout the inspection, the staff at the hospital were receptive to our views, findings, and recommendations.

4. Next steps

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 how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No ligature cutters kept at the hospital	Risk to patient safety	Raised with senior management	Ligature cutters were immediately delivered to the hospital.

Appendix B - Immediate improvement plan

Service: Learning Disability Hospital

Date of inspection: 24 - 25 January 2023

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.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate assurances were identified during the inspection.				

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:

Appendix C - Improvement plan

Service: **Learning Disability Hospital**

Date of inspection: **24 - 25 January 2023**

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/ Regulation	Service action	Responsible officer	Timescale
1. The health board must ensure that a range of information for patients is displayed within the ward that includes: • Guidance around mental health legislation • Healthcare Inspectorate Wales • Healthy eating and well-being. • Advocacy Service	4.2 Patient Information	Unit Manager will ensure these are updated in the information board located in the entrance of the ward. They currently have information on a range of health promotion dates, so will amend this to include the improvements required.	Unit Manager	April 2023
2. The health board must make sure that staff have access to personal safety alarms, or a policy	2.1 Managing risk and promoting health and safety	The Unit Manager will review the environmental risk assessment to determine whether there is a need for	Unit Manager	April 2023

is put in place around the use of safety alarms.		personal alarms. This will be reviewed on a minimum of an annual basis. Currently there is not a requirement for personal alarms. There are door alarms on the doors and staff carry pagers to alert them to doors that have been opened.		
3. The health board must ensure that the hospitals main telephone is fixed or replaced.	2.1 Managing risk and promoting health and safety.	BT contacted to check the landline.	BT landline has been checked and issue resolved.	7.3.23
4. The health board must ensure that all relevant information is provided to staff when patients are admitted into the hospital	2.1 Managing risk and promoting health and safety.	We can confirm we provide a service to people with a learning disability who may also have mental health issues. Through the Division's Transition and Transfer meeting which manages all movements between inpatient areas we will review the list of information that is essential for safe and effective transfer of care and ensure that this is made available to all clinical teams.	Lead Nurse	April 2023

		We will thereby ensure that information is provided prior to admission by the presenting ward to inform staff of the known issues and risks.		
5. The health board must ensure that COSHH equipment is always stored correctly.	2.4 Infection Prevention and Control and Decontamination.	Unit Manager completes an environmental risk assessment annually. The Standard operating procedure in place for laundry will be circulated to all staff as a reminder and all staff will be reminded of the requirement to lock away all COSHH preparations when not being used. The laundry room will be locked when not in use and the cupboards in the laundry room are lockable. Service users will be supported to do their own laundry and do have access to detergents but with supervision from staff.	Unit Manager	April 2023
6. The health board must ensure that orange waste bags are stored appropriately.	2.4 Infection Prevention and Control and	Unit Manager to review the plan and audit process for storing clinical waste bags.	Unit Manager	April 2023

	Decontamination.	Staff will be reminded of appropriate IPC processes with the correct bag use being displayed clearly on the wall where the bags are located. The bags will be removed from the wire basket and stored more appropriately.		
7. The health board should review patient menus to ensure that the menus meet the nutritional requirements of the patients.	2.5 Nutrition and Hydration.	The unit manager will ensure that the Adult Nutritional Risk Screening Tool (WAASP) is conducted for each patient and liaise with dietetics for review as deemed appropriate. This will be cascaded across the LD service group.	Unit Manager Lead Nurse/Head of Nursing	April 2023 April 2023
8. The health board must ensure that the fridge temperature checks are recorded and escalate if temperature is not at the required setting	2.9 Medical devices, equipment and diagnostic systems.	Unit Manager to ensure there is a process for using the food thermometers consistently to take and record cooked food temperatures. The unit manager will ensure that any anomalies in the medication fridge temperatures are reported and actioned where this is required.	Unit Manager	April 2023

		The unit manager will ensure that any anomalies in the food fridge temperatures are reported and actioned where this is required.		
9. The health board must ensure that the hospital is provided with pharmaceutical support to improve medication management.	2.6 Medicines Management	The gap in provision of pharmacy input to LD (including this setting) has been identified and highlighted in the Service Group Risk Register. Funding for 0.4 x 8a specialist mental health pharmacist has recently been agreed, and successfully recruited from 1st April 23. This will help to provide pharmacist input across the 9 LD units into MDTs, clinical review of prescriptions and participation in audits e.g. antimicrobials, controlled drugs and POMH-UK.	Divisional Manager & Pharmacy Manager (Cefn Coed Hospital)	April 2023
10. The health board must ensure that patient status at a glance board is covered to protect patient details.	4.1 Dignified care.	We will ensure the patient status at a glance board is able to be covered to protect patient sensitive information. We will source an appropriate cover if required.	Unit Manager/Directorate Manager	April 2023
11. The health board must ensure that governance and audit documents can be accessed in	Governance, Leadership and Accountability	Unit Manager to review the plan and audit process for the daily/weekly/monthly audits to ensure they are available for all	Unit Manager	April 2023

absence of ward managers.		staff to access and are reviewed with an action plan.		
12. The health board must ensure that they review rotas and ensure that staff have sufficient rest days between shifts	7.1 Workforce.	Rotas will be reviewed by Unit Manager and approved 6weeks in advance. These will ensure sufficient days off and breaks between shifts to support staff well-being. The unit manager will continue to review the rota as it changes. The unit manager will attend monthly e-roster meetings to highlight anomalies with the roster. This includes staff working too many hours or too many days in a row for example. Unit Manager to remind staff that days off/annual leave are for them to have rest from the workplace for their well-being. Review compliance with roster policy with the current roster harmonisation process.	Unit Manager/Lead Nurse/E-roster	April/May 2023
13. The health board must ensure that staff meetings are recorded, and minutes can be produced when	Governance, Leadership and Accountability	The unit manager will consult with staff to agree an appropriate way to hold staff meetings/communication to	Unit Manager	May 2023

requested.		provide reassurance on information to and from the team. We will ensure staff meetings are arranged and minutes/recordings are available for all staff.		
14. The health board must ensure that training figures are improved for DoLS training.	Governance, Leadership and Accountability	Unit manager will review training levels and provide staff access to DoLS training to improve compliance. DoLS Training compliance will be monitored through the Division's performance Scorecard. The target compliance on the scorecard is 90% which we would expect to achieve by October 2023 with incremental improvements in May and August reported to performance review with escalation in these meetings if progress is not achieved.	Unit Manager Divisional Manager Divisional Manager	May 2023 May 2023 October 2023
15. The health board must ensure that that the following policies are updated and reviewed: • Infection Prevention and	Governance, Leadership and Accountability	All staff will be reminded of where to search for the most up to date policy on the intranet. Unit Manager will remind staff	Unit Manager/Lead Nurse	April 2023

Control policy • Health and safety Policy • Safe and supportive engagement and observation policy		that paper copies are not to be kept in the unit/ward area. The Health & Safety Policy and Safe and Supportive Observation policy are within date on Coin. While the review date on the IPC policy was December 2022. On 28th September 2022, the corporate Infection Prevention & Control Committee approved the extension of policy validity for 6 months so it remains live. The status of policies will continue to be overseen by that Committee. Extended dates will be added to front pages of IPC policies in future for clarity.	Corporate Head of Nursing IPC	April 2023

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): Janet Williams

Job role: MH&LD Service Group Director

Date: 09.03.2023