Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Learning Disability Inspection Report - 03100 (Unannounced)
Aneurin Bevan University Health Board
Inspection date: 31 January and 01 February 2023
Publication date: 04 May 2023

This summary document provides an overview of the outcome of the inspection

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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.

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. Therefore, we could not be assured that patients were being monitored, fully protected and safeguarded on the unit.

We reviewed six Datix incidents relating to medication errors and patient restraint incidents and found there was no investigation update within all six incidents. Therefore, we were not assured that incidents were being effectively investigated, managed and scrutinised to prevent reoccurrence and encourage shared learning.

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. Therefore, we were not assured that staff and patients were being fully protected and safeguarded against injury.

Our concerns regarding these issues were dealt with under our immediate assurance process.

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

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.

This summary version of the report is designed for members of the public.

A full report, which 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 can be found on our website.

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.

Where the service could 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.

Where the service could 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.

Where the service could 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.

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 appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health boards to provide documented evidence of action taken and/or progress made.