Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Gastroenterology Ward A7, University of Wales Hospital, Cardiff and the Vale University Health Board

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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 5

2. Summary of inspection 6

3. What we found 9

- Quality of Patient Experience.....9
- Delivery of Safe and Effective Care 12
- Quality of Management and Leadership 17

4. Next steps 20

Appendix A – Summary of concerns resolved during the inspection 21

Appendix B – Immediate improvement plan..... 22

Appendix C – Improvement plan 25

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 at University Hospital of Wales, Cardiff and Vale Health Board on 12 and 13 June 2023. The following hospital wards were reviewed during this inspection:

- Ward A7 - 31 beds in total, 13 on the South wing and 18 on the North Wing, providing treatment for gastroenterology issues.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 14 questionnaires were completed by patients or their carers. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Our team for the inspection comprised of two HIW Healthcare Inspectors, two clinical peer reviewers and one patient experience reviewer. 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:
Patients provided very positive feedback about the care and treatment provided to them.

We found staff treated patients with respect and kindness, and overall made efforts to protect their privacy and dignity when providing care.

Patients appeared well cared for and we found staff responded promptly to patient requests for assistance.

While we saw information displayed on notice boards, this did not include health promotion information or signposting to specific services.

This is what we recommend the service can improve:

- The health board must provide health promotion information on both sides of the ward.

This is what the service did well:

- We saw many examples of staff treating patients with respect and kindness
- We were told about the Katie's Wish initiative to assist patients with cognitive impairment
- We saw staff promoting patients independence whilst in hospital.

Delivery of Safe and Effective Care

Overall summary:
We found the hospital wards to be providing safe and effective care to patients. We found good arrangements in place to prevent patients from developing pressure damage and prevent patient falls. We also found good arrangements were in place to meet the specialist nutrition and hydration needs of patients.

We saw evidence of timely and robust mental health and capacity referrals.

We found that the ward needed to improve the discharge planning process to include multi-disciplinary team (MDT) meetings to facilitate safe discharges and transfer to other areas of care provision.

Immediate assurances:

- During our inspection of the medication storage room we found that the lock on the main door was faulty and required staff to manually force the lock to shut. On occasions where staff had not done this the door remained unlocked. Also, a random check of drugs in the storeroom found two boxes of expired medication.

This is what we recommend the service can improve:

- The health board must improve the planning of safe discharge and referral process and increase the frequency of MDT meetings
- The health board must review the storage of intravenous fluid within the drug storage room
- The health board must perform a deep clean of the ward to remove surface dust.

This is what the service did well:

- We found good arrangements were in place to prevent patients from developing pressure damage and patient falls
- We saw good medicines management processes
- We saw comprehensive record keeping.

Quality of Management and Leadership

Overall summary:
We found a suitable management structure was in place with clear lines of reporting and accountability.

Senior staff described a system of audit to monitor the quality and safety of services provided on the wards. We found the quality and safety arrangements on the wards were appropriate.

The health board had a comprehensive mandatory training programme. However, compliance needed to be improved.

We saw that the majority of available staff had received an up-to-date appraisal.

This is what we recommend the service can improve:

- The health board must ensure mandatory training is completed by all staff
- The health board must display the safety cross or equivalent information for patients and visitors to view.

This is what the service did well:

- We found a good management structure in place with clear lines of reporting and accountability
- We found the Safe Care programme a reliable tool to ensure there were safe staffing levels on the ward
- We saw a variety of clinical audits were regularly completed.

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

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we used paper and online questionnaires to obtain views and feedback from patients and carers. A total of 14 were completed. Patient comments included the following:

"Staff and medical attention is spot on."

"Excellent care given by nurses and assistants. They were very good and supportive"

"When I have become acutely unwell on the ward, treatment has always been prompt and reassurance and comfort given."

Person Centred

Health promotion
We saw sufficient information displayed on certain health conditions such as alcohol dependency. However, there was no health promotion information on smoking cessation, nutrition or screening for cancers displayed on either ward.

The health board must ensure health promotion information and advice is displayed on the ward for a range of health conditions. In addition, include signposting information for services such as smoking cessation in order that patients an access these services.

We were told smoking was not permitted anywhere within the hospital. We were also told patients were signposted to health board's smoking cessation service where they could access advice and support to help them stop smoking.

Dignified and respectful care
During our inspection we saw many examples of staff treating patients with respect and kindness and making efforts to maintain their dignity.

Where patients were accommodated in multi-bedded bays, we saw dignity curtains were drawn. We also saw doors to toilet facilities were closed when personal care was taking place.

Patients appeared well cared for and suitably dressed in their own clothing or hospital gowns. We saw evidence that patients were having their pain measured, actioned and evaluated regularly using a suitable pain assessment tool.

We saw that patients had access to a relatives room where they could take family and friends to sit and have discussions in private. We saw that family and friends were invited onto the ward to assist patients at meal times.

We saw a variety of meal choices being provided to patients. Meals appeared appetizing.

Individualised care
Patients we saw appeared well cared for. We saw staff encouraging patients to mobilise and perform their own personal care which promoted independence.

We were told about the initiative, Katie's Wish which was introduced to promote care for patients with cognitive impairment. Staff told us this initiative has been adopted throughout many wards in the hospital.

Timely

Timely care
We found the care and treatments on the ward to be completed in a timely and calm manner. The ward was a calm yet busy environment with staff undertaking tasks and treatments with a structured and organised approach.

Patients expressed that they experience delays in the admission process. However, they stated that the care they had during the waiting process was very good.

Equitable

Communication and language
We saw signage to help visitors find their way to and from the wards and to other wards and departments within the hospital. We found this was generally easy to follow.

We found that translation services were available, and patients had access to a sign language service if required. We saw that a hearing loop was available on the

ward and information was available in a variety of formats including easy read and large print.

Rights and Equality
During our inspection, we found staff providing care to patients in a way that recognised their individual needs and rights. We saw an up-to-date Equality and Diversity policy.

While there were restrictions in place, we were told patients were able to receive visits from relatives and friends. We observed relatives visiting the ward at mealtimes to assist patients who had difficulty feeding themselves. Senior staff provided us with compliance figures showing that most staff had completed Equality and Diversity training as part of the health board's mandatory training programme.

We saw that a multi-faith chaplain service is available, and a chaplain regularly visits the ward. We were told there is a multi-faith room situated on the third floor.

Delivery of Safe and Effective Care

Safe

Risk management
We saw the ward was accessible to patients, staff and visitors. There was level access to the hospital with lifts to access all wards which were located over several levels.

The ward areas were observed to have limited space for storage meaning corridors were lined with equipment leaving minimal space for wheelchairs, stretchers and trollies.

Domestic cleaning staff were present on the wards throughout our inspection. We found the wards to be mostly clean and tidy. However, we noticed surface dust present underneath beds and on sills. We found the ward areas to be in need of updating. Paint was flaking in some parts, there was visible dust in areas and there was minimal space for storage. Staff were seen to be making the best use of the area they had, however, it had been noted that refurbishments were required.

The health board undertake a deep clean of the ward and clinical areas whilst more long-term arrangements are made for refurbishment.

Senior staff described suitable arrangements for the reporting, recording and investigating incidents and for providing feedback to ward staff.

During our record review, we saw evidence of patients having been assessed for the risk of developing pressure damage. Appropriate care plans were in place according to the risk identified. Where needed, we saw evidence of patients being repositioned frequently. We also saw evidence of ongoing monitoring of patients' skin particularly when patients were acutely ill and were less mobile.

We saw evidence of patients having been assessed for their risk of falls. Where patients had been identified as at risk of falls we saw appropriate care plans were in place.

Infection, prevention, control and decontamination
The ward was found to be mostly clean and tidy. However, we did see visible dust on some surfaces which is covered above. Equipment was cleaned in between patient use. We saw that mattresses and beds were cleaned following patient use. We saw cleaning staff were visible on both wards throughout the course of the

inspection. The ward area was found to be dated and in need of refurbishment. We saw that most furnishings allowed for effective cleaning.

Safeguarding of children and adults
Senior staff described suitable arrangements for responding to safeguarding concerns. We saw a current written policy and procedures were in place. These were in accordance with the Wales Safeguarding Procedures. Senior Staff confirmed staff could contact the health board safeguarding lead for advice on safeguarding matters.

During our inspection, staff were required to complete a Deprivation of Liberty Safeguarding (DoLs) referral. We found this to be very well documented, timely and robust. This evidenced good practice around mental health capacity and referral processes on the ward.

Safeguarding training was part of the health boards mandatory training programme. Data provided by senior staff showed that compliance with training required improvement. This is covered under mandatory training.

Blood management
We found strict arrangements were in place to ensure the safe administration of blood products on both wards. Staff were also aware of the correct process in which to report adverse events relating to blood products.

Staff we spoke to were confident in the process of administering and monitoring of blood products including patient checks. We were told that a record of all staff competent in the administration of blood products was kept by the ward managers.

Management of medical devices and equipment
We saw a range of equipment was available to meet the assessed needs of patients, such as pressure relieving mattresses, mobility aids, commodes and vital sign monitoring machines. Staff we spoke to agreed that they had access to the correct equipment to assist with patient care. However, although we saw that equipment was being cleaned following patient use there was no system in place to identify clean equipment.

The heath board must implement a process by which staff are able to identify cleaned equipment such as the green label system.

We saw equipment had labels to show when they required servicing and saw this was up to date.

Staff we spoke with were aware of the correct procedure to follow to report equipment found to be faulty. We saw staff cleaning shared equipment following use to prevent cross infection.

Medicines Management
We found that medications were prescribed, documented and administered correctly in line with the medicines management policy. Drugs were stored appropriately in locked cupboards within a locked room. However, during our inspection we found the lock on the door to the drugs room was broken. This was escalated to the ward managers and a request was made to the estates department to arrange a repair or replacement lock. Staff were informed by the ward manager that the door must be manually locked until the problem was rectified. The ward manager contacted the estates team to supply a new lock and they were seen to be present on the ward actioning this during our visit.

We found that the intravenous (IV) fluids within the drug room were stored in solid plastic drawers. This did not follow correct IPC guidelines.

The health board must review the storage of IV fluids in order that it follows safe IPC guidelines.

The Medicines management policy was found to be sufficiently robust. Medication storage fridge temperatures were appropriately checked and recorded on a daily basis. However, staff we spoke to were unsure what action to take if fridge temperatures were outside the recommended parameters. We also noted the lock on the fridge was broken. The room had a locked door and so we were assured that no unauthorised person could gain access. However, we recommended this is repaired or replaced.

We recommend that the health board disseminate information on what action is to be taken in the event that fridge temperatures are found to be outside the recommended parameters. We also recommend repairing the lock on the fridge or replacing it.

Medicines administration charts were generally completed correctly. We saw that patient details were shown on all charts, however, this was not always consistent throughout the chart.

The ward had a dedicated pharmacist and staff were able to access medication from the site manager out of hours. Staff stated they felt that they were able to access medications and were supported by pharmacy staff. Oxygen was not prescribed on the medications chart, however, this was documented in the NEWS.

We recommend ensuring that oxygen requirement is prescribed on the medication chart.

Effective

Effective Care

We saw evidence that services are arranged to ensure movement though pathways. We were told that Multi-Disciplinary Team (MDT) meetings did not routinely take place. These were performed on a case-by-case basis. Staff explained that they rely on verbal referrals for discharge planning, however we did not find evidence to support this in the nursing notes. Due to the complex nature of the speciality and high risk patient group a robust referral system is required.

The health board must implement a robust referral system to include regular discharge planning meetings in order to facilitate safe transfer.

We found that there was good communication between staff including shift handovers and disseminating information throughout the team.

Staff we spoke to were aware of how to access the hospital clinical policies and procedures to support them in their practice.

We saw on both wards Patient Status at a Glance (PSAG) boards were clearly displayed, which included patients initial and surname along with abbreviated information about the status of each patient to assist communication between members of the multi-disciplinary team.

Nutrition and hydration

Information regarding patient nutritional needs was given at handover and documented in the patient records. Relatives were welcomed onto the ward at meals times to assist patients who required help to eat and drink. Patients were found to have access to water and hot drinks were served around meal times or on request.

Due to the specialism of the ward and acuity of patients, we saw signs at the patient bedsides stating dietary requirements.

We were told that the ward was part of the speciality Total Parenteral Nutrition (TPN) pathway for Wales and had been awarded extra funding to provide this specialist service for gastroenterology patients.

We saw that a nutritional screening tool was used along side the red tray system to identify patients who required assistance. Staff on the ward were found to be very

good at addressing the specialist nutritional needs of each patient. We found the All Wales Nutritional Assessment tool was implemented and used correctly and documented in the notes.

Quality of Management and Leadership

Leadership

Governance and Leadership
We found a suitable management structure was in place and clear lines of reporting and accountability were described and demonstrated. Senior staff confirmed they visited the ward regularly and were available to provide advice and support the ward managers and ward teams.

Senior staff described a system for audit and provided examples evidencing this process. We saw that a variety of audits had been undertaken which included hand hygiene, Infection Prevention and Control and Lead Nurse Clinical Audit.

We saw good quality and safety monitoring arrangements on the ward. Suitable arrangements were described for sharing relevant information and updates to policies and procedures with the wider ward teams.

During our inspection, managers engaged positively and cooperatively with the HIW inspection process. They demonstrated a commitment to learn from the inspection and make improvements as appropriate.

Workforce

Skilled and Enabled Workforce
We saw doctors, nursing staff, allied health professionals, healthcare support workers, administration staff, catering/hostess staff and domestic staff working on the ward.

During our inspection the staffing levels and skill mix on both wards appeared appropriate to meet the assessed needs of patients. We were told bank staff were used to cover any shortfalls in staffing that could not be covered by members of the ward team.

We found that the ward has protected beds for gastrointestinal patients and that these beds were protected as much as possible.

The ward manager explained that the ward received additional funding for staff under the TPN (Total Parenteral Nutrition)[1] Service. The ward requires specially trained staff in order to provide this service safely.

The ward manager told us they used the digital programme Safe Care to ensure the correct number of staff were present for the level of acuity on the ward. This was completed twice daily at the change of shift and could also be updated at any point during the shift where there was a change in staff or patient situation.

Staff we spoke to agreed that the number of staff and skill mix was appropriate for the acuity of the ward. They explained that when acuity is high, senior staff and managers assist with the high acuity patients.

We were told that agency and bank staffed are used from a pool of regular staff who are orientated with the ward and its processes.

We requested details of mandatory staff training. Compliance was low for all topics.

The health board must ensure mandatory training is completed by all staff.

Staff described the process in which incidents would be reported which included completion of Datix incident report.

We found that staff Performance Appraisal and Development Reviews (PADR) were completed annually, and compliance rates were found the be good. Staff told us that during the PADR they were able to develop an action plan for the year ahead and request to attend training courses. Details of these were documented and recorded in individual staff files.

Culture

People engagement, feedback and learning

We saw that mangers were visible on both wards and seen to be friendly and professional. We saw managers were involved in delivering care and assisting with doctors rounds.

The ward followed the Putting Things Right complaints process. Managers told us that complaints were documented in patients notes and on the Datix system.

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[1] Total Parenteral Nutrition (TPN) is when the intravenous administered nutrition is the only source of nutrition the patient is receiving. This is indicated when there is impaired gastrointestinal functionand contraindications to enteral nutrition.

Complaints were captured in a database and investigated by the ward managers and putting it right team. The ward managers shared learning through safety briefings, emails and via the ward Whatsapp group.

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
During the inspection we found expired medication in the drug preparation room.	This posed a risk of expired medication being administered to a patient and could potentially cause harm.	This was escalated at the time to the ward manager.	Nursing and pharmacy staff were instructed to remove and dispose of all expired medication and perform a full stock check of all medications.
During the inspection we found COSHH equipment exposed in the sluice area where patients and visitors can easily access.	This posed a potential risk of exposure to harmful substances by contact with skin or ingestion.	This was escalated immediately to the ward manager.	Staff removed the COSHH equipment immediately and instructed all staff to ensure COSHH storage guidelines were adhered to.

Appendix B – Immediate improvement plan

Service: University Hospital of Wales

Date of inspection: 3 and 4 June 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.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
During our inspection of the medication storage room we found that the lock on the main door was faulty and required staff to manually force the lock to shut. On occasions where staff had not done this the door remained unlocked. Also, a random check of drugs in the storeroom found two boxes of expired medication.	The health board must provide HIW with details of how it will ensure that medication is stored in line with regulations, national and local guidelines, standards and policies, and there is a robust process in place to check expiry dates of medication.	1. Fix the lock on the main door of the medication storage room. 2. Include inspection of medication expiry dates in the daily Control Drug / fridge temperature check and weekly senior management checklist. Monthly audits of compliance to be undertaken to monitor.	Estates Senior Nurses	Completed Completed

		3. Arrange for the pharmacy technician that supports the ward to also undertake checks and carry out a full stock check to dispose of any expired medications.	Lead Nurse	Completed
		4. Provide communication to staff regarding the importance of medicines management requirements. Medicine Clinical Board Governance Newsletter, HIW staff feedback meeting. Staff safety briefings / handover.	Lead Nurse	Completed Completed
		5. Medicines Management will be included on the scheduled audits / Tendable. Meeting arranged with the senior nurse for	Lead Nurse/Senior Nurse for Professional Standards	June 2023

		professional standards 21/6/23	

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: University Hospital of Wales - Gastroenterology Ward A7

Date of inspection: 12 & 13 June 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.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
During our inspection we noted that no health promotion information was displayed for patients and visitors.	The health board must ensure health promotion information and advice is displayed on the ward for a range of health conditions. In addition, include signposting information for services such as smoking cessation in order that patients an access these services.	Charge nurse to link with specialist nursing teams to access a range of health promotion which will include signposting information. This information will be displayed on display boards and will be monitored on a monthly basis via Tendable.	Charge Nurse/ Senior Nurse	September 2023
During our inspection we saw surface dust was present on sills and bed frames. We saw paint flaking on walls.	The health board undertake a deep clean of the ward and clinical areas whilst more long-term arrangements were made for refurbishment.	The Housekeeping team to be contacted to perform a deep clean of the ward	Charge Nurse	Completed

		Housekeeping audits will be monitored though weekly DMT cleaning audits	Charge Nurse/ Senior Nurse	Completed - ongoing
		Charge Nurse/Senior Nurse will continue to undertake Core standards & core IPC audits which will be recorded and monitored monthly as part of Tendable audit process.	Charge Nurse	Completed - Ongoing
		Flaking paint to be escalated to Estates for repair.	Charge Nurse / Lead Nurse	Completed
		An estates request to attend the ward to undertake a walk around to assess any repairs required and agree timescales for completion	Charge Nurse / Lead Nurse	August 2023
During our inspection we found that we were unable to identify cleaned equipment.	The heath board must implement a process by which staff are able to identify cleaned equipment such as the green label system.	Green label ('I AM CLEAN') system to be implemented on the ward. This system will be shared to staff via safety briefings and will be monitored via the monthly cleaning audits.	Charge Nurse	Completed-Ongoing

During our inspection we found IV fluids stored in solid plastic containers which allowed dust and dirt to collect in the bottom.	The health board must review the storage of IV fluids in order that it follows safe IPC guidelines.	A review of IV fluid storage to be undertaken with the IPC team and implement any of their recommendations	Lead Nurse	September 2023
During our inspection we identified that staff were unable to explain the process to escalate when fridge temperatures were outside the required parameters. We also noted the drug storage fridge was unable to be locked.	We recommend that the health board disseminate information on what action is to be taken in the event that fridge temperatures are found to be outside the recommended parameters. We also recommend repairing the lock on the fridge or replacing it.	The escalation process for fridge temperature to be shared with staff via safety briefings. Fridge temperature escalation process to be displayed on staff communication boards Medication storage room lock to be repaired. Broken fridge lock to be escalated to estates. In the event the fridge lock cannot be repaired a new lockable fridge to be ordered.	Charge Nurse Charge Nurse Charge Nurse Charge Nurse	Completed Completed Complete - 15th July 2023 September 2023
During our review of patient records we noted that referrals to MDT members was mostly	The health board must implement a robust referral system to include regular discharge planning	A robust discharge communication planning sheet to be implemented onto the ward, which will be reviewed in six	Lead Nurse, Director of Nursing	Competed-ongoing

verbal and discharge planning meetings rarely took place.	meetings in order to facilitate safe transfer.	months. The sheet will include discussion of the MDT discharge daily board round. Within the discharge communication planning sheet Discharge 2 Recovery and Assess (D2RA) Pathway information to be incorporated to improve communication of discharge planning for more complex patient.		
During our review of staff training we found that compliance with mandatory training was low for all staff.	The health board must ensure mandatory training is completed by all staff.	Compliance of staff mandatory training and appraisals will be monitored on a monthly basis through the senior management team meetings. Staff to be supported with assigned time to complete mandatory training. Practice development nurse will support staff who are unable to access ESR (Electronic staff record) to support their training requirements	Lead Nurse Charge Nurse/ Senior Nurse/ Practice Development Nurse	October 2023 October 2023 October 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): Jane Murphy

Job role: Director of Nursing for Medicine Clinical Board

Date: 23/08/2023