Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Learning Disability Inspection Report - 03100

(Unannounced)

Aneurin Bevan University Health Board

NHS Hospital Setting

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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 inspection of a learning disability hospital setting at Aneurin Bevan University Health Board on 31 January and 1 February 2023.

Our team for the inspection comprised of two HIW Healthcare Inspectors and two clinical peer reviewers. The inspection was led by a HIW Senior Healthcare Inspector.

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:
We generally observed respectful interactions between staff and patients, but some improvements were required in relation to appropriate and effective patient engagement. The furniture, fixtures and fittings of the unit were appropriate for the patient group, but further decorative measures should be undertaken to make the unit a more pleasant and therapeutic environment in line with patient needs. We were not assured that there was an effective and stimulating therapeutic activity programme being provided for patients on the unit. A full time Occupational Therapist must be recruited to the unit and a comprehensive therapeutic activity programme should be developed and provided to patients.

This is what we recommend the service can improve:

- The health board should consider value-based training for staff to ensure that appropriate language is used in relation to patient care, so that patients are actively listened to, acknowledged and respected on the unit
- Relevant and up to date patient information should be displayed in the communal areas of the unit
- The health board should undertake measures to ensure that the spiritual, religious and pastoral element of patient care is recognised and addressed
- A process should be put in place to engage patients and carers to gain feedback of their experience on the unit.

Delivery of Safe and Effective Care

Overall summary:
We found that patient records evidenced detailed and appropriate physical assessments and monitoring. Patient Care and Treatment Plans (CTPs) were individualised, person-centred and contained an appropriate amount of detailed information to support patient care. It was positive to note that improvements had been made in relation to Mental Health Act record keeping since our previous inspection of the unit, but there were some errors in Mental Health Act and Deprivation of Liberty Safeguards (DoLS) documentation. We identified that staff should be provided with additional training and governance to ensure that documents comply with legislation and are completed and submitted correctly. We saw evidence of good practice in relation to medication and controlled drugs administration, but some improvements were required in relation to medicines management and infection prevention and control.

Immediate assurances:
During the inspection HIW could not be assured that the health, safety and welfare of patients, staff and visitors was being actively promoted and protected. In addition, potential risks of harm were not being identified, monitored and where possible, reduced or prevented. The following issues required immediate action by the health board:

- We saw three examples of immediate potential risk to patient safety and advised staff to remove them, but only one risk was removed prior to the conclusion of our inspection
- We reviewed four records of patients who were undergoing therapeutic observations and found that the therapeutic observation records contained many significant gaps during which they were not updated for extended periods of time
- We reviewed six Datix incidents relating to medication errors and patient restraint incidents and found there was no investigation update within all six incidents. Senior staff confirmed that they did not understand the correct procedure to follow in order to successfully manage and investigate Datix incidents in accordance with their duties
- Staff compliance with Positive Behaviour Management (PBM) and Breakaway Training was 79%. Staff were unable to provide HIW with accurate restrictive practices data to determine the number of patient restraints which had occurred within the past three months. Staff could not identify whether members of staff who were not compliant with their restraint training had participated in patient restraints during this period.

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

This is what we recommend the service can improve:

- An audit process must be implemented to ensure that all visitors to the unit are documented and accounted for
- Clinical audits must be routinely reviewed by senior management so that any issues are identified and any opportunities for quality improvement are shared
- Measures should be undertaken to ensure that staff are compliant with the All Wales NHS Dress Code, and workplace clothing must address key Health and Safety recommendations
- The health board should undertake a review of the choice, quality and preparation of patient food provided at the hospital to ensure that it is appetising and meets patient satisfaction

- A robust programme of governance oversight should be implemented to ensure that the clinic room is appropriately maintained, that medication is managed effectively and that regular audits are undertaken by qualified staff
- The practice of using the visitors room as an additional bedroom when the unit is at full capacity must be avoided to ensure the safety of patients and staff.

Quality of Management and Leadership

Overall summary:
Staff confirmed there is a governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care. However, we were not assured that the governance structure provided strong operational support, clear leadership and accountability to ward staff. We found a general lack of robust governance oversight in relation to aspects of patient safety, mandatory training compliance, therapeutic observations and Datix investigations. We were not assured that the governance systems and arrangements in place supported continuous improvements and shared learning from incidents and serious untoward events.

This is what we recommend the service can improve:

- The health board must fully engage with ward staff to strengthen leadership and management systems in order to provide robust governance and oversight of the unit
- The health board must identify staff training needs and areas requiring improvement to ensure that the unit is effectively managed
- The health board should ensure that all staff members fully understand their role and responsibilities on the unit
- A robust programme of governance oversight should be implemented to ensure that mandatory training is completed, regularly monitored and that staff are supported to attend the training
- Supervisory staff should be trained to utilise the Electronic Staff Record system so that they can access staff training records and supervise staff training compliance
- The current training matrix system should be reviewed with a view to recording all staff training compliance on one system for ease of governance and monitoring.

3. What we found

Quality of Patient Experience

Staying Healthy

Health Protection and Improvement
We looked at a sample of patient records during the inspection and saw evidence that their physical health needs had been considered in addition to their mental healthcare. Patients were able to access GP, dental services and other physical health professionals as required. Patient records evidenced detailed appropriate physical assessments and monitoring.

During our previous inspection of the unit in 2017, we found that a number of areas needed attention to make the environment less sparse and more comfortable for patients. During this inspection it was positive to note that some improvements had been made in this area, including the recent installation of a new Hi Lo sensory bath which provided psychological and medical benefits for patients. However, we again found that the environment was generally bare and sparsely decorated. The unit floors and walls were marked, and there were very few examples of soft furnishings which would provide a relaxing and calming environment for the patient group. **We recommend that further decorative improvements are undertaken to make the communal areas of the unit a more pleasant environment for patients.** We also found that the ambient temperature of the unit was generally cold during our inspection. **We recommend that the ambient temperature should be reviewed to ensure the comfort of patients, staff and visitors.**

Patients were able to move freely within the unit and had access to their bedrooms, communal areas and an enclosed garden area. The garden area had decking and grass areas as well as raised beds which we were told were used for patient activities and therapies. During our tour of the unit, we noted that the decked area was very slippery and posed a safety risk to anyone using the garden area. **We recommend that measures are undertaken to improve the safety of the decking for the benefit of patients, staff and visitors.**

We observed that the day room of the unit was a very large, open living and dining area, with a limited amount of furniture present. Due to the emptiness and acoustics of the room the noise level in this area could become very loud and was increased by the sound of the unit office doors slamming shut throughout the day.

We recommend that measures are taken to reduce the noise levels on the unit for the comfort of patients, staff and visitors.

During the inspection we were told that individual patient needs and risk assessments prevented certain therapeutic activities from taking place on the unit. However, we were not assured that there was an effective and stimulating therapeutic activity programme provided for patients. We were advised there had been no Occupational Therapist (OT) on the unit for some time, but that a recruitment process was currently ongoing. We were told that a part time agency OT was appointed on the unit, but there was no timetable of organised therapeutic and recreational activities for patients. The activity boards and timetables in the day room were blank, so patients would not be aware of any activities available to them. **We recommend that the activity timetable should be kept up to date and made available to patients.**

During our discussions with staff we were told that a cupboard containing puzzles and games had recently been moved to the visitors' room due to recent damage, leaving no recreational activities in the day room. The activity room of the unit was being used as a storage room for general clutter and patient personal belongings but we were told that this room will be made into a protected activity room in the future. **We recommend that the process of creating a protected activity room is accelerated for the benefit of patients. We further recommend that a full time OT must be recruited to the unit, and a comprehensive therapeutic activity programme should be developed for patients.**

We saw no patient and carer information on the unit in respect of health promotion or smoking cessation. We observed that there were numerous cigarette butts in the planters and borders of the garden area which presented as unsightly and unhygienic. **We recommend that the garden area must be cleaned and maintained for patient use.**

Dignified care

Dignified care

Throughout the inspection, we generally observed respectful interactions between staff and patients, but some improvements were required in respect of appropriate and effective patient engagement. It was positive to note that staff were prompt in responding to patients in situations requiring immediate action. However, we observed that patients were sometimes ignored when they knocked on the nursing station glass to speak to staff, and we witnessed some staff speaking to patients through the glass rather than engaging in meaningful face-to-face conversation with them. We further observed some staff discussions around patient care to be depersonalised, in that staff used terminology and language such as they were 'on'

a patient rather than being allocated to support a patient, or they were going to 'do a shower' rather than stating that they were going to support a patient to have a shower. **We recommend that the health board should consider value-based training for staff to ensure that appropriate language is used in relation to patient care, so that patients are actively listened to, acknowledged and respected on the unit.**

It was pleasing to see that regular nursing staff were knowledgeable about patients and it was clear that some good professional relationships had been developed to support patient health and wellbeing. However, we noted that some agency staff members were not routinely seen to engage nor undertake activities with patients in the communal areas of the unit. We spoke to patients who confirmed that regular staff were responsive, supportive and helpful, but told us they had not built relationships with agency staff as they felt that agency staff did not know how to support them. During our conversations with staff, they disclosed concerns that agency staff members were not fully engaging with patients and would spend much of the day passively observing them. **We recommend that measures are undertaken to ensure that all staff fully engage with patients in order to build meaningful staff and patient relationships.**

During the inspection, we observed that a female patient was staying on the same corridor as two male patients and they shared a communal bathroom on the same corridor. We noted that these arrangements were not in line with the health board's Division of Mental Health and Learning Disabilities Principles for the Management of Mixed Sex Wards. We discussed this matter with staff and as a result, a member of staff was allocated to monitor the corridor overnight to ensure patient safety. **The health board should ensure that the unit adheres to the Division of Mental Health and Learning Disabilities Principles for the Management of Mixed Sex Wards, that safeguarding measures are put in place, and care plans and risk assessments are updated accordingly.**

Communicating effectively

Daily shift handover meetings were held for nursing staff to share patient information and to update the multidisciplinary team (MDT) on any concerns, issues or incidents that had taken place the day before. Unit staff demonstrated a good level of understanding of the individuals they were caring for. The unit used digital technology as a tool to support effective communication by way of online meetings, telephone discussions and email exchanges to ensure timely patient care.

It was positive to see that patient communication needs were outlined in their Care and Treatment Plans (CTPs) and advised on the use of visual schedules where applicable. Staff also described how they help patients to understand their

medication and its potential side effects by using appropriate language and providing easy read documentation.

Patient information
During the inspection we generally found a lack of relevant information displayed for patients, families and carers on the unit. A 'Getting To Know You' staff organisational photo board had been partially completed in the day room but it was not yet finished. The Staff Team Board displaying information including the lead nurse for each shift was left empty. During our tour of the unit we saw that no information was displayed regarding visiting times for family and carers, the role of Healthcare Inspectorate Wales, the Mental Health Act, nor translation services. We also did not see Health and Safety law information displayed on the ward.

The health board should ensure that relevant and up-to-date patient information is displayed in the communal areas of the unit and provided in an accessible format for patients with communication difficulties or cognitive impairment.

Timely care

Timely Access
During the inspection we observed that patients received timely care in accordance with clinical need. The unit held shift handover and daily staffing meetings to establish bed occupancy levels and to discuss patient care needs. There were regular multidisciplinary (MDT) meetings during which information was shared to ensure the timely care of patients. We observed that there were many additional meetings and processes that supported patient care and monitored the progress of patients who were awaiting discharge and community placements.

Individual care

Planning care to promote independence
During the inspection we reviewed the CTPs and Positive Behaviour Support Plans (PBSs) of three patients on the unit. It was positive to find that the plans were person centred, well-completed and provided a detailed overall picture of individual patients. The plans were focused on the individual recovery and rehabilitation of patients, and we saw evidence of patients, their representatives and community services involvement in the process. There were active discharge planning arrangements in place for patients who were ready for discharge.

The unit had a visiting room for patients to see their families in private and they were able to maintain regular contact with family and friends with the support of

staff. We observed that some patients were engaging in external activities with community-based services who provided additional support to them. Patients could make their own food and clothing choices and were encouraged to do their own laundry with the support of staff if required. However, we found the laundry room to be untidy during our inspection, with patient clothing strewn on the floor. **We recommend that the laundry room should be tidied and maintained for patient use.**

People's rights

During the inspection we reviewed two records of patients who had been detained at the hospital under the Mental Health Act and one record of a patient under a DoLS authorisation. The Mental Health Act legal documentation we reviewed was compliant with legislation, but some improvements were required in respect of document completion. Patients had access to a mental health advocate who can provide information and support to patients with any issues they may have regarding their care. Further information on our findings on the legal documentation is detailed in the Mental Health Act Monitoring section of this report.

The hospital had established policies to help ensure that patient equality and diversity were respected and their human rights maintained. However, we noted the health board's Equality and Diversity policy was out date and had expired in November 2021. It is important that policies are reviewed and kept up to date to provide clear guidance to staff. Patient care was generally consistent in accordance with the patient age group and requirements. Reasonable adjustments were in place so that everyone could access and use services on an equal basis. The furniture, fixtures and fittings were appropriate for the patient group. The doors to the main unit and the internal corridors were wide enough to accommodate wheelchair access. Mechanical hoists and specialist equipment were available for use where required.

During the inspection we did not see evidence of processes put in place by the health board which recognised the spiritual, religious and pastoral element of patient care. We discussed how the setting approaches the diversity and rights of individuals and were advised that there were no resources nor adjustments available on the unit to accommodate religious, cultural or spiritual patient needs. Staff advised that they would seek further guidance from the health board if any such patient admissions occurred. **The health board should undertake measures to ensure that the spiritual, religious and pastoral element of patient care is recognised and addressed.**

Listening and learning from feedback

The health board had a process in place where patients could escalate concerns via the health board's Putting Things Right complaints procedure. Senior staff told us that wherever possible they would try to resolve complaints immediately and share learning from incidents appropriately. However, we found that some improvements were required in respect of listening and learning from feedback.

During the inspection we noted that the health board's Putting Things Right Procedure on the Management of Concerns raised by Patients and their Representatives was out of date and expired in January 2019. We saw a 'How do I Make a Complaint Board' dated September 2022 near the main entrance of the unit, but there was no specific Putting Things Right information regarding the process of making a complaint displayed on the wards. This means patients and carers were not clearly signposted to the complaints process. **We recommend that Putting Things Right information should be displayed on the ward for the information of patients and carers.**

During a previous inspection of the unit in 2017 we found there was no formal process to obtain feedback from patients regarding the service, but staff were involved in an ongoing project to develop a formal system to obtain patient feedback. During this inspection, it was disappointing to find that there was still no formal process in place whereby patients could discuss issues and provide feedback. Staff told us that they regularly speak to patients to gain their views and that the unit held a coffee morning every Friday where patients could discuss any issues. However, we found no evidence which would demonstrate that feedback is routinely captured and acted upon as necessary. We noted that the 'You Said We Did' board had not been updated since August 2022. Staff told us that the unit's previous family and carer survey process no longer took place and this had already been identified as an issue requiring improvement. **We recommend that a process should be put in place to engage patients and carers to gain feedback of their experience on the unit, and the patient feedback boards should be kept up to date.**

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety
We saw that staff had access to personal alarms to call for immediate and urgent assistance and we were assured that there was a sufficient number of personal alarms for all staff. The unit was appropriately secured from unauthorised access and all visitors used the intercom system to gain entry. However, we were told that the number of keys provided to staff was insufficient and prevented them from conducting their duties safely. **We recommend that a sufficient number of keys must be provided to staff to ensure safety.** Staff confirmed that there was a visitor sign-in process on the unit, but that any family and carers known to staff would not routinely be asked to sign in nor their details recorded. We highlighted our concern that this presented as a potential Health and Safety, fire and security risk if any persons were to enter the unit and not be accounted for in the event of an emergency. **We recommend that an audit process must be implemented to ensure that all visitors to the unit are recorded and accounted for.**

During the inspection we found appropriate risk assessments and Health and Safety audits had been undertaken. Ward staff showed awareness and understanding of these audits, but it was concerning to note that some senior staff showed a lack of awareness and oversight of these processes. We found there was a lack of clarity surrounding the governance oversight of ward-based risk assessments which would evidence that they were being reviewed at senior management level and that any identified issues were appropriately addressed and shared to prevent reoccurrence. **Clinical audits must be routinely reviewed by senior management so that any issues are identified and any opportunities for quality improvement are shared.**

During our inspection of the unit, we saw three examples of potential risks to patient safety within a corridor of the unit:

- A bedsheet was left in the empty bath of the communal bathroom which presented a potential ligature risk to patients
- Plastic bottles of toiletries were left out in the same bathroom which presented as a potential risk to patients liable to self-harm
- A hoist was left in the corridor which presented as a potential ligature risk to patients.

On the first day of the inspection, we advised senior staff of the requirement to remove these items in order to ensure patient safety. On the second day of our

inspection we noted that the hoist had been removed, however, the bedsheet and toiletries were still present. It was concerning that senior staff did not address the seriousness of the issues present and the remedial actions required. Therefore, we were not assured that patients were being fully protected from harm within the unit.

During our inspection, we noted that all patients staying on the unit were subject to therapeutic observations which ranged from 'line of sight' to 'general observations'. We reviewed four records of patients who were undergoing therapeutic observations while at the unit. We found that in all of the records, the therapeutic observation records contained many significant gaps during which they were not updated for extended periods of time. It was unacceptable to find that none of the observation records we viewed had been completed correctly. We saw twenty examples in which nothing was documented in the records for periods of up to ten hours at a time, and two dates in January 2023 where a record was left completely blank. We further noted that several observation records were not named or dated and there were gaps in the behavioural descriptions section of the records. Additionally, none of the observation records had been signed by the Nurse in Charge, so we were not assured that there was effective governance oversight in respect of therapeutic observations, and we saw no evidence that staff were completing therapeutic observations in accordance with policy. We discussed this matter with senior staff who confirmed that a recent health board audit had found that the unit was not using the correct documentation to record therapeutic observations, yet it was still being used. We discussed the significant gaps in the documentation with staff, who responded that patients were not left unmonitored, but rather staff did not always have the time to complete the records correctly. We discussed the poor quality of the behavioural descriptions with staff, who advised that the current paper forms did not provide enough space to record detailed descriptions. Because staff had failed to update patient therapeutic observation records to reflect that they had been conducted, we could not be assured that patients were being monitored, fully protected and safeguarded on the unit.

During the inspection we were not assured that incidents were being recorded, investigated, analysed and followed up to ensure learning. The unit used the Datix Risk Management Information System to collect and manage data, escalate concerns through governance systems, identify learning and implement improvement. We reviewed three open Datix incidents of medication errors which had occurred in November 2022. It was concerning to find that there was no investigation update within any of the Datix records. The medication errors related to different medications which had been administered to one patient. In the first Datix, medication had not been signed for, so it was not clear whether the patient had received it. The second Datix related to incorrect medication being provided

to the patient from the wrong packaging, and the third Datix related to incorrect medication having been administered to the same patient over the course of a week. It was concerning and unacceptable to note that they had not been investigated by senior management.

Additionally, we reviewed three examples of closed Datix patient restraint incidents and found was no investigation update in any of the incidents. Therefore, we were not assured that restraint incidents were appropriately investigated and shared at senior level, nor that patients and staff were provided with appropriate post-incident support. During our discussions with senior staff, they confirmed that they did not fully understand the correct process and procedure to follow in order to successfully manage and investigate Datix incidents in accordance with their duties and responsibilities. We did not see evidence that the lack of investigation of Datix incidents had been identified and addressed by the senior management team. Therefore, we were not assured that incidents were being effectively investigated, managed and scrutinised to prevent reoccurrence and encourage shared learning.

We noted that staff compliance with positive behaviour management (PBM) and breakaway training was 79%. We further noted that the health board's Use of Restrictive Physical Intervention' policy was out of date. Staff were unable to provide HIW with accurate restrictive practices data to determine the number of patient restraints which had occurred within the past three months. We were further advised that details of involved staff and their actions throughout the restraint incident were not routinely captured on the new version of the Datix system. It was not possible to accurately identify whether members of staff who were not compliant with their restraint training had participated in patient restraints during this period. Therefore, we are not assured that patients and staff were being fully protected from harm within the unit.

Our concerns regarding these issues were dealt with under our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Further information on the improvements we identified, and the actions taken by the health board, are provided in Appendix B.

Infection prevention and control (IPC) and Decontamination

We found a range of suitable infection prevention and control (IPC) arrangements in place on the unit but we noted that some improvements were required. Appropriate and up to date IPC policies were in place which provided guidance to staff. We saw evidence of regular cleaning throughout our inspection. All staff wore face masks where required and there were suitable facilities to enable patient isolation if necessary. However, we found that the environment of care

required general updating and we saw that some staff office spaces were disorganised. **We recommend that the staff office areas should be tidied and maintained to provide appropriate working conditions for staff.**

Effective hand hygiene audits and facilities were in place on the unit, but we did not observe any staff hand washing or using hand gel during the inspection, nor did we observe patients being offered hand gel or being reminded to wash their hands. We did not see evidence of disinfectant wipes to clean areas in between uses. **We recommend that further measures should be undertaken to ensure that staff and patients are encouraged to practice good hygiene on the unit. We further recommend that that disinfectant wipes should be made readily available for staff use.**

It was positive to note that regular audits had been completed to check the cleanliness of the environment and compliance with hospital procedures. Within the cleaning schedule it was pleasing to see that a process of using coloured stickers to highlight completed cleaning activities had been commenced. However, it was not clear from the schedule when each cleaning activity had been completed, nor what cleaning activities were required each day. **We recommend that a process should be introduced to ensure all relevant details are recorded in the cleaning schedules so that staff are aware of which tasks require completion and their responsibilities each day.**

During our discussions with staff they showed awareness and understanding of their responsibilities around IPC and of the audit process which ensures that healthcare is being provided in line with legislation. However, it was concerning to find that some senior staff did not demonstrate an awareness and governance oversight of the audits in accordance with their supervisory responsibilities on the unit. Therefore, we were therefore not assured that clinical audits were reviewed and supervised, and any learning opportunities identified to promote quality improvement. **The health board must ensure that all senior staff understand their role and responsibilities in respect of audit governance. Clinical audits must be routinely reviewed by senior management so that any issues are identified and any opportunities for quality improvement are shared.**

During the inspection, we observed that staff were generally not compliant with the All Wales NHS Dress Code. Staff wore a mix of uniform and personal clothing to and from work including jewellery and nail polish, which presented as an IPC risk and a safety hazard. We discussed this matter with staff and confirmed that there were changing facilities on site which would allow staff to change in and out of their work clothing. Staff advised that Learning Disability Directorate staff did not usually wear uniform due to the barriers this created between staff and patients. **We recommend that measures should be undertaken to ensure that staff are**

compliant with the All Wales NHS Dress Code and that workplace clothing must address key Health and Safety recommendations.

Nutrition and hydration
Our examination of case notes and clinical entries found that patients were supported to meet their individual dietary needs and provided with diets in accordance with their medical needs. Patient nutritional and hydration needs were assessed, recorded and addressed on an individual basis. Diabetes Specialist Nurses and Speech and Language Therapists (SALT) were available on site for patients where required.

Patients were supported to make food choices and could access drinks and snacks throughout the day. In addition to the food provided on the unit, patients were able to purchase and store food and snacks in the kitchen of the unit. However, we did not see any evidence of healthy-eating initiatives in the service. The patient snacks were self-bought and generally included sweets, chocolate and crisps**. We recommend that healthy eating initiatives are implemented on the unit for the benefit of patients.**

During our previous inspection of the unit in 2017, we found that the food was unappetising and were told that the variety and quality of food had been the subject of previous patient complaints. During this inspection we found that the food provided to patients met their basic nutritional needs, but it again appeared to be unappetising and poor in quality. The hot food served to patients was pre-cooked in the main hospital and then transported to the wards for serving. Menus were provided to patients in written form the day before, but there were no pictures of the meals provided which would help patients to make an informed choice. **We recommend that the health board should undertake a review of the choice, quality and preparation of patient food provided at the hospital, to ensure that it is appetising and meets patient satisfaction. We further recommend that pictures of the menu choices should be provided so that patients can view a pictorial and written menu.**

Medicines management
We observed that relevant policies, such as Medicines Management and Rapid Tranquillisation, were available to staff electronically on computers but were out of date.

During our tour of the unit, we viewed the clinic room and found that there were several issues which we requested staff to rectify during the inspection. The clinic room was accessed from the nursing office which was secure from unauthorised access, but the clinic room door was found to be unlocked, which presented as a

security risk. We saw two freestanding oxygen cylinders outside the clinic room door that were not secured and presented as a safety hazard. **Oxygen cylinders must be appropriately secured to protect the safety of patients, staff and visitors.** Inside the clinic room, the drugs fridge was unlocked with medication inside. There were numerous gaps in the refrigerator temperature and room temperature monitoring logs, and the sharps box was full and required collection. The drugs cupboard and Controlled Drugs storage cabinet were found to be secure within the clinic room, but in a disorganised state. The medication cupboard was very full and contained items of disused medication as well as duplicate medication boxes which had been opened needlessly. Staff confirmed there was no formal programme of audit which would ensure there were adequate supplies of in-date items, nor to prevent any theft or loss. We highlighted these issues to staff and discussed the need for a weekly review of the medication stored within the unit. It was positive to note that ward staff were receptive to our recommendations. **We recommend that a robust programme of governance oversight should be implemented to ensure that the clinic room is appropriately maintained, that medication is managed effectively and that regular audits are undertaken by qualified staff.**

We viewed a sample of Medication Administration Records (MAR charts) and saw examples of good practice in relation to medication administration. There was evidence of regular medication reviews completed during weekly ward rounds. We saw examples of individualised medication management plans and observed appropriate prescribing of medication. Controlled Drugs were signed for and administered correctly, according to legislation and guidance. However, we noted that some MAR charts did not have photographs of patients attached, which highlighted a potential risk in relation to the administration of medication. The unit had a high usage of agency staff who were unfamiliar with patients, which posed a risk of medication errors. **We recommend that the health board should attach photographs of patients to MAR charts to assist with identification.**

Safeguarding children and safeguarding adults at risk

At the time of our inspection we were informed that there were no open Adult at Risk reports under investigation on the unit. There were established health board policies and processes which supported the safeguarding of vulnerable adults which staff could access via the intranet. We saw a high level of staff training compliance with mandatory safeguarding courses. During discussions with staff it was pleasing to note that the unit maintained good contact with the NHS Safeguarding Team.

Medical devices, equipment and diagnostic systems

There were regular audits of resuscitation equipment; staff had documented when these had occurred to ensure that the equipment was present and in date.

Effective care

Safe and clinically effective care

There was an established electronic system in place for recording, reviewing, and monitoring patient safety incidents via the Datix system. However, we found evidence that incidents had not been investigated and we were not assured that patients and staff were safe and protected from avoidable harm on the unit.

Some staff we spoke to during the inspection expressed concerns regarding the safety of staff and patients on the unit. Some staff told us there was some confusion about the role and responsibilities of senior staff which created challenges in providing consistent care and support to patients. We were further told that some previous incidents which had resulted in injury to unit staff were not appropriately investigated and no resolution was provided to the staff members concerned. We were further told that the staff involved in such incidents did not receive adequate support and aftercare from the service. Previously, the setting had provided weekly reflective practice meetings for staff, and post-incident debriefings with a clinical psychologist. However, the clinical psychologist post at the unit was currently vacant. **We recommend that the health board should conduct a review of incidents which have resulted in injury to staff, to ensure they have been investigated and finalised appropriately.**

During the inspection staff expressed concerns that the unit occasionally accepted an additional patient even when it was at full capacity. This resulted in the visitors' room being used as an additional patient bedroom, which created additional pressure and safety risks for staff and patients. Staff told us that the visitors' room was not appropriately equipped as a patient bedroom and had no vision panel for therapeutic observations, which posed a risk to patient safety. **The practice of using the visitors' room as an additional bedroom when the unit is at full capacity must be avoided to ensure the safety of patients and staff.**

It was positive to see that CTP and PBS plans were individualised, person-centred and contained an appropriate amount of detailed information to support patient care. Physical health care was monitored and recorded, and MDT reviews were undertaken weekly to conduct more formal reviews of patient care. Discharge planning was evident throughout the patient admissions and the unit made post-discharge contact with patients to provide additional support. **To support the CTPs, we would recommend that pen profiles should be attached to patient files for staff awareness, particularly agency staff who are unfamiliar with patients.**

Safe and clinically effective care – Behaviours that challenge

During our discussions with staff they demonstrated an understanding of how patient physical health needs could impact on challenging patient behaviour. The patient PBS plans were comprehensive, regularly reviewed and included strategies for managing challenging behaviour. However, we saw little evidence of therapeutic engagement aligned to reducing restrictive practices or preventing challenging behaviour being used in the care and treatment provided to patients. Staff correctly outlined the process to follow when incidents of challenging behaviour or restrictive practices occurred. However, we were not assured that such incidents were correctly recorded, supervised, investigated and scrutinised to prevent reoccurrence and share learning as outlined previously in this report.

Quality improvement, research and innovation
During our discussions with ward staff and senior managers, we were provided with examples of how they were reviewing the provision of service on the wards and the wider health board. These included shift handover meetings, daily staffing meetings, weekly MDT meetings and monthly Quality and Patient Safety meetings.

It was positive to learn that the Senior Leadership Team were providing additional training to enhance the career progression of staff with a view to retaining qualified nurses on the unit. We were advised that two staff members were completing an Advanced Nurse Practitioner Course on the unit and two additional staff members had been selected to complete the course in future.

Record keeping
It was positive to see that there were secure file storage arrangements in place to prevent unauthorised access and breaches in confidentiality. In the nurses' office there was a patient status board displaying comprehensive and confidential information regarding each patient being cared for on the unit. The information was hidden when not in use. This meant that the staff team placed an emphasis on protecting patient confidentiality.

The hospital had recently adopted a new electronic health record system which resulted in patient Care and Treatment Plans being recorded on two formats, but it was pleasing to find they were easy to navigate. Any missing or out of date information within the written documentation was found to be correctly updated onto the new Welsh Community Care Information System (WCISS) system. The entries we viewed were comprehensive and recognised assessment tools were used to monitor mental and physical health. We were assured that the new health record system will improve working practices in the future. This demonstrates that the health board is working towards putting effective systems and processes in place which will improve long term quality and performance.

During the inspection we were advised that administrative staff sickness on the unit was causing additional workload and pressure for staff. We were further advised that there had been no working printer on the unit for the previous two months prior to inspection. **We recommend that the health board should ensure there is adequate administrative cover on the unit. We further recommend that the unit must be provided with a fully functional printer to assist staff in their duties.**

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision Mental Health Act Monitoring

Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010. We reviewed three patient records to ensure compliance with the Mental Health Act (MHA). This included two patients detained under the MHA, and one patient under a Deprivation of Liberty Safeguards (DoLS) authorisation. Overall, we found that there had been improvements in the organisation of the MHA records since our previous inspection of the setting. The files were divided into sections whereby statutory forms could be easily located and read in context. However, within the MHA files, there were some duplicates or out of date versions of statutory detention forms which should be removed to avoid any confusion. **We recommend that patient MHA records should be reviewed to ensure that documents are not unnecessarily held on file.**

We found there were some minor omissions in MHA documentation. The Approved Mental Health Practitioner's (AMHP) signature was found to be missing from a professional report. The CTPs for the two patients detained under the MHA were not signed by the patient. Section 17 Leave forms were generally completed correctly, but some errors were noted which included circulation boxes unticked and Nearest Relative contact details which had not been fully completed. **Measures must be implemented to ensure that Mental Health Act documentation is fully and correctly completed.**

On reviewing the DoLS documentation, we found that the statutory authorisation paperwork was missing from the patient file. We highlighted this issue to staff who later produced the authorisation document, but there were significant errors within the form. The form wrongly cited an alternative health board as the supervisory body, not Aneurin Bevan University Health Board. The urgent authorisation was authorised for a seven-day period in October 2022, after which it expired, but there was no further DoLS authorisation documentation on file. We discussed this matter directly with the health board's DoLS team, who advised that the incorrectly completed form initially submitted to them by unit was rejected and returned to the unit to be rectified and resubmitted. During the inspection the DoLS team advised that the unit had never returned the correct documentation to

request a further extension of the patient's DoLS authorisation which meant the DoLS authorisation had expired. Following the inspection, we were later advised that the documentation had been amended correctly and sent to the DoLS team therefore authorisation had not expired.

We discussed these issues with staff and noted that staff compliance with non-mandatory Mental Capacity Act training was 63 per cent. We were advised that additional Mental Health Act training will be arranged for staff. **We recommend that unit staff should be provided with additional training, instruction and governance with regards to the MHA and DoLS to ensure compliance with legislation and that documents are completed and submitted correctly.**

In 2017, HIW recommended that the health board should make copies of the Mental Health Act Code of Practice for Wales (the Code) available on the unit and were assured this would be actioned. However, during this inspection they were again not found to be present on the unit and staff could not account for this. **We again recommend that copies of the Mental Health Act Code of Practice for Wales (the Code) should be made available on the unit.**

Quality of Management and Leadership

Governance, Leadership and Accountability
Staff confirmed there is a governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care. The unit had a manager and deputy who were supported by a committed ward and multi-disciplinary team. Staff we spoke to during the inspection told us that the team provide good peer support to each other and put the patients at the forefront of their duties. It was positive that, throughout the inspection, all staff were receptive to our views, findings and recommendations.

However, we were not assured that there was a clear governance structure for the unit which provided operational support and clear lines of management and accountability to ward staff. Over the course of our inspection, it was concerning to observe a general lack of robust governance oversight on the unit in relation to aspects of patient safety, mandatory training compliance, therapeutic observations and Datix investigations. We were not assured that the governance systems and arrangements in place supported continuous improvements and shared learning from incidents and serious untoward events.

During our discussions with unit staff, they told us that the management support at unit level was adequate, but there was some confusion about the role and responsibilities of senior staff on the unit. We also spoke to supervisory staff who confirmed that they did not fully understand their role and responsibilities and stated that they would like additional support. Additionally, some staff told us that they felt there was little visibility, involvement and support from the senior management team. During our inspection, we observed that some staff members did not appear to have been given any instruction from senior staff and were left waiting for long periods of time not knowing what to do. We were informed that there was an induction process in place for new staff, but that some staff told us they had not received an induction to the unit. Therefore, we were not assured that there was an effective management and supervision process on the unit which provided clear guidance to staff.

We recommend that the health board must fully engage with ward staff to strengthen leadership and management systems in order to provide robust governance and oversight of the unit. The health board must identify staff training needs and areas requiring improvement to ensure that the unit is managed effectively. Inductions should be provided to all staff to ensure they are aware of their role and responsibilities on the unit.

During the inspection, we requested mandatory training compliance information from staff. The majority of training was completed on the Electronic Staff Record (ESR) system. It was concerning to note that supervisory staff did not display oversight of mandatory training compliance and were not able to search the training system to locate this information. We were further advised that some training courses were recorded by other means, which caused difficulties in obtaining an overall picture of training compliance. Therefore, we were not assured that mandatory staff training levels were regularly reviewed and scrutinised at supervisory level, to ensure that staff were up to date with their professional requirements and had the necessary skills and knowledge to care for the patient group.

We were provided with overview of staff training compliance which indicated that overall mandatory training compliance was 85%. However, training compliance with Moving and Handling Level 1 was 75 percent and Moving and Handling level 2 was 53 per cent. Training compliance in both Fire Safety and Resuscitation courses was 75 per cent. Staff we spoke to during the inspection told us that they do not receive protected time for online training which caused difficulties for them when completing their mandatory training courses.

We recommend that the health board must implement a robust programme of governance oversight to ensure that mandatory training is completed, regularly monitored and that staff are supported to attend the training. Supervisory staff should be trained to utilise the training matrix system so that they can access staff training records and provide oversight of staff training. We further recommend that the current training matrix system should be reviewed with a view to recording all staff training compliance on one system for ease of governance and monitoring.

During the inspection we noted that several health board policies or procedures were out of date and required review. These included:

- Medicines Management Policy (2021)
- Equality and Diversity Policy (2021)
- Putting Things Right (2019)
- Use of Restrictive Physical Intervention Policy (2019)
- Access to Health Records Guidance for Staff (2021)
- Corporate Induction Policy – (2016)
- Standard Operating Procedure – Covid Safety in the Workplace General Guidance Policy (2021)
- Occupational Health and Safety Policy (2018).

The health board must review any outdated policies to ensure that policies and procedures are kept up to date and provide clear guidance to staff.

Workforce

Regular staff meetings took place to ensure that staffing levels were sufficient to support the safety of patients on the unit. The unit relied on support from bank and agency members of staff as and when required. However, staff told us that the unit was often short staffed, which left them without sufficient time to care for patients. Staff further told us that the high usage of bank and agency staff created challenges on the unit, as agency staff were often unfamiliar with the patients and their complex needs. Senior staff told us that that they tried to ensure staff continuity to benefit the patient group, by using regular and bank staff as much as possible. The health board offered enhanced financial incentives for regular and bank staff who wished to work additional shifts on the unit. The unit had put processes in place to retain and develop regular staff by providing additional training and creating additional posts for them within the unit. The senior management team were also implementing a twelve-hour shift pattern on the unit which would improve staffing cover. **We recommend that the health board should continue to actively implement measures to reduce the high level of bank and agency staff on the unit.**

At the time of our inspection the staffing levels were appropriate but there were a small number of staff vacancies which were being recruited to, including vacant clinical psychologist and occupational therapist posts. We were told there was a supportive team of regular staff on the unit but that several staff members had recently left their posts due to career progression. **The health board should continue to actively focus on the recruitment of permanent staff into vacant posts on the unit.**

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
A hoist was left in the communal corridor	This presented as a potential ligature risk to patients	We advised staff of the need to remove the hoist to ensure patient safety	The hoist was removed during the inspection

Appendix B – Immediate improvement plan

Service: Learning Disability Hospital

Date of inspection: 31 January and 1 February 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	Regulation/ Standard	Service action	Responsible officer	Timescale
Delivery of Safe and Effective Care				
During the inspection HIW could not be assured that the health, safety and welfare of patients, staff and visitors at the unit was being actively promoted and protected. In addition, potential risks of harm were not being identified, monitored and where possible, reduced or prevented. The following issues require immediate action by the health board:				
During our tour of the unit, we saw three examples of potential risks to patient safety within a corridor of the unit: • A bedsheet was left in the empty bath of the communal bathroom which presented a potential ligature risk to patients	Standard 2.1 Managing Risk and Promoting Health and Safety	Bed sheet & toiletries have been removed.	Ward(WM) Manager	Complete - 01/02/23
		Staff have been reminded of the importance of timely removal of items from the ward area. A daily 'task sheet' has been developed which includes 'environment walkthroughs' to ensure staff are	Ward Manager	Complete - 06/02/23

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Plastic bottles of toiletries were left out in the same bathroom which presented as a potential risk to patients liable to self-harm • A hoist was left in the corridor of Cefn Gwlad which presented as a potential ligature risk to patients. We advised staff on the first day of the inspection of the requirement to remove these items in order to ensure patient safety. On the second day of our inspection we saw that the hoist had been removed, however, the bedsheet and toiletries were still present. Staff did not address the seriousness of the issues present and the remedial actions required. Therefore, we were not assured that patients are being fully protected from harm within the unit. The health board must ensure that suitable and effective measures are in place to ensure potential risks to patient safety are identified, assessed and mitigated.		alert to risks such as no bin liners, that toiletries have been locked away etc. Agency/Bank staff are also made aware of such risks at the start of the shift so everyone is alert to them.		
		Hoist is now stored in the assisted bathroom (this is where the hoist is usually stored however it had recently been in use and had not been returned) which is locked unless in use and staff support service users at all times when in this area. (Daily task sheet also references this).	Ward Manager	Complete - 01/02/23
		Environmental walk around added to daily checks which include escalation process, signature and date.	Ward Manager/ NIC	Complete - 07/02/23

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
During our inspection we noted that all patients staying on the unit are subject to therapeutic observations which range from 'line of sight' to 'general observations'. We reviewed four records of patients who were undergoing therapeutic observations while at the unit. We found that in all four records the therapeutic observation records contained many significant gaps during which they were not updated for extended periods of time. We saw an example of one record which had not been updated for over six hours and another left entirely blank. Because staff had failed to update patient therapeutic observation records to reflect that they had been conducted, we could not be assured that patients were being monitored and fully protected and safeguarded on the ward. The health board must provide HIW with details of the actions to be taken to ensure that:	Standard 2.1 Managing Risk and Promoting Health and Safety	A spreadsheet has been developed to record the date that all staff have completed the competencies set out in the Division's Therapeutic Observations and Engagement policy. These are signed off by WM/ DWM Reminders are also included in the Handover sheet	Ward Manager and Deputy Ward Manager (DWM)	By end of February 2023
		The Band 6 Clinical Nurses will take on this responsibility and ensure audits are undertaken as per policy.	Clinical Nurses	Ongoing from March 2023
		Governance processes on the ward have been reviewed to ensure that spot-checks by WM/DWM are undertaken weekly; ensuring any issues are dealt with promptly & escalated to the Senior Nurse/ Directorate team.	Senior Nurse, Ward Manager	17/02/23

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Consistent therapeutic patient observations are being undertaken by staff as determined • Therapeutic observations are recorded and appropriately documented • Staff are provided with provide additional training and guidance in this area.		The Nurse in Charge must check and sign each observation chart at the end of each shift to ensure these are being completed.	Nurse in Charge/Ward Manager	Completed - 07/02/23
		Face to face training re Therapeutic Observations and Engagement policy is being reviewed to ensure all staff are aware of their responsibilities under the policy.	Ward Manager/ Senior Nurse	By April 2023
We reviewed three open Datix incidents of medication errors which had occurred in November 2022. We also reviewed three examples of previous Datix restraint incidents which had been closed.	Standard 2.1 Managing Risk and Promoting Health and Safety	These errors were immediately reviewed by the Senior Nurse. Staff involved have been spoken to. This has been captured and updated on Datix.	Senior Nurse	Completed – 02/02/23

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
We found that there was no investigation update within any of electronic Datix records for all six incidents. During our discussions with senior staff, it was confirmed that staff did not fully understand the correct process and procedure to follow in order to successfully manage and investigate Datix incidents in accordance with their duties and responsibilities. Therefore, we were not assured that incidents were being effectively investigated, managed and scrutinised in order to prevent reoccurrence and encourage shared learning. The health board must ensure robust processes are in place to ensure all incidents are effectively investigated, managed and scrutinised.		Procedures now in place to ensure that Datix review is part of the ongoing duties of the WM/DWM to ensure Datix review is completed in a timely manner.This will be monitored by the Senior Nurse fortnightly.	Ward Manager & Senior Nurse	Completed
		Incident reporting through the Datix system will be reviewed at weekly managers meetings. These meetings are attended by ward manager, professional leads, senior nurse, service improvement manager and clinical director. The Datix's will be reviewed at this meeting and closed appropriately.	Clinical Director	14/02/2023
		Training dates for Datix incident review/investigation have been booked for managers in February (15th and 23rd).	Ward Manager	End of February 2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
During the inspection we noted that staff compliance with positive behaviour management (PBM) and breakaway training was 79%. We further noted that the health board's Use of Restrictive Physical Intervention' policy was out of date. Staff were unable to provide HIW with accurate restrictive practices data to determine the number of patient restraints which had occurred within the past three months. We were further advised that details of involved staff and their actions throughout the restraint incident are not routinely captured. It was not possible to accurately identify whether members of staff who were not compliant with their restraint training had participated in patient restraints during this period. Therefore, we are not assured that patients and staff are being fully protected from harm within the unit. The health board must provide HIW with details of how it will ensure that robust processes are put in place to ensure that	Standard 3.1 Safe and Clinically Effective care	The Health and Safety team has reviewed the Restrictive Physical Intervention Policy. This is due to be presented to the Health Board's Health & Safety Committee on 9 February. Following a period of consultation, it is anticipated this will be in place in March/April 2023.	Head of Health, Safety & Fire	April 2023
		All staff who are currently out of compliance with PBM training have trainings booked before the end of April 2023. Annual training dates for all staff have been allocated for 2023.	Senior Nurse/Ward Manager	Complete
		Restraint incidents were recorded on the Datix system. However, these have been recorded previously under the category of 'behavioural incident' only. To ensure consistent and accurate data is collected, staff have been	Senior Nurse/Ward Manager	14/02/2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
restraint incidents are being effectively recorded, investigated, managed and scrutinised in order to prevent reoccurrence and encourage shared learning. Measures must be taken to ensure that all relevant details of restraint incidents are captured and recorded to include all involved members of staff and their actions throughout the incident.		reminded to record the 'sub category' as 'restraint' in order that the correct part of the template is populated. A 'how to' guide has been provided to the ward. These will be reviewed at the weekly managers meetings as above.		

Additional actions identified by ABUHB to address the impact on governance and leadership				
Improvement needed	**Regulation/ Standard**	**Service action**	**Responsible officer**	**Timescale**
Strengthen leadership and management systems and assurance Strengthen quality governance and assurance	Quality of Management & Leadership	Bespoke training and supervision for managers and leaders. Greater visibility of senior leaders. Assurance / Safety Walk-Arounds to proactively support engagement of staff and identify areas for further improvement / safety issues.	Senior Management Team MH/LD Corporate Nursing Team Clinical Executive MH/LD	Commenced and ongoing
		Additional oversight and assurance to provide further support and identify further improvements. Improvement plan to be developed and overseen by a unit development group and senior management.	Senior Management Team MH/LD Corporate Nursing Team Clinical Executive MH/LD	Commenced and ongoing

		Infection Prevention & Control Team to undertake an observational visit to provide support and education. Reviewing previous audit outcomes to identify trends and ensure all areas of concern have been actioned.	Infection Prevention & Control Team	By 24/02/23
		Ensure staff know how to raise concerns and provision of support for the ward-based leadership team and escalate appropriately.	Senior Nursing Leadership Team	End of February 2023
		Proactive process for review of ward environment across the Division, to include: • Health and Safety	Head of Health, Safety & Fire	By 11 March 2023
		• Facilities	Service Improvement Manager – Facilities	By 11 March 2023

		• Ensure engagement with the person centred care team to ensure appropriate and meaningful activities are offered and available to service users.	Head of Nursing - Person Centred Care	By 11 March 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): Michelle Forkings

Job role: Divisional Nurse, MH & LD

Date: 15.2.23

Appendix C - Improvement plan

Service: **Learning Disability Hospital**

Date of inspection: **31 January and 01 February 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
Decorative measures should be undertaken to make the communal areas of the unit a more pleasant therapeutic environment for patients.	Staying Healthy	Meeting held with furniture provider on 24/03/23. Paper will be developed and provided to the Health Board for funding for the new furniture. A 'Hospital Environment Board' (HEB) walkaround with the Lead Nurse (LD), and which included a representative from works and estates was carried out on 20/03/23. Floor repairs, wall repairs and painting were identified. Costings are being sought for the work required.	Lead Nurse, LD	June 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The ambient temperature of the unit should be reviewed to ensure the comfort of patients, staff and visitors.	Staying Healthy	Works and Estates have replaced the boiler and water tanks. The heating is now fully functioning and the temperature on the ward is consistently at an appropriate level.	Supervisor, Works & Estates	Complete
		Daily room temperature checks are being completed to ensure the temperature on the unit remains within the recommended guidelines.	Ward Manager	Complete
Measures should be undertaken to improve the safety of the decking for the benefit of patients, staff and visitors.	Staying Healthy	Works and Estates request has been raised to assess the decking and remedy any actions required.	Supervisor, Works & Estates	September 2023
Measures should be taken to reduce the noise levels on the unit for the comfort of patients, staff and visitors.	Staying Healthy	Meeting held with furniture provider on 24/03/23. Paper will be developed for Divisional/ Health Board approval to fund new furniture and acoustic tiles. Works and Estates have fitted soft close hinges on the doors to reduce noise levels.	Lead Nurse, LD	June 2023 Complete

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The activity timetable should be kept up to date and made available to patients.	Staying Healthy	Process has been implemented to ensure that the activity board is updated every Monday after staff and patient mutual help meeting (as per 'Safewards' approach).	Ward Manager	Complete
		A 2-week OT visual easy read activity timetable has been displayed on the unit.	Ward Occupational Therapist	Complete
The activity room should be decluttered and converted into a protected activity room for patients.	Staying Healthy	Room has been cleared and sensory activities put in place in the room.	Ward Manager	Complete
A full time OT must be recruited to the unit and a comprehensive therapeutic activity programme should be developed for patients.	Staying Healthy	Interviews held on 21/02/23 and appointment made. Start date of 01/04/23 has been agreed.	Professional Head OT for LD	Complete
The health board must ensure that they adhere to the current Welsh Government smoking guidelines.	Staying Healthy	The Health Board is compliant with WG legislation.	Divisional Nurse	Complete
The cigarette butts in the garden area must be removed and the	Staying Healthy	Raised with Facilities Division and meeting held 17.02.23.	Senior Manager, Facilities	Next meeting is April 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
garden should be cleaned and maintained for patient use.		Outcome: to scope resources required to inform a funding case to maintain outdoor areas cleaning schedules on MH and LD units.		
The health board should consider value-based training for staff to ensure that appropriate language is used in relation to patient care, so that patients are actively listened to, acknowledged and respected on the unit.	Dignified Care	All staff complete Positive Behaviour Support (PBS) training which encompasses value-based training.	Lead Nurse, LD	June 2023
		4-weekly staff meetings will be structured using the 'Safewards' approach; encouraging positive words and other safe wards principles and priorities.		
Measures should be undertaken to ensure that all staff fully engage with patients in order to build meaningful staff and patient relationships.	Dignified Care	Pen profiles of patients which include 'The things I like doing' will be formulated for bank and agency and staff to read prior to their shift.	Ward Manager & Senior Nurse	April 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Daily shift plan to focus on allocating staff for patient engagement activities whilst providing enhanced observations.		
The health board should ensure that the unit adheres to the Division of Mental Health and Learning Disabilities Principles for the Management of Mixed Sex Wards, that safeguarding measures are put in place, and care plans and risk assessments are updated accordingly.	Dignified Care	All bedrooms in the unit are single occupancy. Bedrooms are along two corridors which are designated male and female, where toilets/bathrooms are situated. Two bedrooms are en suite.	Ward Manager	Complete and Ongoing
		Where it is not possible to accommodate a female person in the female corridor due to bed availability, individual care plans and risk assessments will be formulated to ensure appropriate safeguards are in place as per the Division's principles.		

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Relevant and up-to-date patient information should be displayed in the communal areas of the unit and provided in an accessible format for patients with communication difficulties or cognitive impairment.	Patient information	The Health Board provides patient information in different languages and in easy read format. These are updated regularly and are available via the staff intranet page.	Ward Manager/ Senior Nurse/ Lead Nurse	Complete and Ongoing
		Lockable display cabinets have been ordered so patient information relating to patients on the unit can be displayed in the main ward area, and not be removed by patients.	*note – a significant amount of information that is usually on display had been removed due to the distress it causes a particular patient on the unit who has had an extended admission	July 2023 (due to lead time on order)
		Patient information is now on display in the visitors' room until the display cabinets are delivered.		Complete
		There is a patient information leaflet that should be provided to all patients on admission. This will be reviewed to ensure all information is up to date.		June 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The laundry room should be tidied and maintained for patient use.	Planning care to promote independence	The laundry room has been re-organised and added to the daily task form.	Ward Manager	Complete
The health board should undertake measures to ensure that the spiritual, religious and pastoral element of patient care is recognised and addressed	People's rights	The Health Board provides a chaplaincy service that can be called to offer pastoral (wellbeing), religious or spiritual care to anyone in the Health Board who feel they would benefit from it. Their contact details have been displayed on the ward. Within the 'The things I like doing' form there is a section for patients to identify their spiritual and or religious preferences and needs.	Ward Manager/ Senior Nurse/ Lead Nurse/ Professional Head OT for LD	Complete
		OT professional lead has arranged to meet with members of the chaplaincy service to discuss how they can be more visible and provide support to the unit staff and patients.		

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Putting Things Right information should be displayed on the ward for the information of patients and carers.	Listening and learning from feedback	The Health Board provides patient information in different languages and in easy read format. These are updated regularly and are available via the staff intranet page.	Ward Manager	Complete
		Lockable display cabinets have been ordered so patient information relating to patients on the unit can be displayed.		July 23 (due to lead time on order)
		Putting things right contact details have now been displayed on the ward.		Complete
		There is a patient information leaflet that should be provided to all patients on admission. This includes information on how to make a complaint. Staff have been reminded to provide this leaflet to patients & their carers on admission.		Complete

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
A process should be put in place to engage patients and carers to gain feedback of their experience on the unit, and that the patient feedback boards should be kept up to date.	Listening and learning from feedback	As part of the unit care pathway there is a feedback questionnaire for patients and carers. Feedback from the questionnaires is reported to the unit development meeting. The pathway and its embedded documents including the feedback questionnaire will be re-established within the team on the unit.	Directorate Manager/ Clinical Director/ Led Nurse	June 2023
		Process has been implemented to ensure that the patient feedback is updated every Monday after staff and patient mutual help meeting as per 'Safewards' approach.	Ward Manager	Complete
A sufficient number of keys must be provided to staff to ensure safety.	Managing risk and promoting health and safety	Every member of regular staff is allocated their own key and a record of this is kept by the Service Improvement Manager. There are 4 spare keys for agency/bank workers which need to be signed in and out. There is	Service Improvement Manager (SIM), LD	Complete

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		now also a process for staff leaving and new starters for the allocation of keys. There is an audit in place for keys which is completed 3 monthly.		
An audit process must be implemented to ensure that all visitors to the unit are recorded and accounted for.	Managing risk and promoting health and safety	A visitors' 'signing in' book is now in the visitors' room. Staff have been informed that all visitors should be taken immediately to the visitor's room and asked to sign in before they access the unit. Weekly spot check now in place to monitor compliance.	Ward Manager Lead Nurse	Complete and Ongoing Complete
The health board must ensure that all senior staff understand their role and responsibilities in respect of audit governance.	Managing risk and promoting health and safety	The Directorate's audit programme is discussed and reviewed at bi-monthly Directorate Quality and Patient Safety meetings.	Lead Nurse	Complete

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Clinical audits must be routinely reviewed by senior management so that any issues are identified and any opportunities for quality improvement are shared.		Ward based clinical audits have been allocated to designated members of staff and will be reviewed on a monthly basis by the ward manager.	Ward Manager	Complete
		Spot checks are now in place to oversee these.	Senior Nurse	Complete
		Directorate senior managers have organised bi-monthly assurance meetings with ward managers and team leads, focussing on clinical governance and assurance. These will be fed back to the Divisional team at the existing Divisional Assurance meetings with the Directorate.	Directorate Management Team	Completed and Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Staff office areas should be tidied and maintained to provide appropriate working conditions for staff.	Infection prevention and control (IPC) and Decontamination	Work has commenced to de-clutter the environment and a skip has been provided to dispose of unwanted and unnecessary items.	Ward Manager	May 2023
		A day has been allocated for the Deputy ward manager, administrator and Service Improvement Manager (SIM) to remove all obsolete documentation.	Deputy Ward Manager, SIM, Administrator	
Further measures should be undertaken to ensure that staff and patients are encouraged to practice good hygiene on the unit. Disinfectant wipes should be made readily available for staff use.	Infection prevention and control (IPC) and Decontamination	There are disinfectant wipes available within the stock cupboards and there is a process for ensuring that stock levels are maintained. Disinfectant wipes will be added to the daily cleaning checklist to ensure they are readily available in staff areas and easily accessible to be used in clinical areas.	Ward Manager	March 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Hand gel is not easily accessible to patients due to the risk of ingestion, however staff have been reminded to encourage patients to wash their hands (or offered gel) before meals and at pertinent times.		
A process should be introduced to ensure all relevant details are recorded in the cleaning schedules so that staff are aware of which tasks require completion and their responsibilities each day.	Infection prevention and control (IPC) and Decontamination	Nurse in charge daily task allocation forms have been implemented for all of tasks required throughout the day with allocated staff identified.	Ward Manager	Complete
		These will be audited by the ward manager on a monthly basis to ensure tasks are being completed.		

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that all senior staff understand their role and responsibilities in respect of audit governance	Infection prevention and control (IPC) and Decontamination	A Continuing Professional Development Day was held on 08/03/23 involving the senior nurse, ward manager, deputy ward manager and clinical lead nurses to establish roles and responsibilities.	Lead Nurse, Senior Nurse, Ward Manager	Complete
		This will continue to be monitored through managerial supervision and PADR.		Completed and Ongoing
Measures should be undertaken to ensure that staff are compliant with the All Wales NHS Dress Code and that workplace clothing must address key Health and Safety recommendations.	Infection prevention and control (IPC) and Decontamination	The Division will review its position across in-patient services with regard to wearing of uniform across all disciplines.	Divisional Nurse	June 2023
		The All Wales dress code will inform decision making and the code will be recirculated across all professions within the Division.		

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
We recommend that healthy eating initiatives are implemented on the unit for the benefit of patients.	Nutrition and hydration	There is healthy living information and leaflets available on the unit and in a range of formats. This is part of the care pathway. The unit will identify a 'Healthy Living Champion' to re-introduce a healthy living group on the ward.	Ward Manager	April 2023
		Catering Dietician has approached the Division to discuss and share guidance around healthy choices. To be discussed at Divisional QPS meeting.		May 2023
The health board should undertake a review of the choice, quality and preparation of patient food provided at the hospital, to ensure that it is appetising and meets patient satisfaction.	Nutrition and hydration	The Health Board recently undertook a full review of patient catering across the Health Board's estate. The Health Board will continue to seek and consider feedback with regard to catering and food.	Senior Manager, Facilities Division	Completed and Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Pictures of the menu choices should be provided so that patients can view a pictorial and written menu.	Nutrition and hydration	Division to liaise with Facilities Division to create a visual library of menu options.	Head of Quality & Improvement, MH & LD Senior Manager, Facilities	July 2023
Oxygen cylinders must be appropriately secured to protect the safety of patients, staff and visitors.	Medicines management	Two oxygen bottles have been secured to the resuscitation trolley.	Ward Manager/ Senior Manager, Facilities	Complete
A robust programme of governance oversight should be implemented to ensure that the clinic room is appropriately maintained, that medication is managed effectively and that regular audits are undertaken by qualified staff.	Medicines management	Nurse in charge daily task allocation forms have been implemented for all tasks required throughout the day with allocated staff identified, including an audit of the clinic room.	Ward Manager	Complete
		These will be audited by the ward manager on a monthly basis to ensure tasks are being completed.	Ward Manager	Completed and Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board should attach photographs of patients to MAR charts to assist with identification.	Medicines management	All patients now have a photograph alongside their MAR chart (with their consent).	Ward Manager	Complete
The health board should conduct a review of incidents which have resulted in injury to staff to ensure they have been investigated and finalised appropriately.	Safe and clinically effective care	All datix's are now reviewed weekly at unit Managers meetings. These meetings include representation from the MDT and directorate senior management. The ward senior staff have reviewed and finalised all outstanding datix's.	Ward Manager, Directorate Management Team	Completed and Ongoing
		Datix themes are also reviewed and discussed at Quality and Patient Safety meetings and lessons learned identified and shared.	Directorate Management Team	Completed and Ongoing
		Datix themes will also be discussed and reviewed in the quality assurance meetings that have been implemented by directorate senior management.	Directorate Management Team	Completed and Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		The clinical lead psychologist vacancy for the unit has successfully been appointed to. Re-establishment of weekly reflective practice and de-briefs for the staff team will form part of this role.	Clinical Lead Psychologist	June 2023
		Reflective practice and de-briefings are available to staff and have been offered by the psychology team whilst there has been a clinical lead psychologist vacancy.	Head of Psychology	Completed and Ongoing
The practice of using the visitors room as additional bedroom when the unit is at full capacity must be avoided, to ensure the safety of patients and staff.	Safe and clinically effective care	The unit has never accepted patients over the capacity of the 7 beds available, and this practice will continue. The visitor's room has been utilised as a bedroom for short periods of time due to safeguarding issues between patients at the time. The directorate will ensure that in future, the room will not be used as a bedroom and will	Directorate Management Team Lead Nurse	Complete

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		include this in the unit's operational policy.		May 2023
To support the CTPs, pen profiles should be attached to patient files for the awareness of staff, particularly agency staff who are not familiar with patients.	Safe and clinically effective care	Pen profiles will be added to the care pathway to ensure that named nurses complete pen profiles for patients. These will be reviewed and updated on a monthly basis.	Ward Manager	April 2023
The health board should ensure there is adequate administrative cover on the unit.	Record keeping	At the time of the inspection, the unit's administrator was on long term sickness absence. Since this time, the staff member has handed in their notice. The vacancy is currently being advertised but in the interim is being backfilled by another member of admin staff.	Ward Manager	June 2023
The unit must be provided with a fully functional printer to enable staff to perform their duties.	Record keeping	Printer engineer has looked at the printer and has confirmed that an updated printer is required. This has been ordered. In the interim current printer has been temporarily	Ward Manager	June 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		fixed and the printer in Alders House (adjacent building) can be used.		
Patient MHA records should be reviewed to ensure that documents are not unnecessarily held on file.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision Mental Health Act Monitoring	A monthly audit of the MHA records and files will be completed by senior ward staff to ensure the documents held are the most up to date. The MHA Administration Department will continue to complete regular audits of MHA documentation.	Ward Manager MHA Administration team/ Head of Q & I	April 2023 Completed and Ongoing
Measures must be implemented to ensure that Mental Health Act documentation is fully and correctly completed.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision Mental Health Act Monitoring	As above	As above	As above
Staff should be provided with additional training, instruction and governance regarding the MHA and DoLS to ensure compliance with	Monitoring the Mental Health (Wales) Measure 2010: Care	All staff have been booked onto MHA and DOLS training through April and May 2023.	Ward Manager	June 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
legislation and that documents are completed and submitted correctly.	planning and provision Mental Health Act Monitoring			
Copies of the Mental Health Act Code of Practice for Wales (the Code) should be made available on the unit	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision Mental Health Act Monitoring	Mental Health Act Code of Practice for Wales (the Code) has been placed in the main office and is accessible to all staff.	Ward Manager	Complete
The health board must fully engage with ward staff to strengthen leadership and management systems in order to provide robust governance and oversight of the unit.	Governance, Leadership and Accountability	Directorate senior managers have organised bi-monthly assurance meetings with ward managers and team leads, focussing on clinical governance and assurance. Managers meetings are held on a weekly basis. These meetings include representation from the MDT and directorate senior management. A system is in place to ensure feedback is shared with staff and patients as	Directorate Management Team Ward Management team/ Directorate Management Team	Completed and Ongoing Completed and Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		appropriate following this meeting.		
The health board must identify staff training needs and areas requiring improvement to ensure that the unit is managed effectively and to protect the safety of patients, staff and visitors.	Governance, Leadership and Accountability	The training matrix for the unit has been reviewed and all staff have been allocated dates for mandatory training for 2023. Additional training needs are reviewed and considered at the the unit development group.	Ward Manager/ Directorate Management Team	Completed and Ongoing
Inductions should be provided to all staff to ensure they are aware of their role and responsibilities on the unit.	Governance, Leadership and Accountability	An induction process has been formulated and agreed by the members of the unit management meeting. All new staff will now complete this induction process.	Ward Manager/ Professional Heads of OT/ Psychology	Complete
The health board must implement a robust programme of governance oversight to ensure that mandatory training is completed, regularly monitored and that staff are supported to attend the training.	Governance, Leadership and Accountability	The training matrix has been reviewed and all staff have been allocated dates for mandatory training for 2023. Additional training needs are reviewed and considered at the unit development group.	Ward Manager/ Directorate Management Team	April 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Training statistics will also be reported at the bi-monthly governance assurance meetings.		
Supervisory staff should be trained to utilise the training matrix system so that they can access staff training records and provide oversight of staff training.	Governance, Leadership and Accountability	The health board provides ESR (training matrix system) training and an ESR guide book. The business support manager has allocated dates to meet with team managers and senior staff to offer additional training around ESR.	Business Support Manager	May 2023
The current training matrix system should be reviewed with a view to recording all staff training compliance on one system for ease of governance and monitoring.	Governance, Leadership and Accountability	Management of training records via ESR has been raised with Workforce & Organisational Development colleagues in the Division.	Senior Manager, WOD	Completed and Ongoing
The health board must review any outdated policies to ensure that policies and procedures are kept up to date and provide clear guidance to staff.	Governance, Leadership and Accountability	The Health Board's policy group identifies review dates of policies to flag with the relevant 'owner' for review. Divisional policies are reviewed via a task & finish group, approved by the bi-monthly Divisional policy group and ratified by the	Health Board Policy Group Head of Q & I	Ongoing Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Division's Quality & Patient Safety Group before Health Board ratification and uploading to the intranet.		
The health board should continue to actively focus on the recruitment of permanent staff into any vacant posts on the unit.	Workforce	The directorate has filled a large number of vacancies since January and continues to advertise vacancies in a timely manner. National processes such as streamlining for nursing are also followed.	Directorate Management Team and WOD Business Partner	Ongoing
		The vacancy tracker is updated on a weekly basis and is fed back to the Division on a bi-weekly basis for nursing vacancies.		
		Therapy vacancies are managed and discussed with the professional head. Vacancies are advertised in a timely way via TRAC and also via social media.		

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board should continue to actively implement measures to reduce the high usage of bank and agency staff on the unit.	Workforce	The Health Board continues to scrutinise bank and agency use across all Divisions. Measures have been taken to reduce agency use.	Senior Manager, WOD Director of Nursing	Ongoing
		Recent discharges from the unit have resulted in a significant decrease in the use of bank and agency staff on the unit.		

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): Michelle Forkings

Job role: Divisional Nurse for MH & LD

Date: 3 April 2023