Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Learning Disability Inspection (unannounced)

Abertawe Bro Morgannwg University Health Board, Learning Disability Residential Unit

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1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW completed an inspection to the learning disability service on 7 June 2016. Our team, for the inspection comprised of an HIW inspection manager (inspection lead), an HIW assistant inspection manager and a clinical peer reviewer.

HIW explored how the learning disability service met the standards of care set out in the Health and Care Standards (April 2015).

Inspections of learning disability services are unannounced and we consider and review the following areas:

- Quality of the patient experience - We speak to patients, their relatives, representatives and/or advocates to ensure that the patients' perspective is at the centre of our approach to how we inspect
- Delivery of safe and effective care - We consider the extent to which, services provide high quality, safe and reliable care centred on the person
- Quality of management and leadership - We consider how services are managed and led and whether the culture is conducive to providing safe and effective care. We also consider how services review and monitor their own performance against relevant standards and guidance.

More details about our methodology can be found in section 6 of this report.

2. Context

The service is a small residential unit providing care to for up to five patients with learning disabilities. The unit forms part of learning disability services provided within the geographical area known as Abertawe Bro Morgannwg University Health Board.

A unit manager, who is a registered nurse, is responsible for the day to day management of the unit. The manager is supported by a deputy and a team of staff, including registered nurses and healthcare support workers.

3. Summary

Overall, we found evidence that the service provided person centred care that was safe and effective.

This is what we found the service did well:

- Patients were helped to stay healthy and take part in activities they liked to do both at the unit and within the local community.
- We saw staff treating patients with respect and kindness.
- Patients told us they enjoyed living at the unit and that staff helped them feel safe.
- All patients had a written care plan setting out the help and support they needed.
- Staff appeared to have a good understanding of the patients' care needs.
- There was good liaison between the local GP service and the unit enabling prompt availability of medication for patients physical health needs.

This is what we recommend the service could improve:

- Repairs and maintenance around the unit must be completed in a timely way.
- The type of emergency equipment needed at the unit must be agreed as a matter of priority and checks done to ensure it remains safe to use.
- Staff should be supported to attend training they are required to attend and have formal supervision meetings with their managers.
- Record keeping needs to be improved to ensure that staff are able to access complete information in a timely manner.
- Governance arrangements for the unit need to be developed to ensure the quality care provided can be evidenced.

4. Findings

Quality of the patient experience

Patients were helped to stay healthy and take part in activities they liked to do. We saw staff treating patients with respect and kindness. All patients had their own care plan. Whilst there was good development of care planning documentation there were areas of poor completion and maintenance of the documentation that needs to be improved.

The inspection team sought patients' views with regard to the care and treatment provided at the residential unit through face to face conversations with patients.

Staying healthy

People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manager their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities. (Standard 1.1)

Patients at the unit were helped to stay healthy and take part in activities to promote their wellbeing.

Senior nursing staff told us that patients at the unit were registered with a GP and were helped to see a dentist and optician according to their needs. Where necessary a dentist will attend the unit. Patients we spoke to also confirmed this. We looked at a sample of three patients' care plans and saw that all had received annual health checks[1] with their GP.

[1] The Welsh annual health check for adults with learning disabilities was specifically introduced in Wales in April 2006 to promote early detection and treatment of health problems in people with learning disabilities.

Patients had hospital passports[2] in place in the event of admission to general hospital. However, we noted for one patient the most recent hospital passport was not available as a hard copy, it was updated electronically but not printed out. This is not appropriate for when it is required in the event of an emergency. We also saw that one patient's hospital passport had not been updated since a Speech and Language Therapy (SALT) assessment. This identified that the patient had swallowing difficulties and therefore at a risk of choking. Whilst staff at the unit were aware of the choking risk, without the patient's hospital passport being updated, if the patient was admitted to a general hospital the risk would be unknown to staff working there and therefore pose a health risk for the patient.

Improvement Needed

The health board must ensure that all hospital passports are kept up-to-date.

The health board must ensure that all health passports are available in paper format in case of an emergency admission to general hospital.

Patients had their own bedrooms that they could access throughout the day. There were also lounges in the unit where patients could spend quiet time away from other patients if they wished to do so. The unit had a private garden that patients could freely access; two patients had their own sheds which they used for their hobbies. Patients were able to access the facilities at the unit and in the local area and when required staff would assist patients. Patients we spoke to confirmed that they were helped by staff and that they enjoyed going to the community for social activities and work.

Some patients had been identified as requiring dietary needs for weight management and preventing angina[3]. We saw that patients had been seen by a dietician to help them make healthy food and drink choices.

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[2] Hospital passport is a document which contains important information about someone with a learning disability and provides hospital staff with important information about them and their health when they are admitted to hospital.

[3] Angina is chest pain that occurs when the blood supply to the muscles of the heart is restricted. It usually happens because the arteries supplying the heart become hardened and narrowed.

Dignified care

People's experience of health care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical psychological, social, cultural, language and spiritual needs. (Standard 4.1-Dignified Care)

We found that patients at the unit were treated with dignity and respect by the staff working there.

We saw staff treating patients with respect and kindness. All the patients had been living at the unit for some time and staff appeared to have a good understanding of their individual likes and dislikes. All patients had their own bedroom which were individualised to each patient's tastes and interests. Patients could lock their bedroom doors so they could have privacy, which staff could over-ride if required for safety. We found staff respecting patients' privacy as far as possible. We saw staff knocking doors and asking patients if it was alright to go into their bedrooms before doing so. Patients also told us that members of staff were respectful and kind to them.

Patients were helped with their personal hygiene according to their needs and all patients appeared well cared for.

Patients we spoke to told us that they felt safe most of the time. They did tell us, however, that the behaviour of other patients living at the unit did unsettle them sometimes. We saw nursing staff managing patients' behaviours to promote the safety and well being of other patients and staff working at the unit.

Timely care

All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

We saw that patients' needs were being met in the unit by the staff team.

We looked at the care plans for three patients. These showed that members of the multi disciplinary health care team had been involved in the patients' care and treatment. We saw evidence of six month multi-disciplinary team (MDT) meetings, or more frequent if required. These monitor patients' care plans so that any problems can be identified early on and care planned to address these.

All of the patients had been living at the unit for many years and appeared settled there. Patients were very much engaged in the community and spent

large periods of their time away from the unit. Patients we spoke to told us they liked living there and that staff helped them as needed. Staff appeared to have a good understanding of the patients' individual care needs.

Individual care

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional well being. (Standard 6.1 Planning Care to Promote Independence)

We saw that patients at the unit each had their own written care plan. These showed that their needs had been assessed, their care and treatment planned and that care had been provided by those involved in their care. Patients had care and treatment plans as required under The Mental Health (Wales) Measure 2010[4] legislation.

We looked at the care plans for three patients which were very detailed with evidence that patients were involved in their care planning. The care plans reflected the patient needs, strengths and abilities. There were very detailed physical health care assessments reflected in the care plans.

In particular there were very detailed Positive Behaviour Support (PBS) plans and patient Pen Pictures. There were also very detailed MDT reports.

Staff actively involved patients in their care and about daily decisions such as meals and activities. We saw patients being independent throughout the inspection. We also staff were very supportive and assisting patients when required based on their individual care needs.

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.(Standard 6.2 Peoples Rights)

[4] The Mental Health (Wales) Measure 2010 is a law made by the Welsh Government which will help people with mental health problems in four different ways.
http://gov.wales/topics/health/nhswales/mental-health-services/measure/?lang=en

We found that care and treatment for patients at the unit was provided in ways to ensure their human rights were upheld.

We saw staff respecting patients' privacy and allowing them choice in their daily routines. We were told that patients were helped to keep in contact with their families and friends. Where patients' choices were restricted we saw that the reasons for this had been written in their individual care plans. The care records we saw also showed that where restrictions were in place, Deprivation of Liberty Safeguards[5] (DoLS) authorisations had been obtained in accordance with the DoLS arrangements.

From speaking with staff and looking at the care plans, staff appeared to have a good understating of the DoLS arrangements. Staff training records showed that 95% of staff had attended training on the Mental Capacity Act and DoLS.

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is nor, and they must receive and open and honest response. Health Services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback. (Standard 6.3-Listening and Learning from Feedback)

There was no formal system in place at the unit to obtain feedback from patients and their families.

Senior staff described informal and ad hoc ways of receiving feedback from patients and their relatives on their experiences of the care provided. We were told that the health board were looking to introduce a more formal way to regularly obtain feedback from patients and their families. This was to be an electronic based survey where questions could be presented in different formats, including the use of pictures and symbols. This meant that people who had difficulty reading or difficulty understanding words would be helped so they could provide their views.

The health board should progress with plans to introduce a suitable system to obtain feedback that can be used by people using the service at the service.

[5] The Deprivation of Liberty Safeguards is a framework of safeguards for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.

Delivery of safe and effective care

Overall we found that safe and effective care was provided to patients. Improvements were needed to make sure repairs were completed without a delay. Work was also needed to improve fire safety and senior managers told us this was being done.

No emergency resuscitation equipment was available at the unit. We were informed by senior management that they would check what equipment was needed as a matter of priority and make sure it was available on the unit.

We saw good liaison with the GP service to ensure that medication was promptly available when prescribed by the GP. This noteworthy practice should be emulated throughout the health board's services.

Staff talked to patients to help them understand their care and treatment. The use other forms of communication to help patients understand should be considered and used by staff.

Safe care

People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented. (Standard 2.1-Managing Risk and Promoting Health and Safety)

Overall we found that patients' health, safety and welfare were protected. We did, however, find that improvement was needed to make sure repairs were completed without delay. Improvement was also needed to keep patients safe in the event of a fire:

- The glass vision panels of an interior fire-door had become damaged and therefore the fire resistance of the door compromised. A maintenance request was made on 1 June 2016.
- The fire security system panel was indicating an intermittent mains fault. A maintenance request was made on 2 June 2016.

At the time of our inspection the required works had not been completed. Both these issues were a risk to the safety of patients, staff and visitors at the service. Senior managers were aware of this and we were assured that work was being done to improve fire safety at the learning disability service. In accordance with HIW's process, we requested immediate written assurance from the health board on the action taken.

Improvements Needed (requiring an immediate improvement plan)

The health board must ensure that the damaged glass vision panel of an interior fire-door is replaced.

The health board must ensure that the fault being displayed on the fire security system panel is reviewed and rectified.

The health board provided an immediate assurance plan within the timescale we agreed. We were assured that suitable arrangements have been put in place to address the improvement needed with regards to the internal fire-door and that the fire alarm system is working as it should. However, the service a replacement part was still required to be installed by the providers of the fire security system.

Improvements needed

The health board must ensure that the replacement part is installed to the fire security system.

The unit was secure against unauthorised access and staff were vigilant to ensure the patients' safety was maintained. Areas were free from visible trip hazards. Staff told us that risks to patient safety were assessed and that action is taken to reduce these risks as far as possible. We also saw that risk assessments had been done within the care plans we looked at.

The environment was reasonably well maintained, the unit undertook monthly environmental audits. However, we were provided with a log of outstanding maintenance work. Some areas that were outstanding included, broken integrated blinds in the self-contained flat, there was also an ongoing issue with the ventilation in the flat. We informed senior managers of the outstanding maintenance work and they told us they were looking at ways to improve this.

Improvement Needed

The health board must make suitable arrangements to complete outstanding repairs and maintenance work at the learning disability service. In addition any future work must be completed in a timely manner.

We raised our concerns of the lack of ligature point audits at the sevice, whilst risks need to be managed for individual patients, it would be appropriate for the service to undertake regular ligature point audits.

Improvement Needed

The health board must undertake regular ligature point audits and appropriate mitigating actions to ensure that the environment is safe for patients.

Training records we saw showed that all but two staff had attended CPR and choking management training within the last year, with one of those staff's dates falling out of compliance the month previous to the inspection. Five members of staff were out of date with Manual Handling training. Due to the patient group being cared for at the service it is essential that staff have up-to-date training in these areas. For those staff who had not attended training, the health board should explore the reasons why and where needed support the staff to attend training.

There was no resuscitation equipment maintained at the service in the event of a patient emergency (collapse). We were told that in the event of a patient collapse, the emergency services would be called to attend. Staff at the unit had previously had access to emergency equipment but this had been removed and not replaced once it become out-of-date. Therefore at the time of our inspection there was no resuscitation equipment to use before the emergency services arrived. We informed senior managers of our findings. They agreed to check what equipment was needed as a matter of priority and to make sure regular checks were then being done to ensure it was safe to use.

Improvement Needed

The health board must establish what emergency equipment is needed at the learning disability service.

Arrangements must be made so that checks are being done to make sure the equipment is safe to use in the event of a patient emergency (collapse).

People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury. (Standard 2.5 Nutrition and Hydration)

We found that patients at the unit were helped to eat and drink. We saw detailed care plans setting out the help patients needed with eating and drinking.

Staff explained that patients were supported by staff in choosing meals, shopping for ingredients and preparing meals. A recently refurbished kitchen

was available at the unit that patients could use with the support of staff when required. Drinks, snacks and fruit were freely available at all times.

Staff also told us that patients could see a dietician to help them make healthy food and drink choices. The care plans we saw showed that the dietician had been involved in helping patients with their food choices. Patients we spoke to told us they had a choice of meals and that they enjoyed the food.

People receive medication for the correct reason, the right medication at the right dose and at the right time. (Standard 2.6 Medicines Management)

Overall, we found that people's medication was managed safely at the unit. We observed noteworthy practice with a positive working relationship with the GP surgery where GPs would write their prescription on to the in-patient Medicine Administration Record[6] (MAR Chart). This maintained patient safeguards whilst streamlining the process for community and inpatient services.

A designated room was used for storing medication used at the unit. We saw that this was locked when not being used to prevent people, who were not allowed to, from entering. Medicines were stored in locked cupboards for safety.

The instances of administration of *as required medicine* were detailed in the patient records. There was also a flowchart for epileptic drugs and detailed Joint Epilepsy Committee (JEP) plans. On reviewing the MAR Charts we did note that there was an instance where medication had been administered to a patient but not recorded, this error was recorded on the health board's incident recording system.

Improvement Needed

The health board must ensure that MAR Charts are completed accurately.

We also observed the interaction between staff and patients during the administration of medication; on the whole we saw good interaction between staff and patients. However, on one occasion we observed a nurse approach a patient and handed the medication to the patient for them to take with very little

[6] Medicine Administration Records (MAR Chart) are the formal record of administration of medicine within a care setting.

exchange between the staff and patient, including not telling the patient what the medication was. This in not the practice we'd expect to see during the administration of medication.

Improvement Needed

The health board must ensure that staff engage with patients and communicate with dignity and respect when undertaking administering medication whilst adhering to professional standards.

Patients we spoke to were able to tell us about their medication. Information leaflets were available to patients to tell them about their medicines and health conditions. These would, however, benefit from being made available in a format more suitable for people with learning disabilities to understand.

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time. (Standard 2.7-Safeguarding Children and Safeguarding Adults at Risk)

Staff had access to information on what to do to protect the welfare and safety of patients at the unit.

Senior nursing staff described the process staff would be expected to follow should they identify a safeguarding issue. This was in keeping with the All Wales Vulnerable Adult procedure. We were told that there were no safeguarding issues at the time of our inspection. Patients we spoke to told us staff helped them feel safe.

We saw training records that showed all-but-one member of staff were up to date with training on safeguarding adults. For the member of staff who had not attended training, the health board should explore the reason why and where needed support the member of staff to attend training.

Effective care

Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs. (Standard 3.1-Safe and Clinically Effective Care)

We saw that patients at the unit had individualised person-centred care plans. These showed that care was planned to make sure patients were safe and protected from avoidable harm.

We were told that members of staff were expected to attend training arranged by the health board. The training records we saw showed that staff had attended training on topics relevant to do their jobs. For those staff who had not attended training, the health board should explore the reasons why and where needed support the staff to attend training required.

We saw that positive behaviour support plans were being used. These help staff identify when patients need help to manage behaviour that other people may find challenging. Staff appeared to have a good understating of the patients' needs and we saw them helping patients to be safe and reduce any anxiety they were showing. The positive behaviour support plans in place meant that staff did not use restraint or seclusion at the unit.

If patients needed their own space away from other patients staff would encourage patients to go to their own bedrooms or quiet communal areas away from other patients on the unit.

In communicating with people health services proactively meet individual language and communication needs. (Standard 3.2-Communicating Effectively)

The communication needs of patients were recorded within their individual care plans. We were told that staff talked to patients to help them understand decisions about their care. Depending on an individual patient's needs, we also noted that staff would use basic sign language or the use of photograph/image aids to assist with communication.

Record keeping

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance. (Standard 3.5-Record Keeping)

Records used at the unit were stored securely to prevent unauthorised people from reading them. Patient records were stored securely; however the records were stored in two separate areas of the unit, with daily clinical records secured in the clinical room on the ground floor and medical records stored in a secure room upstairs. There was noteworthy practice of the ABM Health Board recordkeeping guidelines in each patient folder. However, the storage of files was poor and disorganised; the files were not systematically stored.

Improvement Needed

The health board must ensure that patient records are stored and organised systematically.

Patients' care plans were in paper format and we saw that entries made by staff had been signed and dated. This showed which staff members had helped and supported patients and who was responsible for the care provided.

Whilst we saw detailed care plans there was incomplete and inconsistent record keeping by staff, with some information not dated, not contemporaneous with entries not being completed sequentially and record entry of poor professional quality. Some of the risk plans were out-of-date. There was a record of instances of epilepsy seizures recorded but the detailed information required regarding the epilepsy seizures was not recorded. Patient care plans had audit sheets for all relevant staff to state that they had read the patient care plan, in all files there were incomplete records.

Improvement Needed

The health board must ensure that members of staff maintain a high level of professional standards when completing patient records.

Quality of management and leadership

We saw good management and leadership at the learning disability service. Work was being done to improve audits so that areas of care could be looked at and improved where needed.

We saw a committed staff team who had a very good understating of the needs of the patients living at the unit. Staff told us they could talk to their managers about their work; however we feel that arrangements for this needed to be more formal. Training completion rates were high but there were elements of training that had lapsed for some members of staff.

Governance, leadership and accountability

Effective governance, leadership, and accountability in-keeping with the size and complexity of the health service are essential for the sustainable delivery of safe, effective person-centred care.

A recently appointed nurse manager was responsible for the day to day management of the unit and was supported by a deputy. The nursing team was established with the majority of the staff working at the establishment and with most of the patients since it opened over 10 years previous.

Prior to the appointment of the unit manager, there had been a period of five months where there was no unit manager in place. It was evident that governance arrangements had not been maintained during this period and had fallen out of practice. The new unit manager was in the process of redeveloping governance arrangements at the time of our inspection.

Improvement Needed

The health board should progress with the arrangements for improving the system for audit and ensure that where areas for improvement are identified, action is taken to address this and relevant learning shared with other services within the health board.

Senior staff described suitable arrangements for reporting and investigating patient safety incidents. We were told that learning from incidents that had happened at the unit was shared with the staff team; however this was through informal discussions as opposed to a formularised structure. We were also told that learning form incidents was not routinely shared more widely amongst services within the health board. The health board should explore the reason for this and make arrangements to routinely share learning from patient safety incidents as appropriate.

Improvement Needed

The health board should explore the reasons why learning from patient safety incidents are not routinely shared amongst services within the health board and take suitable action to promote shared learning.

We were told that team meetings had ceased to happen however the unit manager was in the process of reintroducing monthly meetings. These meetings will provide an opportunity for discussion and provide updates on issues affecting the service.

Staff and resources

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need. (Standard 7.1-Workforce))

There appeared to be enough staff working with the right skills to meet the needs of patients at the unit. The unit did not use agency staff or health board bank staff meaning that patients were supported by members of staff who were familiar to them. Staff had a very good understanding of the needs of the patients, built up over many years working at the unit. Staff were very flexible with their working patterns to enable patients to undertake community activities during the day, evening and weekends. The stability of the staff team provided patients with consistent care and there was a genuine feel of a family ethos at the unit.

It was positive to note that student nurses have been working at the unit on placements; we saw a large number of thank you cards from previous student placements saying how much they enjoyed working at the unit with the staff and patient group.

We invited staff to provide their views on working at the unit. We did this by speaking to staff and asking them to complete a HIW questionnaire. Staff told us that communication amongst the team was good and they felt that discussions could be held openly.

Staff had completed annual appraisals and they told us that they had opportunities to discuss issues related to their work with their manager. However, this was on an informal basis and lacked structure. Arrangements should be made to ensure that members of staff have formal supervision meetings with their manager with records kept to demonstrating this process.

Improvement Needed

Arrangements should be made to ensure that members of staff have formal supervision meetings with their managers at an appropriate frequency and that these are recorded.

Throughout the report we have described that not all staff were up to date with elements of the health board's mandatory training. For those staff who were not up to date with training, the health board should explore the reasons why and where needed support the staff to attend training.

Improvement Needed

The health board should explore the reasons why members of staff are not up to date with mandatory training and where needed support staff to attend training required.

5. Next steps

This inspection has resulted in the need for the learning disability service to complete an improvement plan (Appendix A) to address the key findings from the inspection.

The improvement plan should clearly state when and how the findings identified at the learning disability service will be addressed, including timescales.

The action(s) taken by the service in response to the issues identified within the improvement plan need to be specific, measureable, achievable, realistic and timed. Overall, the plan should be detailed enough to provide HIW with sufficient assurance concerning the matters therein.

Where actions within the service improvement plan remain outstanding and/or in progress, the service should provide HIW with updates to confirm when these have been addressed.

The improvement plan, once agreed, will be evaluated and published on HIW's website.

6. Methodology

The new Health and Care Standards (see figure 1) are at the core of HIW's approach to inspections in the NHS in Wales. The seven themes are intended to work together. Collectively they describe how a service provides high quality, safe and reliable care centred on the person. The standards are key to the judgements that we make about the quality, safety and effectiveness of services provided to patients.

Figure 1: Health and Care Standards

During the inspection we reviewed documentation and information from a number of sources including:

- Information held to date by HIW
- Conversations with patients and interviews of staff including doctors, nurses and administrative staff
- Examination of a sample of patient medical records
- Scrutiny of policies and procedures

- Exploration of the arrangements in place with regard to clinical governance.

These inspections capture a *snapshot* of the standards of care within learning disability services.

We provide an overview of our main findings to representatives of the service at the feedback meeting held at the end of each of our inspections.

Any urgent concerns emerging from these inspections are brought to the attention of the service and the local health board via an immediate action letter and these findings (where they apply) are detailed within Appendix A of the inspection report.

Appendix A

Learning Disability Service: Improvement Plan

Service: Residential Unit (Ref 16160)

Date of Inspection: 7 June 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
Quality of the patient experience					
6	The health board must ensure that all hospital passports are kept up-to-date.	1.1	Unit manger to ensure Primary Nurses review individual patient hospital passports monthly and to use review sheets to indicate changes made on what date.	Unit Manager	1 September 2016
6	The health board must ensure that all health passports are available in paper format in case of an emergency admission to general hospital.	1.1	Operational leads to email all unit managers to communicate the requirement for all health passports to be current and in paper form.	Unit Manager and Lead Manager for Residential Units	30 August 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
Delivery of safe and effective care					
11	**Improvement Needed (Requiring immediate improvement plan** The health board must ensure that the damaged glass vision panel of an interior fire-door is replaced.	2.1	Met with manager for the Estates Services to highlight the issues and delay on 10 June 2016. Workmen on site on 13 June 2016 and measured for the replacement glass which will be installed as soon as received.	Estates Manager and Interim Assistant General Manager	Completed 30 June 2016
11	**Improvement Needed (Requiring immediate improvement plan** The health board must ensure that the fault being displayed on the fire alarm panel is reviewed and rectified.	2.1	Met with manager for the Estates Services to highlight the issues and delay on 10 June 2016. Estates Manager has instructed the fire alarm company to attend the unit to review and repair. The fire alarm maintenance provider were called on 13 June 2016, fire alarm panel will be repaired as soon as possible.	Estates Manager and Interim Assistant General Manager	30 June 2016
11	The health board must ensure that the replacement part is installed to the fire alarm system.	2.1	Fire alarm maintenance provider was instructed to complete necessary work on the fault with the panel. Work Completed	Estates Manager and Interim Assistant General Manager	Completed 24 June 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
11	The health board must make suitable arrangements to complete outstanding repairs and maintenance work at the learning disability service. In addition any future work must be completed in a timely manner.	2.1	Develop an escalation plan for all maintenance requests and prioritise requests against appropriate budgets.	Interim Assistant General Manager	Complete
12	The health board must undertake regular ligature point audits and appropriate mitigating actions to ensure that the environment is safe for patients.	2.1	The unit will complete an initial ligature risk assessment of the complete environment and then an annual review. This will take into consideration the level od risk identified from individual patients risk assessments who reside within the unit in relation to self harm.	Unit manager and Lead Manager for Residential Units	30 August 2016
12	The health board must establish what emergency equipment is needed at the learning disability service.	2.1	Action to be taken on emergency equipment and the checking of this in line with recent changes to Health Board Resuscitation Strategy.	Interim Assistant General Manager and Lead Manager for Residential Units	30 August 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
12	Arrangements must be made so that checks are being done to make sure the equipment is safe to use in the event of a patient emergency (collapse).	2.1	Action to be taken on training equipment and the checking of this in line with recent changes to Health Board Resuscitation Strategy	Interim Assistant General Manager and Lead Manager for Residential Units	30 August 2016
13	The health board must ensure that MAR Charts are completed accurately.	2.6	Unit manager to ensure that all medication charts are checked daily during the handover to ensure that all medication given has been signed appropriately. Any errors in relation to this will be reported and reviewed on Datix and the medication error documentation completed and investigate as part of this in line wit Health Board procedures.	Unit Manager and Lead Manager for Residential Units	31 July 2016
14	The health board must ensure that staff engage with patients and communicate with dignity and respect when undertaking administering medication whilst adhering to professional standards.	2.6	Interim Lead Nurse to cascade Values Training to the unit qualifies staff focusing on respectful interaction.	Interim Lead Nurse	30 June 2016

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
16	The health board must ensure that patient records are stored and organised systematically.	3.5	Unit Manager to review current systems in line with ABMU record keeping policy.	Unit Manager	30 June 2016
16	The health board must ensure that members of staff maintain a high level of professional standards when completing patient records.	3.5	Unit Manager to conduct an audit of current patient records in line with ABMU record keeping policy and include the actions of this audit into the 15 step audit action plan for the unit.	Unit Manager	1 November 2016
Quality of management and leadership					
17	The health board should progress with the arrangements for improving the system for audit and ensure that where areas for improvement are identified, action is taken to address this and relevant learning shared with other services within the health board.	Governance, leadership and accountability	To complete 15 step challenge in audits in all Units. Review the audits and complete an action plan fro the findings. Circulate the visual audit cycle to all unit managers.	Interim Lead Nurse and Lead Manager for Residential Units Interim Lead Nurse and Lead Manager for Residential Units Interim Lead Nurse	31 July 2016 30 September 2016 Complete

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
			To develop with the Governance Team a system for the collation, monitoring and reporting of all audits completed by the unit managers.	Interim Assistant General Manager and Delivery Unit Governance Lead	1 December 2016
18	The health board should explore the reasons why learning from patient safety incidents are not routinely shared amongst services within the health board and take suitable action to promote shared learning.	Governance, leadership and accountability	Lessons' learnt from reports via Datix will be cascaded to all areas after being reviewed in the Delivery Unit Risk Management Meeting and wider within the Health Board in the Health Board's Health and Safety Meeting if appropriate to other areas of the Health Board.	Delivery Unit Governance Lead	1 November 2016
19	Arrangements should be made to ensure that members of staff have formal supervision meetings with their managers at an appropriate frequency and that these are recorded.	7.1	Review of the systems for the supervision for all staff at the unit to ensure that all staff receive supervision and this is recorded locally. Audit of supervision to be reported annually and actions included in the Unit 15 steps audit action plan.	Manager for Residential Units Unit Manager and Lead Manager for Residential Units	30 July 2016 30 November 2016 (as per audit cycle)

Page Number	Improvement Needed	Standard	Service Action	Responsible Officer	Timescale
19	The health board should explore the reasons why members of staff are not up to date with mandatory training and where needed support staff to attend training required.	7.1	Identify the specific areas of low training levels, explore issues affecting low completion and to devise a plan to support increased compliance.	Unit Manager and Lead Manager for Residential Units	30 August 2016

Service representative:

Name (print): Dermot Nolan…..

Title: Interim Assistant General Manager.....

Date: 11 July 2016…….....