Meeting Date	**28 June 2022**	**Agenda Item**	**3.2**
Report Title	**Quality and Safety Report Mental Health and Learning Disabilities**		
Report Author	Shelley Horwood: Quality and Safety Manager		
Report Sponsor	Stephen Jones Nurse Director		
Presented by	Stephen Jones Nurse Director		
Freedom of Information	Open		
Purpose of the Report	This report is to update the Quality and Safety committee on the progress, achievements and risks to quality and safety in the mental health and learning disability service group.		
Key Issues	The report identifies the achievements and risks under: • Quality Assurance Framework • Serious incidents Investigation • Complaints • Heath Inspectorate Wales Visits • Patient Feedback • Clinical Audit • Closure of Datix Cymru		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☒	☒	☐

Recommendations	Members are asked to: • **NOTE THE REPORT**

QUALITY AND SAFETY REPORT MENTAL HEALTH AND LEARNING DISABILITIES

1. INTRODUCTION

This report is to update the Quality and Safety committee on the progress, achievements and risks to quality and safety in the mental health and learning disability service group.

2. BACKGROUND

The report sets out the assurances for the Quality & Safety Committee in respect of the MH&LD Service Group and details the relevant actions and updates building upon previous reports submitted.

3. GOVERNANCE AND RISK ISSUES

Mental Health and Learning Disabilities Quality Assurance Framework

In February the MH&LD Quality and Safety Group agreed the implementation of a quality assurance framework across all areas of the Service Group. The Service Group Quality Assurance Framework (QAF) forms the building blocks for how safe, effective, person-centered health services are monitored and continually improved through governance, leadership and accountability.

Through a series of monthly audits by Ward / Team managers and Lead Nurses and a tiered process of 15 Step Walkabouts and targeted Nurse Director reviews across each Division, the SG can gain assurance to support the provision of high quality, safe, effective and person centered healthcare that meets Service User's and public expectations of Mental Health and Learning Disability Health Services.

The Ward / Team Managers and Lead Nurse audits are being piloted for the first 6 months and working groups are underway to track any variance and finalise the tools. 15 step reviews have been active since the ratified framework and reported on via the MH&LD Quality and Safety Committee. The targeted Nurse Director's reviews have commenced and 2 have been carried out to - date these will be reported to the MH&LD Quality and Safety Committee at the next reporting period.

The Quality Assurance Framework has been put forward to be included (once agreed) for the Audit Management and Tracking (AMaT) system as an active module for the Mental Health and Learning Disabilities Service Group.

The Ratified Quality Assurance Framework can be found in Appendix 1

Serious Incident Position

Backlog

The current position for the backlog of investigations into serious incident are:

- 2019 /2020 - nil outstanding
- 2020/2021 - 1 x prison investigation open
- No cases currently open with Welsh Government

Development of Proportional Investigation Processes

For deaths of individuals with a learning disability and any deaths of individuals where it may be a potential drug related death, there is a peer review process being implemented which allows the clinical team to identify any concerns and the cases closed as appropriate. An escalation strand has been included in the processes to ensure that where concerns are identified by clinical services or families the case can be escalated to a full review.

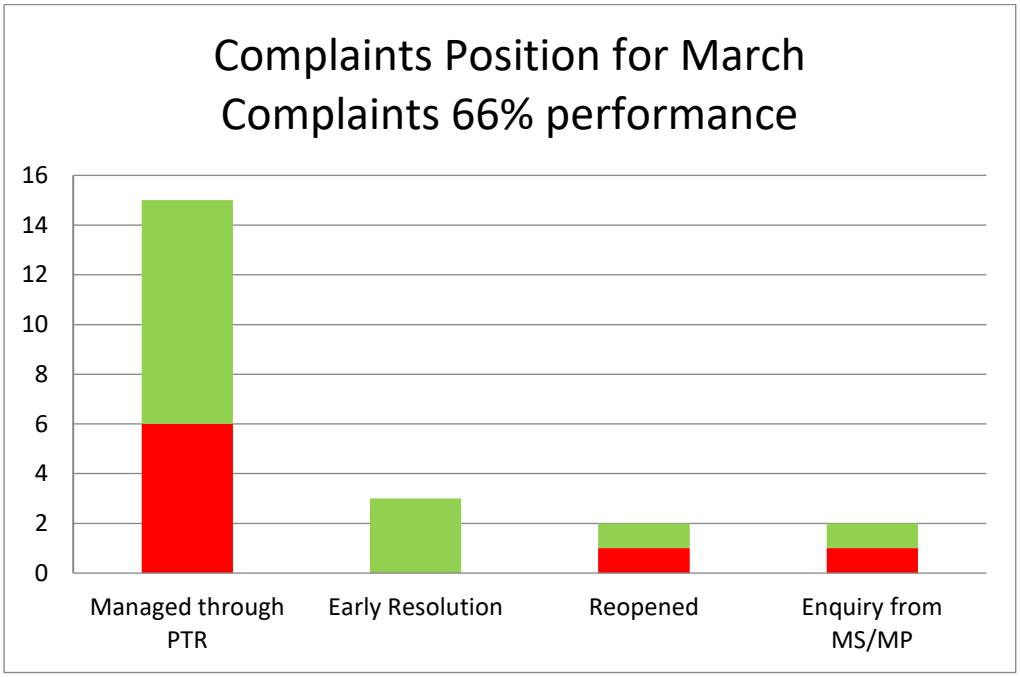
Medical Examiner Service

Where cases have been reviewed by the medical examiner the case is closed subject to the case being referred to the Learning from Death panel when an investigation will be undertaken by the relevant team.

Complaints

A joint Quality improvement plan is being developed with the corporate nursing team to address low performance against the Health Board's 80% target for completion within 30 days of receipt.

Performance in May (which relates to March complaints) was 65%.



Impacts on Performance Include the Complexity of Complaints

To improve performance on complaints both in the timeliness of the response and the quality of the response, staff will be allocated from the Serious Incident Investigation Team to investigate the complex concerns. In the last 2 months, this work has started, investigators have increased the opportunities to meet / converse with the complainants and support them within the ongoing investigations. This approach is being reviewed to better understand the effectiveness in providing a holistic response and improve the complainants experience through having the opportunity to meet and be listened to. Although, it is recognised that this is resource intensive having its focus more on the improvement of patient experience, the quality of the response and the learning outcomes.

Health Inspectorate Wales (HIW)

Cefn Coed Hospital: Adult Mental Health Wards

HIW visited the adult mental health wards on the Cefn Coed Hospital site between the 14th – 16th March 2022.

The summary of the HIW findings:

- HIW found a dedicated staff team that were committed to providing a high standard of care to patients. We observed that staff interacted with patients respectfully throughout the inspection.
- Care plans drew on individual patient strengths with balanced input from all members of the multi-disciplinary team. However, patient records were disorganised and inconsistencies of record keeping across the hospital provided a challenge for staff accessing the most up-to-date and completed documentation.
- HIW found that the out dated design of Cefn Coed Hospital impacts negatively upon the patient's experience and provides difficulties for staff working in this environment.

HIW also identified areas where the service were doing well:

- All staff were observed to interact and engage with patients respectfully.
- Providing multidisciplinary patient centred care.
- A good range of health promotion and therapeutic activities.
- Established governance arrangements that assisted in safe and clinically effective care.

HIW recommended areas where the service could improve:

- The environment of care that impacts upon patient privacy and dignity.
- The environment of care for staff to manage the safety of the wards.
- The structure and consistency of documentation used within patient records.

The Service Group has developed an action plan in relation to the findings which has been accepted by HIW (6th May 2022) (Appendix 2).

Dani y Deri Learning Disability Service

An unannounced inspection of Dan y Deri occurred on 15 March 2022.

The summary of the HIW findings:

- HIW found that the arrangements were in place with the intention to meet the Health and care standards relevant to the learning disability service.
- However, did identify improvement was needed around aspects of the service provision and asked the Health Board to take action to address this.
- The inspection also resulted in HIW asking the Health Board to take immediate action in relation to the environment, risk assessment and checking of emergency equipment to promote the safety and wellbeing of patients.

This is what HIW found the service did well:

- HIW found good compliance with the Health Board's staff training programme.
- All staff had received an appraisal of their work within the last year.

This is what HIW recommended the service should improve:

- Aspects of the environment and the arrangements to ensure estates. related issues are identified and addressed in a timely manner.
- The amount of information displayed for patients.
- The recording of checks of emergency equipment.
- Specific review of incidents where data indicates an increase in the use of restrictive practices, specifically the use of seclusion.
- Completion of admission and initial risk assessment documentation.

The formal inspection report was received on 30th May 2022. There are 11 areas for improvement (16 HB actions). The MH&LD Service Group has completed the immediate actions and developed an action plan in relation to the findings which was returned to HIW on Monday, 6th June 2022. (Appendix 3).

Patient Experience and Feedback

The Service user and Carer Feedback and Involvement Team have produced an annual report covering the period from April 1st 2021 to March 31st 2022. During this period the team received 200 referrals that resulted in completed telephone interviews for Feedback.

Of these 200 referrals, 69 were family members, 24 were carers and 107 were service users. 60 were relating to admission / discharge from inpatient setting.

Summary of the results per question:

- 93% found the area helpful
- 96% found everyone friendly and caring
- 95% found staff always listened
- 92% said that they were always given choices

Over All experience - of the 200 completed interviews:

- 93% said that their overall experience was ‘Very Good’
- 3.5% said that their overall experience was ‘Helped with some things’
- 1.5% said that their overall experience was ‘Not much help’
- 2% said that their overall experience ‘Did not help’

This table show the priorities, risks and actions as identified by the Service User and Carer feedback and Involvement Team.

TOP 3 Priorities/Risks & Actions/Mitigation			
Key Area to Note		Brief Description	Action/Mitigation
1.	Numbers of referrals	The team have now been established just over a year, and see varying levels of engagement and numbers of referrals received on a month by month basis.	The team continue to engage and be available to any areas wanting support or addition information. The team are planning to promote the service utilising posters within staff areas They are also continuing to meet with ward and team managers to discuss the implementation of this service.
2.	Areas of learning and improvement	During this reporting period there have been some ratings of ‘Poor’ or ‘Never’.	On each occasion the team have met with the Lead Nurse/Directorate Manager for the areas and shared/explored the feedback in order for the area to identify improvement.
3.	Creative and accessible ways to gather feedback	The Team’s bespoke feedback templates for the Prison In-Reach and Integrated Autism Service are now in circulation, easy read versions and visual displays also utilised within some LD areas, further drop in style clinics being rolled out in Rehabilitation areas.	Remains in progress encouraging referrals, reminder communications have been sent offering support and any assistance that is required. Team continue to be open to ideas around further ways of engagement and gathering feedback

Full annual report in appendix 4.

Infection Prevention Control (IPC)

The MH&LD Service Group has historically reported low incidents of Health Care Acquired Infections (HCAI). The aim of our improvement plan is to continue to reduce incidents of HCAI across the Service Group with a zero tolerance approach. This includes a reduction in antimicrobial and antibiotic medications in line with WG and the All Wales Medicines Strategy Group (AWMSG).

The Covid19 pandemic led to a significant change in the culture of the MH&LD Service Group with its approach to IPC. In partnership with the SBU HB IPC Team the Service Group embraced a learning and improvement approach to the management of Covid19 with IPC now very much embedded into our core business. This same approach will be taken forward in meeting the WG and SBU HB requirements of the Tier 1 IPC targets. Delivering safe and effective care to patients.

The complex mental health and learning disability needs of the patients within our services can increase risk of contamination and subsequent HCAI through behaviours that increase risk of cross contamination and infection. Through working collaboratively with our IPC colleagues we plan to create opportunities for a bespoke approach to risk reduction and harm prevention in HCAI.

The MH&LD Service Group has a designated Head of Nursing who provides the leadership on the IPC agenda for the Service Group. The IPC lead attends relevant IPC forums at Health Board level on behalf of the Service Group ensuing a 2-way process for reporting and assurance on progress against the objectives set out in the improvement plan.

The MH&LD Service Group has established an IPC group into its governance structure. Through strong leadership and group membership that includes representation on a multi professional level and front line clinical staff, expectations for improvement are cascaded for ownership and to create a culture of awareness and recognition that the prevention of HCAI is everyone's business.

The Quality and Safety Committee are asked to note that the attached plan (appendix 5) has been presented at the Infection Prevention Control Committee on the 13th May 2022.

Safeguarding

For the reporting period 1st January to 31st March 2022 the following key points were noted:

- Low use by Child & Adolescent Mental Health Service (CAMHS) of the emergency admission bed.

- Low number of Professional Conduct cases being managed through Local Authority Strategy processes.
- Increase in DoLS breaches within MH due to delays in Best Interest Assessments.

Ward Assurance audits were completed in 5 Learning Disability areas. This was in addition to the MH areas previously audited. An audit cycle is in place for discussion with action plan in development.

The themes identified:

- Qualified staff to access Level 3 Safeguarding training & all other staff to access Level 2.
- The importance of staff feeling confident to contact corporate safeguarding to discuss concerns and that the support is there to prevent referrals.
- Discussed exploitation training and how that would benefit the team in helping them understand how some people behave and why they are admitted in crisis, and help with moving forward with care and support needs.
- Safeguarding posters to be displayed in all areas.
- Lack of knowledge of safeguarding resources available via intranet and quick links.

Further audits to conclude all areas within the Service Group once new Corporate Safeguarding lead is in post.

Clinical Audit

The Clinical Audit Sub Group currently has an active database of audits which are focused on the Health Board's Quality priorities and on any Mental Health and Learning Disability specific risks.

The audits include National Audits and locally identified topics. The audit group has facilitated one event so far in 2022 with two further events planned to feedback audits and ensure that action plans are in place to complete the audit cycle. The next clinical audit event is arranged for July 11th 2022.

Key achievements of the group:

- Successful completion of clinical audits.
- Regular clinical audit events supported by medical, nursing and allied health care professionals.
- The production of a quarterly newsletter.
- Guidance for staff thinking of developing an audit and a quality assurance system which ensures that audits added to the register are relevant to the Health Board and Service Group's identified quality and risk framework.

Future priorities for the group:

- Registering an increased number of Quality Improvement programs.
- Further development of the action planning and improvement programs arising from audit.

Appendix 6 Clinical Audit Newsletter following the event chaired in March 2022.

Closure of RL Datix System

There were a total of 803 incidents that required investigations and closure left on the system at 05/04/22. As of 10/06/22 there are 245 incidents that required investigations and closure (75 less than last month's report).

The Service Group is reporting regularly to the MH&LD Quality & Safety Committee on the progress of closing the incidents and it is anticipated that all incidents will be closed with under 10 serious incidents to be transferred to the new system due to the complexity of the investigation.

Ongoing actions to ensure effective closure of the old system:

- Regular monitoring and support to close incidents.
- Consideration for closing no harm incidents by the Quality and Safety team.
- Reporting via Quality and Safety of progress.

4. FINANCIAL IMPLICATIONS

None identified.

5. RECOMMENDATION

Committee members are asked to:

- **NOTE THE REPORT** as a reflection of the achievements and risks in the Mental Health and Learning Disabilities Service Group.

Governance and Assurance		
Link to Enabling Objectives *(please choose)*	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☒
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☐

Quality, Safety and Patient Experience

This report identifies the key achievements and the challenges noted in implementation of Quality and Safety strategies in the Mental Health and Learning Disability Service Group. The Service Group has a commitment to achieving the best service possible for patients and therefore monitors quality, safety and patient experience though a governance process which ensures the senior management have excellent 'Floor to Board' data and feedback.

Financial Implications

None identified.

Legal Implications (including equality and diversity assessment)

None identified.

Staffing Implications

None identified.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

The report demonstrates how the Mental Health and Learning Disabilities Service Group is achieving a high quality service provision today and developing that service for future generations.

The report will have an impact of the "The Well-being of Future Generations (Wales) Act 2015, 5 ways of working.

- **Long Term** - The importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs.
- **Prevention** - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives.
- **Collaboration -** Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives.
- **Involvement -** The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves.

Report History	Quarterly reports are presented to Quality and Safety Committee	
Appendices	Supporting information to the report should be listed here.	
1	Mental Health and Learning Disabilities Service Group Quality Assurance Framework	 Ratified Quality Assurance Framewo
2	HIW report - Cefn Coed Hospital	 Report published 17.6.22.pdf
3	HIW report - Dan Y Deri and Llwyneryr Learning Disabilities Units	 21160 - Inspection Report - 2022-03-15
4	Patient feedback reports	 14 Feedback Service Report - April 2022 (2
5	MHLD Service Group Tier 1 HCAI Improvement Plan.	 MHLD SG Tier 1 HCAI Improvement
6	Clinical Audit Newsletter	 Clinical Audit News Letter Spring 2022.p

Mental Health & Learning Disabilities Service Group Quality Assurance Framework

Safe, effective, person-centred health services that are continually improving through governance, leadership and accountability

Originator:	Stephen Jones (Nurse Director) Paula Hopes (Learning Disability Nurse Consultant) Marie Williams (Lead Nurse – Quality Improvement) Alison Rickard (Registered Nurse)
Date:	November 2021
Ratified by:	Mental Health and Learning Disabilities Quality and Safety Committee
Date Ratified:	January 2022
Review Due:	July 2022

INTRODUCTION AND BACKGROUND:

During 2016, the Mental Health and Learning Disabilities Delivery Unit ratified the Quality & Assurance Plan. This plan has formed the building blocks for how safe, effective, person-centred health services are monitored and continually improved through governance, leadership and accountability.

THE VISION:

The Service Group's vision is to provide high quality, safe, effective and person centred healthcare that meets Service User's and public expectations of Mental Health and Learning Disability Health Services. We aim to do this through the achievement of quality driven leadership, from empowered clinical Lead Nurses and Allied Health Professionals who lead within a culture of trust, openness and transparency. The aim is to provide the best possible care to people who use our services through a clear, quality- driven agenda.

A FRAMEWORK FOR IMPROVEMENT:

ALWAYS IMPROVING

We have strengthened our basis for improving the quality and safety of Swansea Bay University Health Board's (SBUHB) Mental Health and Learning Disability Service Group healthcare services, by embedding a framework which is used in identification of strengths and highlighting areas for improvement. There is a clearly communicated vision for everyone who works for, or on behalf of the Service Group. This demonstrates the importance we place on quality and the experiences of Service Users and their families/carers.

This will be achieved by:

- Embedding a structure which defines expectations, responsibility/accountability and the ability to influence.
- Enabling a culture that promotes openness and professional pride, where the Health Board values of caring for each other, working together and always improving are realised, visible, embedded, and demonstrated by all.
- Evidencing accountability to Service Users and our ability to both manage and meet their expectations.

- Embedding collaborative working across the Mental Health and Learning Disability Service Group, Divisions, and Directorates.
- Enabling a competent and capable workforce where all staff realise their knowledge, skills, competence, accountability and ability to influence and drive quality services to maximise their role and contribution within the Service Group

WORKING TOGETHER

Achievement of this requires a culture of openness and transparency. This will contribute to elimination of failings within our services, such as those highlighted in scandals and investigations into poor culture and practice. Absolute transparency is key to driving improvements in care standards, as well as a culture of empowerment amongst clinical staff and managers.

CARING FOR EACH OTHER

This is essential in promoting openness, honesty and compassionate practice. Caring for each other will be evident at all levels, and relies on the promotion of wellbeing, listening to feedback and adopting personalised approaches. This will also be demonstrated by compassionate leadership.

We will meet these principles through:

- Recognising the contribution of our clinicians in practice
- Empowering and trusting staff to make decisions
- Supporting staff to access the tools and resources needed for problem solving
- Publication of service user and carer feedback and staff surveys
- Honesty about what the Service Group/Health Board will or won't do
- Open and honest relationship with CHCs and advocates
- Publication of benchmarking data
- Making clear to people who use our services, the public and staff, the chain of accountability within the Service Group

CLARITY OF RESPONSIBILITIES AND ACCOUNTABILITY

To ensure processes support and drive improvement, clarity of responsibilities and accountability are key. Quality and assurance are integral to all roles within the MH/LD Service Group. This framework clearly illustrates what data is collected, triangulated and reported on, how and by whom. We are clear on accountability, responsibility and reporting lines. There is a clear vision on how we use measures.

It's up to us. We all have a duty to be aware of the issues which impact on quality and safety in our environments. We can all take responsibility to directly act on issues, complete incident report forms, highlighting to the rest of our team, reporting issues to estates or escalate as necessary.	
Clinicians	Must ensure that they are aware of relevant policy, practice guidelines and are working in line with professional standards and expectations. Need to include people experience in their assurance processes. Clinicians will be expected to complete and contribute to audit, reviews, DATIX/incident reviews, de brief and reflective practice sessions, lunch and learns etc.
Unit leads/community leads	Are responsible for action planning and responding to the quality and safety issues highlighted through the assurance process. Maintaining standards and addressing issues in a timely and responsive way. Unit leads/community leads will be asked to contribute to aspects of the governance toolkit in other parts of the division or service group and encourage the participation of their team members. They will be responsible for co-ordination of process in their areas and sharing information related to quality assurance with their teams, service users and stakeholders.
Divisional and service group triumvirate	Will engage in quality assurance processes on an announced and unannounced basis. There will be visible leadership via a range of methods. Engagement events will encourage honest and open communication including stakeholder feedback. The triumvirates will receive reports and action plans for oversight and review and will incorporate this information into governance and assurance processes.
The Service User Feedback and involvement Team	The Service User, Carer, Feedback and Involvement Team are a service group wide team, that are independent from the divisions and directorates. The team supports all Service User's, Relatives and Carers the opportunity to give valuable feedback about the care and service that they have received. This feedback allows us as a Service Group to recognise good practice, identify learning

	for any less positive experiences and explore improvements in these areas. Feedback Service reports are provided to the Mental Health and Learning Disabilities Quality and Safety Committee on a monthly basis

GOVERNANCE AND ASSURANCE FRAMEWORK:

In order to ensure that the right infrastructure for monitoring, assurance and governance are in place we will use the following processes:

- Outcome measurement and monitoring
- Audit
- Quality Assurance Spot Checks
- Meet the Leadership Team
- Transparency in the performance scorecard
- Representations of all levels in governance process

This section outlines what we measure, how we measure it, when we measure it and how we report it.

Outcome measurement and monitoring

We will measure what matters to patients and ensure the information we collect is focused on improving their experiences. We will benchmark our services with the best and establish the key outcome measures and targets for all our services. We will focus on collecting outcome rather than process measures. Feedback from our Service users, Carers/Family (Via the Service User Feedback Team) and Staff (via the Staff Survey) will be reported on and analysed to inform improvement in our services

Quality data, such as incident reporting, complaint/concerns and compliments, also inform learning and improvement. Directorate wide Listening, Learning and improvement events are an arena to be able to analyse, triangulate and make sense of the quality data available to us.

Audit

Clinical Audits

Clinical audits are identified and proposed against the Health Board priorities and also any departmental requirements. Audit enables healthcare professionals to measure the quality of the care they offer against Standards developed locally and nationally. It allows

us to compare performance against a standard to see how we are doing and identify opportunities for improvement. Changes can then be made, followed by further audits to see if these changes have been successful and resulted in improvements.

Mental Health and Learning Disabilities Service Group Clinical Audit Strategy has been produced and ratified to support this and is reported on via the Clinical Audit Subgroup.

Performance related audits

Each clinical area captures data relating to their performance that is reported on via their Directorate and Divisional reports. Some of this data feeds into the Performance Scorecard (please see section below).

Care indicators/metrics

This is a Welsh Government directive which is set against the All Wales Health Care Standards. It includes criteria relating to daily, weekly, monthly and annually reporting of data. This data is captured across all inpatient areas in the MH/LD Service Group.

There is a requirement that the data is submitted on a monthly basis and is scrutinised by the Ward/Team Manager initially (1st to 7th of the month) and then by the Directorate Lead Nurse (7th to 14th of the month). For inpatient areas this will inform the Monthly Quality Assurance checks at Divisional/Directorate Level and the Ward/Team level. Additional criteria will be the focus of the Community team's assurance.

Data captured from the Care Indicators also informs the Performance Scorecards.

Quality Assurance Spot checks

This framework sets out the structures and processes for providing assurance against our quality indicators and the appropriate level of responsibility in providing this. There are different levels of reporting as set out below:

Divisional/Directorate/Ward/Team Level Toolkit

There are a number of ways that Quality Assurance occur within the clinical teams/areas and some of these are outlined above and below, such as clinical audits, general audits, Welsh Governments Care Indicators – based around the Health Care Standards and also the performance data produced for the MH/LD Service Groups Performance Scorecards.

The following standardised Quality Assurance Audit Tools have been developed for use across the Service Group for the Divisional/Directorate and Ward/Team level:

- Quality Assurance Review tool undertaken at Ward/Team Level – Appendix 1 for inpatient and community settings
- Quality Assurance Review undertaken at Directorate Level – Appendix 2 for

inpatient and community settings

Each division will have an expectation to ensure the timely review of each team/area on a **monthly** basis using the Directorate Level Toolkit, as assigned by the directorate leads. Each Ward/Team will have an expectation to ensure the timely review using the Ward/Team Level Toolkit on a monthly basis also by the ward/team senior staff (B7/B6).

15 steps reviews

The 15 Steps Challenge is a toolkit with a series of questions and prompts to guide through the first impressions of a health care setting. The 15 Steps Challenge tool asks the reviewer/s to explore the quality of care under four categories;

- Welcoming
- Safe
- Caring and Involving
- Well organised and Calm

The 15 Steps Challenge is designed to help with continuous improvement. The Challenge will help gain an understanding of how Service Users feel about the care provided and how high levels of confidence can be built. This tool can also help organisations understand and identify the key components of high quality care that are important to Service Users and Carers from their first contact with a member of the healthcare team and clinical environment. The Challenge is designed to help organisations in their continuous improvement journey. By enabling the Service User's, Carers and Staff voices to be heard clearly, the tool can be used to highlight what is working well and what might be done to increase confidence.

Within the MH/LD Service Group, it is expected that if any Senior Member of staff from any area across the Directorates, Divisions or the Senior Management Team, attends an area where they are not usually based, then there is a requirement to give feedback of the visit using the 15 step review. This is aimed at being a light touch review, given the ethos of being able to assess and review the area in question within 15 steps of arrival for the visit.

The review document to be used can be found in Appendix 3 which should then be submitted to the Head of Nursing for the Division.

Nurse Director Unannounced Reviews (pseudo HIW review)

The Nurse Directors office will co- ordinate a review team of clinicians, senior leaders and relevant specialist/individuals, drawing on expertise and experience within Mental Health and Learning Disabilities.

Reviews will be arranged and conducted on a monthly basis by the Nurse Director and will be unannounced to the clinical team/area to be reviewed.

Each member of this review team will have an equal level of responsibility to provide valuable feedback, observations and recommendations in relation to the unannounced review of a clinical area or team

These reviews will:

- Help Staff, Service Users and others to work together to identify improvements that can be made to enhance the quality of care and Service User experience
- Provide a way of understanding Service Users and Carers first impressions more clearly
- Provide a method for creating positive improvements in the quality of care through identifying what is working well on wards / services and what could be improved through supporting the sharing of good practice and concentrating on learning and improvements
- Develop the overall quality of practice and the knowledge and skills of practitioners in relation to quality improvement
- Support wider conversations about what is working and what can be improved upon

An overview of the Nurse Directors Quality Assurance Unannounced Review Toolkit can be found in Appendix 4

The review process is underpinned by the following principles:

- The review team will be planned on the basis that they do not have direct line management / responsibility for the area being reviewed to maximise objectivity
- The review will include a minimum of one staff interview and one patient interview
- Once completed findings will be shared with ward/team manager and the clinical team
- Review reports will also be sent to the Lead Nurse for the Directorate to review themes across their Directorate/Division
- The review process will be reviewed regularly and learning utilised to continuously improve the process of reviews.

Following completion of the monthly tools, any 15 step reviews and the Nurse Director Unannounced reviews, any outstanding actions will be placed on the Quality Assurance Action Plan (Appendix 5). A copy of which will also be held by the Ward/Team and also reported on within each Division. Once actions have been completed they will remain on the action plan noted as completed so actions that have been followed through are recorded as evidence of learning and improvement.

Performance Scorecard

Performance scorecards provide an overall analysis of key performance data from each clinical division within Mental Health & LD Services, such as Adult MH, Older People MH, Rehab & Recovery, Perinatal services, Forensic MH services and Learning Disabilities Services. The overall purpose is to provide those responsible for service delivery with the right performance information so that they can measure, manage and improve delivery. The scorecard is also used for data benchmarking across services.

The reports are produced by the Informatics Team and reported at a Directorate and Divisional Level, which include data relating to the following and measuring actual performance:

- Patient Safety Indicators
- Service Users and Carer feedback
- Workforce Indicators
- Training
- Care and Treatment Plans
- Access to Local Primary Mental Health Support Services
- Access to Psychological Therapies
- Access to Mental Health and Learning Disability Services
- Patient Flow Indicators
- Finance

The scorecards feed into a performance statement which is reviewed by the senior team. For each indicator we look at how we are performing against national standards and our own targets.

Meet the Leadership Team

The leadership triumvirate teams at a service group and divisional level will create space and opportunity for open and honest feedback from teams and colleagues within the service group.

There will be a visible presence where members of the senior leadership teams (service group, divisionally and by directorate) can be expected to attend units, wards and community based areas on an announced and unannounced basis. This may involve carrying out quality assurance work as outlined in this document. This will be embraced as an opportunity to capture naturally occurring feedback and informal discussion, sense checking and gathering evidence on quality and safety issues.

There will also be planned question and answer sessions, sometimes this will be open to the whole service group and on other occasions the events may be specific to a division

or directorate. Opportunities to submit questions in advance will be given as well as an open invitation at the event. The events may take place face to face or virtually.

On occasion, there may be planned visits to the mental health and learning disability service group from external partners, stakeholders, or members of the wider health board. These events will be pre-planned and members of the service group and divisions will work together on a timetable to ensure wide representation, service user involvement and the ability to portray accurately the achievements and challenges within the identified part of the health board.

Representations of all levels in governance process

As a Senior Team, we acknowledge the differences between assurance and performance management and are clear of the alignment of these two processes. We will work with front line staff to develop scrutiny processes and checks that are owned and understood.

In order to develop an organisational culture that drives excellence, learning and improvement, we will engage with staff to ensure continuous measurement and clear accountability. We will encourage understanding, trust and respect of the roles we play in delivering quality. With this in mind the tools within this framework will be used from 1st December 2021 for all wards/teams across the service group, this framework will be reviewed in June 2022 after 6 months of data has been collected to ensure effectiveness. A variance Tool has been produced (Appendix 6), that should be completed by the reviewers to show any variance to this framework and will form the analysis of the framework and part of its review in June 2022.

The variance tool should be completed and submitted to the Lead Nurse for Quality Improvement on a monthly basis for collation.

GOVERNANCE AND ASSURANCE FRAMEWORK (OVERVIEW):

Here is an overview of the Quality Assurance Framework for the Mental Health and Learning Disabilities Service Group

Governance focus	Key work plan areas
Outcome measurement and monitoring	Outcome Measures rather than process measures Feedback from Service Users, Carers and Relatives • Mental Health and Learning Disabilities Service Group Feedback Team Feedback from Staff • Staff Survey Working Group

	Quality Data - Listening Learning and Improvement directorate events • Incident Reporting • Complaints/Concerns • Compliments etc.
Audit	Clinical Audits – Overseen by the Clinical Audit Subgroup • National Audits • HB/Service group wide audits • Localise/Departmental Audit Performance related audits • Data Capture around performance related criteria • Please see section below on Performance Scorecard Health care Standards / Care indicators/Metrics • For inpatient settings • Annual / Monthly data capture • Evidence or collation and continued scrutiny of compliance with the standards and feeds into the Ward inpatient level tool kit
Quality Assurance Spot checks	Ward/Team Level Tool kit • Completed monthly Directorate/Divisional level tool kit • Completed Monthly 15 step reviews • Completed by any visiting senior team member Nurse Director Unannounced Reviews • Monthly programme/schedule of reviews
Performance Scorecard	Performance related data • Patient Safety Indicators • Service Users and Carer feedback • Workforce Indicators • Training • Care and Treatment Plans • Local Primary Mental Health Support Services • Access to Mental Health and Learning Disability Services • Patient Flow Indicators • Finance
Meet the Leadership Team	Virtual Question and Answer Sessions • Quarterly sessions via MS Teams Face to Face sessions • attendance at units, wards and community based teams/services Planned Visits from: • external partners • stakeholders

REPORTING STRUCTURES

The Service Group will report via the Mental Health and Learning Disability Service Group Quality and Safety Committee to the Mental Health and Learning Disability Service Group Board which will hold us to account in relation to performance, values and culture and set the strategic direction.

In order to achieve this:

- Each Division will ensure a reporting structure and governance within their internal processes to provide assurance of each stage of the framework as set out above in the form of a report to the Mental Health and Learning Disability Service Group Quality and Safety Committee

Please see reporting template for the exceptions report in Appendix 7.

Appendix 1:

MH and LD Service Group Monthly Health and Care Standards
Quality Assurance Review undertaken by Ward/Unit Managers (inpatient setting)

Ward ..... Date .....

Checks /Question	H&C Standards Ref	Frequency	Yes/No	Comments /Observations	Was the outcome added to the Ward Action plan Yes /No
Staying Healthy					
Is there information displayed on the ward which informs patient/services users/carers of local, regional and national initiatives that aim to support people with their mental and physical wellbeing.	1.1	2 x M			
Is there evidence in the clinical notes that patient /service users are involved in making decisions regarding their own health –look at files	1.1	M			

Safe care					
Is the ward free from clutter and equipment stored appropriately	2.1	M			
Is there evidence that safety alerts have been acted upon	2.1	M			
Are there any outstanding maintenance/ environmental issues that require escalation	2.1	M			
Is there evidence that all patients /service users risk to skin damage has been assessed.	2.2	M			
Are there any pressure ulcers on the ward –if yes is the skin bundle up to date	2.2	M			
Is there evidence that all patients /service users have been assessed for their risk of falls	2.3	M			
If patient/service users have been identified at risk of falls is there a plan in place to reduce the risk	2.3	M			
Are there any infection control issues that require escalation	2.4	M			
Are staff bare below the elbow	2.4	M			
Is there 100% compliance with hand hygiene training – if not does the ward manager have an improvement plan in place	2.4	M			
Is there 100% compliance with SIP training – if not does the ward manager have an improvement plan in place	2.4	M			

Does the ward have protected meal times in place	2.5	2 x M			
Is there evidence that all patient /service users nutrition and hydration needs have been assessed	2.5	M			
If assessed at risk is there evidence that there is all Wales food chart in place. Check two charts for accurate recording.	2.5	M			
Is there evidence that all registered nurses on the ward are competent in the administration of medication?	2.6	2 x M			
Is there evidence that all medication related incidents are reported in line with HB Medication policies and the delivery unit Policy for Management of medication errors	2.6	M			
Are the medicine keys held separate to ward keys and kept on the person of a registered nurse	2.6	2 x M			
Access to Clinical Room / Appropriate storage of Medications and equipment	2.6	M			
On checking 4 medication charts is there evidence of missed doses that have not been explained either on the prescription chart or in the patients notes.	2.6	M			
Are you assured as the ward manager that all staff on the ward are aware of their duty to protect vulnerable people under safeguarding procedures	2.7	2 x M			
Are you assured as the ward manager that every member of staff on the ward would recognise and act on any safeguarding	2.7	2XM			

concerns					
As the ward manager are you assured that all registered nurses on your ward would be able to put in place a safeguarding plan to protect a vulnerable person until they are able to speak to senior member of staff for advice & support.	2.7	2 x M			
Does all the equipment used on the ward have an up to date maintenance sticker. If not has this been escalated	2.9	2 x M			
Effective Care					
Is there evidence that welsh speakers have been identified and supported to communicate in the medium of welsh	3.1	M			
Has the correct documentation been used for all patients on enhanced levels of observation	3.1/3.5	M			
Is there a consistent rationale in the notes explaining the reason for the prescribing of enhanced observation in line with policy requirements	3.1/3.5	M			
Can staff quickly identify the patient's status by reviewing the PSAG board	3.1/3.4	M			
Is the PSAG board used to support discharge planning	3.1/3.4	M			
If staff are required to wear Personal alarms are they being used	3.1/3.5	M			

Does the ward use the NEWS chart in order to inform the clinical team of the patients physical health needs	3.1/5.1	M			
Is the name of the Nurse in charge displayed for patient and relatives.					
Is there evidence that patient /service users communication needs have been assessed	3.2	M			
Is there up to date information displayed on the knowing how we are doing board	3.2	M			
Is there evidence of good record- keeping which reflects management of risk - Check notes	3.5	M			
Is there evidence of good record keeping in line with NMC guidelines in record keeping – check notes	3.5	M			
Is there evidence that all patients that should have a Care and Treatment plan have one.	3.5	M			
Dignified care					
As the ward manager are you assured that people are treated with dignity and respect, courtesy and politeness on your ward.	4.1	M			
As the ward manager are you assured that patients /service user's pain and comfort needs have been assessed	4.1	M			
As the ward manager are you assured that people in your care have been supported to attend to their personal care needs	4.1	M			
Is there evidence that all patients /service users receive regular assessment of their oral hygiene	4.1	M			

Do patients /service users have accesses to dental care should they require it	4.1	2 x M			
Is there evidence that patients'/service users have been provided with information regarding their individual health needs	4.2	M			
Timely Care					
Is EDD displayed on the PSAG board	5.1	M			
Is there evidence the HB Discharge policy is being implemented	5.1	M			
Individual care					
Is there evidence of individualised activity /exercise/recreation plans in place, appropriate to individual needs	6.1	M			
Is there evidence of recovery /re-enablement focused care	6.1	M			
Is there evidence people are informed of available advocacy services to support them.	6.1	M			
Is there evidence that patient/services users spiritual and pastoral needs are recognised and addressed	6.2	M			
Is there evidence that feedback from patients /service users is used to inform learning and improve services	6.3	2 x M			
Is there evidence that carers feedback is actively sought and used to inform learning and improve services	6.3	2 x M			
Is there evidence that patient's relationships with carers family & friends is supported	6.3	M			

according to their wishes					
Staff and Resources					
As the ward manager are you assured that you produce effective rosters in line with SBUHB policy	7.1	M			
Is your Statutory and mandatory training 100%. If not as the ward manager do you have an improvement plan in place.	2.2,2.7,2.9 ,7.1	M			
Are PDR/PADR 100%. If not as the ward manager do you have an improvement plan in place?	7.1	M			

Print name of Ward Manager..... Sign:..... Date:.....

1. On completion of your quality assurance review, place a copy in your quality assurance file so all staff can access the information.
2. Add any outstanding issues from the review are to be added to your ward action plan and copy forward to your Lead Nurse.

Appendix 1

Mental Health and Learning Disability Service Group

Monthly Health and Care Standards Quality Assurance Review tool undertaken by health team managers (Community setting)

Team ..... Date .....

Checks /Question	Yes/No	Comments /Observations	Immediate assurance needed?	Added to the Action plan
Staying Healthy				
Is there evidence of health promotion initiatives e.g. smoking- cessation, physical health screening				
Is there evidence in the clinical notes that Service Users are involved in making decisions regarding their own health				
Is there evidence of physical health monitoring in line with the persons condition and needs.				
Safe care				
Is the area free from clutter and equipment stored appropriately				
Is there evidence that safety alerts have been acted upon				
Are there any outstanding maintenance / environmental issues that require escalation				

Are there any outstanding maintenance / environmental issues that require escalation				
Is there any learning from previous month Datix medication- related Incidents				
Is there evidence that all patients /service users risk to skin damage has been assessed.				
Are there any pressure ulcers on the ward – if yes is the skin bundle up to date				
Is there evidence that all patients /service users have been assessed for their risk of falls				
If patient/service users have been identified at risk of falls is there a plan in place to reduce the risk				
Is there evidence that all patient /service users nutrition and hydration needs have been assessed				
Effective Care				
Is there evidence that Welsh speakers have been identified and supported to communicate in the medium of welsh				
Is there evidence of good record keeping which reflects the management of risk - Check notes				
Is there evidence that patient /service users communication needs have been assessed				
Has the Care and Treatment plan Monthly audit been undertaken				

Has there been any reported SBUHB "never events" for the previous month				
Dignified care				
Is there evidence that people are treated with dignity and respect, courtesy and politeness				
Is there evidence of accessible information and adapted communication for an individual's needs				
How are peoples cultural, spiritual and identity needs evidenced within the care records.				
Is there evidence that patients'/service users have been provided with information regarding their individual health needs				
Timely Care				
Are response times in line with standards set by the team (see active caseload data/performance dashboard)				
Is there an assessment plan within the notes				
Is there evidence the HB Discharge policy is being implemented				
Individual care				
Is there evidence people are informed of available advocacy services to support them				
Is there evidence that patient's relationships with carers family & friends is supported according to their wishes				

Is there evidence that feedback from patients /service users is used to inform learning and improve services				
Is there evidence that carers feedback is actively sought and used to inform learning and improve services				
Staff and Resources				
Is Statutory and mandatory training 100%. If not does the ward manager have an improvement plan in place.				
Are PDR/PADR 100%. If not does the ward manager have an improvement plan in place.				
Where a member of the team is off sick is it clear that their cases have been re-allocated/reviewed				

Print name of Ward Manager..... Sign:..... Date:.....

3. On completion of your quality assurance review, place a copy in your quality assurance file so all staff can access the information.
4. Add any outstanding issues from the review are to be added to your ward action plan and copy forward to your Lead Nurse.

Appendix 2:

Mental Health and Learning Disability Service Group

Monthly Health and Care Standards Quality Assurance Review tool undertaken by Divisional/Directorate Leads (inpatient setting)

Ward/Team ..... Date .....

Checks /Question	H&C Standards Ref	Frequency	Yes/No	Comments /Observations	Added to the Action plan Yes /No
Staying Healthy					
Is there evidence of health promotion initiatives e.g. smoking- cessation, **physical health screening**	**1.1**	**2 x M**			
Is there evidence in the clinical notes that Service Users are involved in making decisions regarding their own health	**1.1**	**M**			
Safe care					
Is the area free from clutter and					

equipment stored appropriately	2.1	M			
Is there evidence that safety alerts have been acted upon	2.1	M			
Are there any outstanding maintenance / environmental issues that require escalation	2.1	M			
Is there any learning from previous month Datix medication- related Incidents	2.6	M			
Have the 3 x monthly CD audits been completed and action taken if required	2.6	3 x M			
On checking 4 medication charts is there evidence of missed doses that have not been explained either on the prescription chart or in the patients notes.	2.6	M			
Effective Care					
Has the correct documentation been used for all patients on enhanced levels of observation	3.1/3.5	M			
Is there good record keeping outlining the reasons for people prescribed enhanced observation in line with current policy	3.1/3.5	M			
Is the PSAG board used to support discharge planning	3.1/3.4	M			
Is the name of the Nurse in charge displayed.	3.2	M			
Is the information displayed on the knowing how we are doing board up to date	3.4	M			

Is there evidence of good record keeping which reflects the management of risk -Check notes	3.5	M			
Has the Care and Treatment plan Monthly audit been undertaken	3.5	M			
If staff are required to wear Personal alarms are they being used	3.1/3.5	M			
Is the ward using the NEWS chart to inform the clinical team of the patients physical health needs	3.1/5.1	M			
Has there been any reported SBUHB "never events" for the previous month	3.1	M			
Dignified care					
Is there evidence that people are treated with dignity and respect, courtesy and politeness	4.1	M			
Timely Care					
Is EDD displayed on the PSAG board	5.1	M			
Is there evidence the HB Discharge policy is being implemented	5.1	M			
Individual care					
Is there evidence that feedback from patients /service users is used to inform learning and improve services	6.3	M			
Is there evidence that carers feedback is actively sought and used to inform learning and improve services	6.3	M			
Staff and Resources					
Is there evidence of effective Rostering in line with SBUHB policy	7.1	M			
Is Statutory and mandatory training 100%. If not does the ward manager	2.2,2.7,2.9,7.1	M			

have an improvement plan in place.					
Are PDR/PADR 100%. If not does the ward manager have an improvement plan in place.	7.1	M			

Print name of Lead Nurse: ..... Sign: ..... Date: .....

1. On completion of the quality assurance review, discussion to be held with the ward manager of any outstanding issues identified and are then placed on the ward action plan.
2. Copy of the review to be placed in the ward quality assurance file .

Appendix 2:

Mental Health and Learning Disability Service Group

Monthly Health and Care Standards Quality Assurance Review tool undertaken by Divisional & Directorate Leads (Community setting)

Ward/Team ..... Date .....

Checks /Question	Yes/No	Comments /Observations	Immediate assurance needed?	Added to the Action plan
Staying Healthy				
Is there evidence of health promotion initiatives e.g. smoking- cessation, physical health screening				
Is there evidence in the clinical notes that Service Users are involved in making decisions regarding their own health				
Is there evidence of physical health monitoring in line with the persons condition and needs.				
Safe care				
Is the area free from clutter and equipment stored appropriately				

Are there any outstanding maintenance / environmental issues that require escalation				
Is there any learning from previous month Datix medication- related Incidents				
Effective Care				
Is there evidence of good record keeping which reflects the management of risk -Check notes				
Has the Care and Treatment plan Monthly audit been undertaken				
Has there been any reported SBUHB "never events" for the previous month				
Dignified care				
Is there evidence that people are treated with dignity and respect, courtesy and politeness				
Is there evidence of accessible information and adapted communication for an individual's needs				
How are peoples cultural, spiritual and identity needs evidenced within the care records.				
Timely Care				
Are response times in line with standards set by the team (see active caseload data/performance dashboard)				

Is there an assessment plan within the notes				
Is there evidence the HB Discharge policy is being implemented				
Staff and Resources				
Is there evidence that feedback from patients /service users is used to inform learning and improve services				
Is there evidence that carers feedback is actively sought and used to inform learning and improve services				
Staff and Resources				
Is Statutory and mandatory training 100%. If not does the ward manager have an improvement plan in place.				
Are PDR/PADR 100%. If not does the ward manager have an improvement plan in place.				
Are wellbeing initiatives evident within the team?				

Print name of Lead Nurse: ..... Sign: ..... Date: .....

1. On completion of the quality assurance review, discussion to be held with the ward manager of any outstanding issues identified and are then placed on the ward action plan.
2. Copy of the review to be placed in the ward quality assurance file and relevant divisional shared drive

Appendix 3: 15 Step Review

Mental Health and Learning Disabilities Service Group
15 STEP CHALLENGE – Reviewers Document

Ward/Team Area:		Date:	
The Reviewer/s:			

The 15 Steps Challenge is a toolkit with a series of questions and prompts to guide you through your first impressions of a health care setting. The 15 Steps Challenge tool asks the reviewer/s to explore the quality of care under four categories;

- Welcoming
- Safe
- Caring and involving
- Well organised and calm

The 15 Steps Challenge is designed to help with continuous improvement. The Challenge will help gain an understanding of how service users feel about the care provided and how high levels of confidence can be built. This tool can also help organisations understand and identify the key components of high quality care that are important to service users and carers from their first contact with a member of the healthcare team and clinical environment. The Challenge is designed to help organisations in their continuous improvement journey. By enabling the service user's, carers and staff voices to be heard clearly, the tool can be used to highlight what is working well and what might be done to increase confidence.

Please see list of questions and prompts in the Appendices A to D.

WELCOMING	
What went well…	**Would be better if…**

SAFE	
What went well…	**Would be better if…**

CARING AND INVOLVING	
What went well…	**Would be better if…**

WELL ORGANISED AND CALM	
What went well…	**Would be better if…**

OVERALL COMMENTS:

APPENDIX A- Welcoming

Did you feel comfortable and were welcomed appropriately? Was the atmosphere pleasant? What is the physical environment like, is it well maintained? Was information easily accessible? Were staff easily identified and had a good attitude? Did they introduce themselves and were they appropriately dressed?

APPENDIX B – Safe

Do I feel safe and secure? Do I feel confident? If so what makes me feel safe/ What is it that gives me confidence?

APPENDIX C- Caring and Involving

Is there evidence that Service Users and Carers are involved in their/their relatives own care? How do the Staff interact with the Service Users /Carers/Relatives? Is dignity, Privacy and Respect demonstrated and maintained? What have I noticed that builds confidence and gives me confidence? Are people addressed taking into account equality and diversity? Are open discussions being held with Service Users?

APPENDIX D – Well organised and calm

Even though busy do Staff maintain a calm attitude and demeanour? Do I feel calm in this environment? Do I feel confident in the Staff's ability to manage the environment? Do I feel the Staff member/s are well organised, knowledgeable and competent? What evidence is visible to support this?

MENTAL HEALTH AND LEARNING DISABILITY SERVICE GROUP

NURSE DIRECTOR UNANNOUNCED REVIEWS CHECKLIST

Overview Document

In addition to the Divisional/Directorate Quality Assurance Reviews, the Nurse Director will lead a team of reviewers to carry out unannounced reviews.

This document provides an overview of the requirements for these unannounced reviews.

The completed overview will be shared with the Ward/Team Manager so that these findings will inform an action plan in order that improvements can be made. A copy of these findings will be retained by the Nurse Director for comparison at future reviews.

SECTION 1: COMPLETED FOR ALL REVIEWS

On arrival the Service Group Senior Team will assess the area bearing in mind the following criteria:

The quality of patient experience, Safe & effective care and Leadership & Management

These areas would include an assessment of how welcoming the area is, which may include - pictures of staff, visibility of information, good leadership and management, general environmental observations and infection control procedures.

SECTION 2: COMPLETED FULLY OR IN PART DEPENDING ON THE FOCUS OF THE REVIEW

Depending on the focus of the review, different members of the Senior Team will be allocated responsibilities to conduct the review. E.g. the Service user representative to interview service users, Pharmacist to audit prescriptions and medication management, Senior nurse to review clinical notes etc.

The different areas of this section will focus on:

Medication Management
Clinical records
Rostering
Clinical Audit
Supervision, PADR and Mandatory/Statutory Training
Handovers
MDT working
Mental Health Act
Communication

Appendix 5

MENTAL HEALTH & LEARNING DISABILITY SERVICE GROUP

QUALITY & ASSURANCE WARD/TEAM ACTION PLAN

Ward/Team: .....

Directorate: .....

Date:..... **Completed by:.....**

Action Required	Source of the review i.e. HIW/Nurse Director etc Embed document	Who will do this?	By When?	Outcome – RAG rated

Appendix 6: Variance tool

Quality Assurance Framework

Variance Report

The Quality Assurance Framework has been developed to support all of the Quality Assurance processes across the service group, as outlined within this document. This framework is multifaceted and therefore requires an initial trial period. This pilot will run for six months from 1st December 2021 until 1st June 2022. During this pilot period, any staff member completing elements of this framework are asked to complete a variance report to record any variance they observe/experience in line with the framework.

Variance Reports will be collated under the divisional Quality and Safety agenda and submitted to the Lead Nurse for Quality Improvement on a monthly basis

Date:	
Reviewer:	
Area reviewed:	
Assurance Tool/Item used:	

Standard	Expected time scale	Reason for variance	Date signature

Appendix 7: Reporting template

Quality Assurance Framework

Divisional Report for Mental Health and Learning Disabilities Quality and Safety Committee

Meeting Date		**Agenda Item**	
Report Author			
Division			
Presented by			
Recommendations			

TOP 3 Priorities/Risks & Actions / Mitigation (from the report below)			
Assurance Area		**Brief Description**	**Action/Mitigation**
1.			
2.			
3.			

Assurance Area	**Feedback from Division**
Outcome measurement and monitoring	
Audit	
Quality Assurance Spot Checks	
Meet the Leadership Team	
Performance scorecard	

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

NHS Mental Health Service Inspection (Unannounced)

Cefn Coed Hospital

Tawe Clinic – Clyne & Fendrod wards

Swansea Bay University Health Board

Inspection date: 14 - 16 March 2022

Publication date: 17 June 2022

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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Contents

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced mental health inspection of Tawe Clinic, Cefn Coed Hospital within Swansea Bay University Health Board on the evening of 14 March 2022 and following days of 15 and 16 March. The following sites and wards were visited during this inspection:

- Clyne – Adult Mental Health Treatment Ward (Female)
- Fendrod – Adult Mental Health Treatment Ward (Male)

Our team, for the inspection comprised of two HIW inspectors, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one patient experience reviewer. The inspection was led by a HIW inspector.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act.

HIW explored how the service met the Health and Care Standards (2015). Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Further details about how we conduct NHS mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed that staff interacted with patients respectfully throughout the inspection.

Care plans drew on individual patient strengths with balanced input from all members of the multi-disciplinary team. However, patient records were disorganised and inconsistencies of recordkeeping across the hospital provided a challenge for staff accessing the most up-to-date and completed documentation.

We found that the out-dated design of Cefn Coed Hospital impacts negatively upon the patient experience and provides difficulties for staff working in this environment.

This is what we found the service did well:

- All staff were observed to interact and engage with patients respectfully
- Provided multidisciplinary patient-centred care
- A good range of health promotion and therapeutic activities
- Established governance arrangements that assisted safe and clinically effective care.

This is what we recommend the service could improve:

- The environment of care that impacts upon patient privacy and dignity
- The environment of care for staff to manage the safety of the wards
- The structure and consistency of documentation used within patient records.

3. What we found

Background of the service

Tawe Clinic provides NHS mental health services at Cefn Coed Hospital, Cockett, Swansea, SA2 0GH, within Swansea Bay University Health Board. Cefn Coed Hospital is a typical large early 20th Century mental health hospital that first opened in the 1930s. A large proportion of the original hospital has been decommissioned with the remaining wards being restructured and refurbished in an attempt to modernise the environment. The Strategic Outline Case (SOC) for the re-provision of adult mental health wards in the health board has been approved by Welsh Government. This will lead to the decommissioning of Clyne and Fendrod Wards and replacement with modern, purpose built facilities.

The Tawe Clinic provides therapeutic interventions and support for individuals experiencing an acute mental health episode where inpatient care is necessary. This is typically following a short period of assessment (typically up to 14 days) at the health board's assessment ward at Neath Port Talbot Hospital.

There are two wards, Fendrod providing care for men (20 beds) and Clyne providing care for women (14 beds). At the time of our inspection both wards were fully occupied. Each ward and its multidisciplinary team work closely with the health board's community mental health services.

Other patient services at Cefn Coed Hospital include:

- Gwelfor provides a slow stream[1] rehabilitation service and a step down service.
- Ysbryd y Coed is a purpose-built service that provides extended assessment, treatment and a range of therapeutic intervention for

[1] A slow stream mental health rehabilitation service gives patients the opportunity to achieve goals, increase their independence and makes sure that they do not lose any of the gains they have already made before returning into the wider community. Step down units provide people with the support and care they need before going back into the wider community.

patients who for one reason or another cannot be managed in any other setting at that time in their illness.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We observed that staff interacted and engaged with patients appropriately, and treated patients with dignity and respect.

There was a good range of health promotion and therapeutic activities at the hospital.

The environment of care at Cefn Coed Hospital is out-dated and impacts negatively upon the patient experience.

Staying healthy

There was clear emphasis on both wards to provide patients with a wide range of activities to help support their independence and aid recovery.

There was a wide range of patient information displayed on both wards, it was positive to note that on Clyne ward there was specific information around female health promotion and services. Our conversations with staff and patients, along with reviewing patient records evidenced that there was a clear drive to support the patients on Clyne ward with their physical health and screenings. Whilst on Fendrod there was evidence of physical health being reviewed and monitored by staff, there was less gender specific information relating to male healthcare.

Throughout the inspection, on both wards, we observed patients to be regularly engaged in activities and therapies. Each ward had a designated activity co-ordinator, both of whom also included some weekend shifts. There is input to both wards from an occupational therapist and occupational therapy technician.

The input from occupational therapy and the activity co-ordinators help provide an appropriate range of assessment activities, within the hospital and the community. Staff spoke of re-connecting links with community organisations that were suspended as a result of the restrictions put in place during of the Covid-19 pandemic.

Whilst there is an understandable emphasis on supporting patients within the community, some patients are required to stay within the hospital and are unable

to access community services. The health board need to consider how to improve the range of exercise facilities available at Cefn Coed Hospital, whilst there was a designated gym area with equipment, this is not routinely accessed by patients. Therefore there was limited opportunities for patients to take part in structured exercise routines in the hospital.

Both wards had an occupational therapy kitchen that provided patients with an easily accessible facility to practice and develop their skills. No regular temperature checks were being completed for the occupational therapy fridges on either ward, these need to be completed to ensure that produce is stored at the correct temperature.

As was the case during our previous inspection in 2019, the kitchen on Fendrod was also being used as a meeting room for clinical discussions, and was therefore inaccessible during these times and restricting the availability for patients. During our previous inspection the health board stated that an additional room on the ward had been refurbished for meetings that will mean the kitchen will no longer be used for clinical meetings. However, throughout this inspection, we observed this room to be regularly used by staff for meetings and therefore significantly limited the opportunity for patients to utilise the facilities within in this room.

Both wards had their own designated garden areas and patients on Clyne could access the garden area through an unlocked door. This was not the case with Fendrod due to the greater difficulty in staff observing the garden area from the ward, which is located on the first floor of the hospital. Therefore garden access for the male patients was dependent on staff availability to accompany them, to maintain their safety. This impacts negatively on freedom of patients into the outside area, as a result of the out-dated design of Cefn Coed Hospital.

Improvement needed

The health board must ensure that a range of male specific health promotion is displayed on Fendrod ward.

The health board must review the provision of physical exercise, therapeutic and social activities that are on offer, both within the hospital and in the community.

The health board must ensure that there is a designated occupational therapy kitchen on Fendrod

The health board must ensure the ease of garden access for patients on Fendrod.

Dignified care

We observed staff interact and engage with patients appropriately and treating patients with dignity and respect. The staff we spoke to were committed to provide dignified care for the patients.

We heard staff speaking with patients in calm tones throughout our inspection. When patients approached staff members they were met with polite and responsive caring attitudes. We observed staff being respectful toward patients including prompt and appropriate interaction, in an attempt to prevent patient behaviours escalating.

The ward environments did not meet current standards[2] for adult acute mental health units in Wales. This presented challenges around aspects of dignified care.

Both wards provided single gender accommodation. Each patient on Clyne Ward had their own individual bedroom that they could use. Most patients on Fendrod Ward had their own individual bedroom (there were two shared bedrooms, each with two beds). Beds within the shared bedroom had curtains between them, however, these only afford the basic level of privacy for patients, and do not reflect modern mental health care provision. It was also noted that in two bedrooms on Fendrod the window blinds were missing and had not been replaced, this will impact upon the privacy of the patients in each of the bedrooms and their sleep routine.

Patient bedrooms did not have ensuite facilities; there were shared toilets, shower and bath facilities on each ward, with three showers and a bath on Clyne

[2]Welsh Health Building Note (WHBN) 03-01 - Adult Acute Mental Health Units http://www.nwssp.wales.nhs.uk/sitesplus/documents/1178/WHBN%2003-01%20Adult%20Acute%20Mental%20Health%20Units%20-%20final.pdf

and two showers and a bath on Fendrod. This is insufficient provision for the number of patients on each ward.

Despite the outdated hospital construction the health board had modified the environment which included ongoing anti-ligature works and decoration to the wards to improve the aesthetics of the patient areas. It was noted however that Clyne ward had a more pleasant feel to the ward than Fendrod.

Throughout both wards there was damage and markings to furniture, fixtures and fittings that need to be repaired or replaced. These areas detracted from the ward appearance and also prevented appropriate cleaning of these surfaces which impacts upon infection prevention and control.

There were a number of restrictions and practices in place on Fendrod ward that were not the case on Clyne ward. As already mentioned this included that patients had open access to garden area and patient kitchen on Clyne but this was not the case on Fendrod. Clyne ward also had its own laundry room which patients could access or be supported to complete their own laundry, however on Fendrod the patient had to use the health board external laundry service because there was no on ward facility for the male patients. This impacts upon the dignity and the maintaining and learning of skills of the male patients. Some male patients also raised the concerns that items of laundry had been lost and not returned when using the health board's laundry service.

In addition, there remained a patients' smoking room located on Fendrod Ward. The smoking room was very unkempt and heavily stained and marked, it was a very unpleasant area of the ward and undignified for patients. The smoking room also lacked any seating for patients to use, we observed patients sitting on the floor or squatting whilst using this room which further reduced the dignity of those individuals wishing to smoke.

Whilst there was ventilation to remove smoke and the door was observed to be closed when patients were using the room, the smell of smoke was still apparent on the ward and impacted upon all patients and staff. During our previous inspection in 2019, the health board informed us that they were in the process of decommissioning the smoking room, with alternative arrangements being made for the ward garden, which was the smoking point for Clyne patients. With changes to smoking legislation in 2022 the health board must ensure that the smoking room is removed. The health board also need to ensure that if patients are able to smoke that this is enabled in a dignified manner and does not impact upon other patients or staff.

Improvement needed

The health board must ensure that the programme of works to modernise the environment of care at Cefn Coed Hospital is progressed in a timely manner.

The health board must ensure that environmental damages is rectified in a timely manner.

The health board must ensure that all patient have the facility to obscure their bedroom window from external light and maintain their privacy.

The health board must review the smoking arrangement for patients on Fendrod Ward.

Patient information

We saw information was available to help patients and their families understand their care, as well as details about organisations that can provide help and support to patients affected by mental health conditions. Information on advocacy was prominently displayed.

Information was displayed on how patients and their families can provide feedback about their experiences of the care provided on the wards. There was also information displayed about how patients could raise a concern about their care which included NHS Wales Putting Things Right[3] arrangements.

There was no information available on the role of HIW and how patients can contact the organisation. This is required by the Mental Health Act 1983 Code of Practice for Wales[4].

[3] Putting Things Right is the process for managing concerns in NHS Wales. Health in Wales | Putting Things Right

[4] Mental Health Act 1983 Code of Practice for Wales (Revised 2016) provides guidance to professionals about their responsibilities under the Mental Health Act 1983. As well as providing guidance for professionals, the Code of practice also provides information for patients, their

It was positive to note that both wards had a board displaying photos of staff members, these assist patients and visitors in identifying individual staff members.

Improvement needed

The health board must ensure that information is displayed on the role of HIW and how to contact the organisation.

Communicating effectively

Through our observations of staff and patient interactions, it was evident that staff ensured that they communicated appropriately and effectively with patients. Staff took time to undertake discussions using words and language suitable to the individual patient. Where patients remained unclear, or what they were trying to communicate was misunderstood, staff would patiently attempt to clarify what they had said.

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. Patient families and carers were also included in some individual meetings.

Individual care

People's rights

We reviewed a sample of care records for patients detained under the Mental Health Act (the Act). We saw that documentation required by legislation was in place. This demonstrated that patients' rights had been promoted and protected as required by the Act.

Patients could also use their mobile phones to keep in contact with their friends and family. Patients who did not have a mobile phone had access to the ward phones.

families and carers. https://gov.wales/topics/health/nhswales/mental-health-services/law/code-of-practice/?lang=en

Neither ward had a designated meeting room where patients could meet with visitors in private. There was a pleasant seating area at the entrance to Clyne which we were informed is used for that ward. However this area did not afford adequate privacy as patients and staff would regularly walk through this area.

Improvement needed

The health board must ensure that there are suitable facilities available for patients to meet with visitors in private.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

There were established processes and audits in place to manage risk, health and safety and infection control. Whilst this enabled staff to continue to provide safe and clinically effective care, the out-dated environment of the hospital impacted upon the efficiency and effectiveness of staff.

Care plan documentation reflected the domains of the Welsh Measure. Care plans drew on individual patient's strengths, and it was evident that patients' views were considered with balanced input from all members of the multi-disciplinary team. However, patient records were disorganised, and inconsistencies of recordkeeping across the hospital provided a challenge for staff accessing the most up-to-date and completed documentation.

Safe care

Managing risk and promoting health and safety

The Tawe Clinic is located in the original Cefn Coed Hospital building, and consists of two wards, Clyne Ward and Fendrod Ward. There was a pleasant and well maintained outside space at the entrance of the Tawe clinic, which included outside seating and raised flower beds.

There is level access to the main entrance of the building and Clyne Ward. This makes access to the ward easier for patients and visitors with mobility difficulties. Fendrod Ward is located on the first floor of the building and can only be accessed via stairs. This means patients who may have limited mobility are unable to access this ward. It was explained that if such care and intervention was required, then the patient would typically be cared for on Ward F at Neath Port Talbot Hospital.

The out-dated structural design of the wards does not allow for ease of observation of patients. There are a number of corridors and recesses out of easy view of staff. The health board have tried to mitigate this by including observation

mirrors; however the wards remain poorly laid out for ease of observation to maintain the safety of patients, staff and visitors at all times.

There was continued improvements being made to the ward environment as part of anti-ligature work. Where ligature points remained these were risk assessed with mitigating actions identified. Ligature cutters were readily available on both wards.

Call points were available in patient bedrooms, bathrooms and toilets. These allowed for patients to notify staff if they required assistance. There were personal alarms that were available to staff. We saw that staff were wearing alarms on Fendrod Ward, but this was not always the case on Clyne. Some staff on Clyne stated that they didn't feel the need to wear an alarm as they had a positive relationship with patients and that during the inspection they did not expect to require urgent assistance from other staff. However, there is great unpredictability with the provision of mental health care that may result in unforeseen assistance being required, including medical emergency. The health board need to ensure that staff are able to alert for assistance without delay when required.

Strategies were described for managing challenging behaviour to promote the safety and wellbeing of patients. We were told that preventative techniques were used and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the safe physical restraint of patients was used, but this was rare and only used as a last resort.

There was an established electronic system in place for recording, reviewing and monitoring incidents and any use of restraint was documented and reviewed. There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner.

Improvement needed

The health board must ensure that there is clarity around the reasons when and why staff wear personal alarms.

Infection prevention and control

There were established infection, prevention and control arrangements in place on both wards. However, the out-dated building hindered the efforts of staff to continuously maintain effective infection prevention and control. There was also

limited storage space on each ward, which resulted in items not being stored appropriately.

Cleaning schedules were in place to promote regular and effective cleaning of the wards. All staff were aware of their responsibilities around infection prevention and control, including wiping telephones and computers with cleaning products between and after use to reduce the risk of cross contamination.

The health board had conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands of the COVID-19 pandemic. Staff we spoke to were aware of infection control obligations. There was COVID-19 documentation to support staff and ensure that staff remained compliant with policies and procedures.

There was access to hand washing and drying facilities throughout the hospital. During our discussions no issues were highlighted in relation to access to Personal Protection Equipment (PPE), including masks and gloves. Staff were observed to be wearing masks throughout the inspection.

There were suitable arrangements in place for the disposal of waste. Appropriate bins were available to dispose of medical sharp items.

As we identified on our previous inspection there were limited numbers of toilet and shower facilities on each ward, these were in high use throughout the day and it was therefore difficult to maintain the cleanliness of these areas. This was commented upon by patients, housekeeping and ward staff. It was also noted that recurring problems with these facilities such as toilet blockages, also limited their availability.

Hand washing and drying facilities, along with hand sanitising gel, were available on both wards. Posters providing instructions on effective hand washing were also displayed. Effective hand washing is important to reduce cross infection.

Improvement needed

The health board must ensure that any reoccurring problems with the toilet facilities are addressed.

Nutrition and hydration

We found that patients were provided with a choice of food and drink. Outside of the main mealtimes, snacks and drinks were available throughout the day. Main

meals were prepared off site and delivered in pre-packed containers to the wards. These were then heated by hostess staff, before being served.

We observed meals being served on both wards. Patients appeared to enjoy the meals provided, although some patient's expressed some dissatisfaction due to the repetitive menu options that were on offer for patients that had been at the hospital for longer periods.

Improvement needed

The health board must review the patient menu options to provide a wide range of choices at Cefn Coed hospital.

Medicines management

All clinic rooms were locked to prevent unauthorised access. All medication trolleys were locked and secured to prevent them being removed from the clinic room. However we observed that the medication fridge on Fendrod ward was left unlocked on the first evening. It was noted that the fridge on Fendrod and Clyne was locked at all other times during the inspection.

The temperatures of medication fridges were being monitored and recorded, to check that medication was stored within the appropriate temperature range. However, whilst there was clinic room ambient temperature checks being completed on Fendrod Ward, this was not in place on Clyne Ward. Therefore we are not assured that medication that did not require refrigeration was being stored within the temperature range advised by the manufactures.

There were appropriate arrangements in place on the ward for the storage and use of Controlled Drugs and Drugs Liable to Misuse. Records viewed evidenced that checks were conducted with the appropriate nursing signatures.

Through our review of medication records it appeared that medication is being used proportionately to the needs of individuals, and where appropriate, other alternatives being considered first.

The Medication Administration Records (MAR Charts)[5] reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages. Each patient's Mental Health Act legal status was recorded on the MAR Chart, however copies of consent to treatment certificates were not always accompanying the relevant MAR Chart. Therefore we are not assured that registered nurses are always checking the consent to treatment certificates to assure themselves that medication is legally authorised.

On both wards there was an individual patient medication folder in place to aid the management of medication. However, it was noted that there was no standardised format to the files and therefore there inconsistencies of filing with in each file. The individual folders were also in poor condition, with loose documents, there was a risk that information could be lost from the individual folders.

Improvement needed

The health board must ensure that medication fridges remain locked when not being accessed by staff.

The health board must ensure that ambient room temperature of clinic rooms are recorded and arrangements are in place to adequately manage the temperature of clinic rooms to enable medication to be stored within the temperature range advised by the manufactures.

The health board must ensure that copies of consent to treatment certificates are maintained with the corresponding MAR Chart.

The health board must ensure that registered nurses refer to the consent to treatment certificate when administering medication.

[5] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

Safeguarding children and adults at risk

There were established processes in place to ensure that the hospital safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

The health board monitored the training completion rates with regards to safeguarding children and safeguarding vulnerable adults to ensure staff compliance with mandatory training.

Effective care

Record keeping

We found that records held at the unit were kept securely when not being used.

Within each ward's office there were Patient Status at a Glance (PSAG) Boards, this provided key information regarding each individual patient. Whilst all confidential information was recorded behind the PSAG boards closing sections, whilst open and being reviewed by staff this information could be read through the windows of each nursing office. Staff were conscious of this and made the best efforts to ensure that information was not being read by on looking patients outside the room. The health board should consider if there are any further precautions they can take to maintain the confidentiality of information recorded on the PSAG Boards.

We reviewed the care records of five patients. This included care and treatment plans and statutory detention documentation. Paper records were being used on both wards for directing patient care. Whilst we saw efforts had been made to organise the information using dividers, patient records were difficult to navigate due to information being filed inconsistently.

The majority of paper documentation was being drafted electronically and with the intention to print and include within the paper records, however this had not always been included in paper records. Therefore we were unable to easily identify within each patient's record the most up-to-date risk assessments, care plan and other associated documentation.

Our specific findings around the quality of care records are described in the following sections.

Mental Health Act Monitoring

We reviewed the statutory detention documents of four patients across the two wards inspected. We also spoke with the mental health act team to discuss the monitoring and audit arrangements in place for the hospital.

It was evident that detentions had been applied and renewed within the requirements of the Act and copies of legal detention papers were available to ward staff at the hospital. It was also evident that those patients' detentions were reviewed by the Mental Health Review Tribunal and at Hospital Manager Hearings [6], when applicable or required.

All leave had been authorised by the responsible clinician on Section 17 Leave authorisation forms. However there was no record of patients signing their leave form or a reason stated why this had not occurred.

There was also a lack of evidence that patients had been routinely informed of their rights under the Act and whether the patient had understood these.

The Mental Health Act documentation stored on the wards were disorganised and difficult to navigate. The records did not include all required documentation in a systematic order; therefore we were not assured that all required documentation was available to ward staff.

Improvement needed

The health board must ensure that there is a clear record of patient receiving a copy of their leave form or the reason why this has not occurred.

The health board must ensure that there is a clear record of patient being informed of their rights and the outcome of the discussion, or the reason why this has not occurred.

[6] The organisation (or individuals) responsible for the operation of the Act in a particular hospital. Hospital managers have various functions under the Act, which include the power to discharge a patient.

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

We reviewed the care plans of a total of five patients.

Whilst we found that paper records were disorganised there was evidence of developed multidisciplinary team care planning in place on both wards. Care plan documentation reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed. However there were inconsistencies between the two ward on the documentation and standardised templates used on each ward. Staff we spoke with who raised their concerns regarding the differences in paperwork, however we were informed that this was already being reviewed with the aim of consolidating the paperwork being used.

To support patient care plans, there were a range of patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them.

Individual care plans drew on patients' strengths and focused on recovery, rehabilitation and independence. Patient records evidenced the patient's view on their care plan, however it wasn't clear from reading the documentation whether the patient had been involved in the multidisciplinary team discussion or whether the plan had been discussed with the patient separately.

Improvement needed

The health board must review the format of patient records and paperwork at Cefn Coed hospital.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

We observed a committed staff team who had a good understanding of the needs of the patients at the hospital.

We found that staff were committed to providing patient care to high standards.

The health board had established clear governance arrangements which focused on the improvement of patient care and clinical practice.

Governance, leadership and accountability

There was a clear organisational structure for the hospital, which provided defined lines of management and accountability. These arrangements were in place during the day, with senior management and on-call arrangements in place for the night shift.

We found that there were defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This is achieved through a rolling programme of audit and the establishment of governance structures, which enabled key/nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

The service had established a reducing restrictive practice group, to review and embed practices that enable staff to provide care in line with least restrictive principles.

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

There was dedicated and committed ward multidisciplinary teams and senior health board managers. It was positive that, throughout the inspection, the staff at the hospital were receptive to our views, findings and recommendations.

Staff and resources

Workforce

The staffing levels appeared appropriate to maintain the safety of patients within the hospital at the time of our inspection. Staff reported that they felt able to keep patients safe but are unable to always undertake the therapeutic engagement with patients that they would like to which would aid and speed recovery.

Whilst there were a number of registered nurse vacancies, there was evidence that the health board was attempting to recruit into the vacancies. Where possible the ward utilised its own staff and regular staff from the health board's staff bank to fill these shortfalls.

Training records provided by senior ward staff showed there was close monitoring of staff training to ensure that health board standards for training were met. The information provided showed that most staff were up to date with mandatory training.

Improvement needed

The health board must ensure that wards are sufficiently staffed with appropriate skill mix to support therapeutic patient engagement.

4. What next?

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 when and how the findings identified will be addressed, including timescales
- 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.

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.

5. How we inspect NHS mental health services

Our inspections of NHS mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of NHS mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Meet the Health and Care Standards 2015

We also consider other professional standards and guidance as applicable. These inspections capture a snapshot of the standards of care within NHS mental health services.

Further detail about how HIW inspects mental health and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection	Not applicable	Not applicable	Not applicable

Appendix B – Immediate improvement plan

Service: Cefn Coed Hospital – Tawe Clinic

Ward/unit(s): Clyne & Fendrod

Date of inspection: 14 – 16 March 2022

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.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

Appendix C – Improvement plan

Service: Cefn Coed Hospital – Tawe Clinic

Ward/unit(s): Clyne & Fendrod

Date of inspection: 14 – 16 March 2022

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	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that a range of male specific health promotion is displayed on Fendrod ward.	1.1 Health promotion, protection and improvement	For the ward team to work with external agencies to provide and display male specific health promotion. Health promotion will be a standing agenda item in patient community meetings.	Ward Manager and Lead OT	June 2022 July 2022
The health board must review the provision of physical exercise, therapeutic and social activities that are on offer, both within the hospital and in the community.	1.1 Health promotion, protection and improvement	Lead Nurse and Lead OT and Directorate Manager to review the accommodation available in order to support physical exercise, therapeutic and social activities	Lead Nurse and Lead OT and Directorate Manager	April 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		within the Cefn Coed Hospital Site. Completed. Space to be identified and decorated. Activities identified and donations to be encourage and charitable fund bids to be developed. Ward manager, OT and activity coordinator to review the provision and promotion of physical exercise, therapeutic and social activities and ensuring that these are available within the hospital and community settings. This will look to include a range of different activities. OT and activity coordinator to gather service user perspective in relation to choices and variety.	Lead Nurse and Lead OT and Directorate Manager Ward Manager, OT and activity coordinator.	September 2022 June 2022
The health board must ensure that there is a designated occupational therapy kitchen on Fendrod.	1.1 Health promotion, protection and improvement	Lead Nurse, Lead OT and Directorate Manager to review the accommodation to provide a more appropriate meeting room space to enable the full use of the OT kitchen for the service users. Completed.	Lead Nurse and Lead OT and Directorate Manager	April 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Space identified and full use of OT kitchen reinstated.		September 2022
The health board must ensure the ease of garden access for patients on Fendrod.	1.1 Health promotion, protection and improvement	Review of access to the garden to be conducted by MDT and included on MDT template. Encouraging access through different activities including gardening groups. Lead Nurse and Fendrod MDT to complete risk assessments regarding the increase availability of garden access.	Fendrod MDT Fendrod Activities coordinator Lead Nurse and Fendrod MDT	June 2022 April 2022 July 2022
The health board must ensure that the programme of works to modernise the environment of care at Cefn Coed Hospital is progressed in a timely manner.	4.1 Dignified Care	Anti-ligature programme of work continues on Tawe Clinic which includes the refurbishment of bathrooms and new furniture in the bedrooms. The Strategic Outline Case (SOC) for the re-provision of adult mental health wards in the HB has been approved by WG. This will lead to the decommissioning of Clyne & Fendrod Wards and	Directorate Manager Senior Management Team	July 2022 Late 2025

Improvement needed	Standard	Service action	Responsible officer	Timescale
		replacement with modern, purpose built facilities.		
The health board must ensure that environmental damages is rectified in a timely manner.	4.1 Dignified Care	Ward manager to conduct thorough inspection of the environment and escalated any damages and improvements required. Directorate Manager to review the process through which environmental work is raised and the effectiveness of this and the escalation process. Complete.	Ward manager, estates teams Directorate Manager	June 2022 May 2022
The health board must ensure that all patient have the facility to obscure their bedroom window from external light and maintain their privacy.	4.1 Dignified Care	Ward managers to review the current facilities in place to ensure they are of a good standard and appropriate. Arrange replacements as required and ensure there is access to a stock should an immediate replacement be required.	Ward managers	June 2022 July 2022
The health board must review the smoking arrangement for patients on Fendrod Ward.	4.1 Dignified Care	Task and Finish group established to explore the options in order to remove the smoking room. An options appraisal will be created and will be informed	Lead Nurse, Ward Manager, Directorate	June 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		through the MDT. Patient engagement will be paramount to feed into this group. Engagement with Smoking Cessation Wales and Help to Quit Wales to continue encouraging both the Welsh Government and Health Board's Smoke free vision.	Manager and operations team	June 2022
The health board must ensure that information is displayed on the role of HIW and how to contact the organisation	4.2 Patient Information	Ward managers and ward clerks to display this information on the patient information boards.	Ward managers and ward clerks	June 2022
The health board must ensure that there are suitable facilities available for patients to meet with visitors in private	6.2 Peoples rights	Lead Nurse, Lead OT and Directorate Manager to review the accommodation to provide a more appropriate private space for patients to meet with visitors. Completed. Scope out the facilities available for children and young people to attend.	Lead Nurse, Lead OT and Directorate Manager Ward manager and ward team	April 2022 August 2022
Delivery of safe and effective care				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that there is clarity around the reasons when and why staff wear personal alarms.	2.1 Managing risk and promoting health and safety	Ward managers to discuss with ward teams the importance of personal alarms in the event of a medical emergency to ensure the team are using the current resource. Operations teams to undergo a review of the use of personal alarms and the systems used and to propose solutions to the senior management team.	Ward managers Operations Team	June 2022 August 2022
The health board must ensure that any reoccurring problems with the toilet facilities are addressed.	2.4 Infection Prevention and Control (IPC) and Decontamination	Fendrod Ward Manager to gain an understanding of the reoccurring problems and address immediately. Estates have undertaken a check of plumbing. Completed.	Ward manager	April 2022
The health board must review the patient menu options to provide a wide range of choices at Cefn Coed hospital.	2.5 Nutrition and Hydration	Lead Nurse and Ward Managers in collaboration with the catering department will discuss the menu options available. Lead Nurses across Mental Health Division to reflect and action upon recent Quality improvement projects in order to	Lead Nurse and Ward Managers Lead Nurses	June 2022 June 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		support a more varied range of menu options.		
The health board must ensure that medication fridges remain locked when not being accessed by staff.	2.6 Medicines Management	Ward managers to ensure reminders are sent to registered nurses, review notices and prompts and carry out spot checks for assurance. Completed.	Ward managers	April 2022
The health board must ensure that ambient room temperature of clinic rooms are recorded and arrangements are in place to adequately manage the temperature of clinic rooms to enable medication to be stored within the temperature range advised by the manufactures.	2.6 Medicines Management	Ward managers to devise process to monitor and manage the temperature in the clinic rooms, this will be carried out using a thermometer and daily checks.	Ward Managers	June 2022
The health board must ensure that copies of consent to treatment certificates are maintained with the corresponding MAR Chart.	2.6 Medicines Management	Ward manager to review the organisation of service users' folders to ensure the copies of consent are clearly marked and referenced in the MAR chart. Ward clerks to order clear-view folders to insert into service users folders to support checks to ensure copies of consent are included. Completed	Ward manager and Ward clerk	April 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that registered nurses refer to the consent to treatment certificate when administering medication.	2.6 Medicines Management	Information regarding this has been well communicated via email and handovers. Complete. Ward managers to ensure via appropriate training that nurses understand the requirement to refer to consent to treatment certificate when administrating medication. Audit systems in place to monitor this going forward. Complete	Ward managers	April 2022 July 2022 April 2022
The health board must ensure that there is a clear record of patient receiving a copy of their leave form or the reason why this has not occurred.	3.5 Record keeping Application of the Mental Health Act	Ward managers to develop process to ensure the ward staff provide a copy of the leave form.	Ward manager	June 2022
The health board must ensure that there is a clear record of patient being informed of their rights and the outcome of the discussion, or the reason why this has not occurred.	3.5 Record keeping Application of the Mental Health Act	Ward managers and clinical leads to develop process of audit for continuing assurance.	Ward manager and ward team	June 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must review the format of patient records and paperwork at Cefn Coed hospital.	3.5 Record keeping Monitoring the Mental Health Measure	Operations team and business improvement manager to engage with the medical records team to review the format of patient records.	Operations team and business improvement manager	September 2022
Quality of management and leadership				
The health board must ensure that wards are sufficiently staffed with appropriate skill mix to support therapeutic patient engagement	7.1 Workforce	Ward managers to complete rosters and identify deficits in a timely manner and follow current process of escalation. Lead Nurse scrutinises the roster. Timely recruitment toward vacancies and review of skill mix to ensure appointment is appropriate which is carried out by the vacancy control process. Workforce meeting held monthly to discuss vacancies. Above actions completed.	Ward managers	April 2022

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

Service representative

Name (print): **Janet Williams**

Job role: **Service Group Director**

Date: **05/05/22**

Learning Disability Service Inspection (Unannounced)

Swansea Bay University Health Board, Learning Disability Service (Ref 21160)

Inspection date: 15 March 2022

Publication date: 17 June 2022

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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Contents

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care
Promote improvement:	Encourage improvement through reporting and sharing of good practice
Influence policy and standards:	Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the learning disability service within Swansea Bay University Health Board on 15 March 2022.

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

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

2. Summary of our inspection

We found that arrangements were in place with the intention to meet the Health and Care Standards relevant to the learning disability service.

However, we did identify improvement was needed around aspects of the service provision and asked the health board to take action to address this.

This inspection also resulted in us asking the health board to take immediate action in relation to the environment, risk assessment and checking of emergency equipment to promote the safety and wellbeing of patients.

This is what we found the service did well:

- We found good compliance with the health board's staff training programme
- All staff had received an appraisal of their work within the last year.

This is what we recommend the service could improve:

- Aspects of the environment and the arrangements to ensure estates related issues are identified and addressed in a timely manner
- The amount of information displayed for patients
- The recording of checks of emergency equipment
- Specific reviews of incidents where data indicates an increase in the use of restrictive practice, specifically the use of seclusion
- Completion of admission and initial risk assessment documentation.

3. What we found

Background of the service

At the time of our inspection, the learning disability service could provide care for up to three patients with learning disabilities. The unit forms part of the learning disability services provided within the geographical area known as Swansea Bay University Health Board.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We saw that staff treated patients with respect and made efforts to promote their privacy and dignity. However, aspects of the environment, which may impact negatively on patient wellbeing, needed to be addressed.

Patients' care records demonstrated that patients had an assessment of their care and treatment needs. We did identify that action was required to promote the full completion of assessment documentation by staff.

We were told that patients were provided with information about their care and treatment. However, further efforts should be made to display relevant information within the unit.

Staying healthy

The unit manager described suitable arrangements for assessing patients' healthcare needs prior to their admission to the unit. We also saw evidence of assessment in the sample of care records we considered as part of the inspection.

The manager explained patients would be encouraged to make healthy lifestyle choices when appropriate to do so. The manager also confirmed that patients would be referred to other members of the multi-disciplinary team for their specialist input as necessary.

Dignified care

We saw that staff treated patients with respect and kindness, and encouraged patients to engage in positive activities according to their interests. However, we identified improvements were needed to the internal and external environment to promote dignified care for patients.

Patients had their own bedroom, own allocated bathroom and private space. However, the window within one of the three bedrooms being used for accommodation could not be opened to allow for ventilation, and another did not have suitable window blinds for privacy.

One of the bathrooms was in a poor state of repair, with an uncovered drainage hole in the floor and tap covers missing. The garden area contained items of broken furniture that needed to be removed and disposed of. As well as looking unsightly, these were potential hazards to patient and staff safety and could impact negatively of patients' wellbeing.

Improvement needed

The health board is required to provide HIW with details of the action taken to ensure the unit environment is maintained to a satisfactory standard.

Patient information / Communicating effectively

We identified that efforts were made by staff to provide patients with information about their care and treatment in a way they can understand.

The unit manager showed us a booklet providing information for patients, in an easy read format, about their stay at the unit. We saw that this contained relevant and useful information, which was clearly presented.

Staff explained that patients are asked about their language preferences when they arrive at the unit. Staff confirmed that leaflets and other written information for patients can be obtained in different language according to their needs and preferences. Staff also confirmed that Welsh speaking staff worked at the unit, which allows patients to communicate in Welsh should they choose to do so.

Staff also explained that professionals involved in patients' care would spend time with them to explain their care and treatment in ways that they can understand.

While efforts were made to provide patients with sufficient information, there was no information displayed within the unit for patients to read e.g. health promotion material, about advocacy available, COVID-19 information and how to provide feedback or complain. The health board should review this and make suitable arrangements to display relevant information that patients may find helpful.

Improvement needed

The health board is required to provide HIW with details of the action taken to display relevant information within the unit that patients may find helpful e.g. health promotion material, about advocacy available, COVID-19 information and how to provide feedback or complain.

Individual care

Planning care to promote independence

We reviewed the care records for the two patients being accommodated at the unit at the time of our inspection.

For each patient there was evidence of an assessment of their care needs on admission to the unit to identify their support needs. Relevant risk assessments had also been completed on admission. However, we did identify that these had not been fully completed for one patient.

Both patients were entitled to have a Care and Treatment Plan (CTP) under the Mental Health (Wales) Measure 2010. An up to date CTP was available for one of the patients but was not available for the other. The manager confirmed that this had already been requested and the manager was actively following this up.

Within the care records for both patients, there was evidence of patients being helped to understand their care and of the input by the multi-disciplinary team as appropriate.

People's rights

At the time of our inspection, we were informed that both patients accommodated at the unit were subject to Deprivation of Liberty Safeguards (DoLS).

We saw that urgent DoLS authorisations had been applied for by staff at the unit in respect of both patients. Standard authorisations had also been applied for at the same time in accordance with DoLS. However, the urgent authorisation for one patient had expired and confirmation of a standard authorisation had not been received. The manager confirmed this matter had been escalated in accordance with the health board's incident reporting arrangements.

The manager confirmed that patients can access advocacy and we saw information for patients was available in easy read format. However, this was not displayed within the unit.

Improvement needed

The health board is required to provide HIW with details of the action taken to promote the timely assessments of patients in accordance with the Deprivation of Liberty Safeguards (DoLS).

Listening and learning from feedback

Senior staff described suitable arrangements for seeking feedback from patients and their families about their experience of using the service. These included a designated patient experience and feedback team that used communication tools to help patients with learning disabilities share their feedback.

We saw that the health board had a current written policy and associated procedures for responding to concerns and complaints about the service. These were in keeping with 'Putting Things Right'.

Senior staff confirmed that feedback and complaints data was reported to the health board as part of the quality and safety monitoring arrangements. We also saw an example of a report.

While suitable arrangements were described and demonstrated, there was no information displayed within the unit to make patients or their representatives aware of how to provide feedback or complain.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

We identified that the arrangements for managing risk and promoting health and safety in relation to the environment required improvement.

Suitable arrangements were in place for infection prevention and control with a particular focus on preventing the spread of COVID-19.

While arrangements were in place for the safe management of medicines, we did identify improvement was needed around the recording of checks of emergency equipment.

Patients had comprehensive Positive Behaviour Plans and written policies and procedures were in place in relation to restrictive practice. One of the policies required review and we were not assured that reviews of incidents are completed in accordance with the arrangements described.

Safe care

Managing risk and promoting health and safety

The arrangements for managing risk and promoting health and safety required improvement in relation to the environment. While we saw the unit was secure against unauthorised access we identified a number of environmental hazards that posed a potential risk to the safety of staff and patients.

We saw the wooden fence immediately outside the unit had fallen over and was on the ground. Parts of the fence were broken and broken pieces of plant pots were also seen near the edge of the fence. In addition we saw broken furniture and other items in the patio area. These were not cordoned off to prevent access by patients or staff.

Apart from looking unsightly, these present hazards and pose a potential risk to patient and staff safety. Senior staff confirmed that arrangements needed to be

made to repair the fence and remove the other items, however, there was no date scheduled for this work to be completed.

Our concerns regarding these matters were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate areas for improvements we identified are provided in Appendix B.

Infection prevention and control

Senior staff confirmed that an up to date written infection prevention and control policy was in place and available to staff via the health board's intranet. Senior staff also described suitable systems for infection prevention and control.

At the time of our inspection a particular focus of these systems was to prevent the spread of COVID-19 and additional measures were in place in this regard.

Information was clearly displayed to guide staff on the correct use of personal protective equipment (PPE) depending on the tasks being performed. We saw that PPE was readily available and being used by staff.

Conversations with staff indicated that they were aware of their responsibilities around infection prevention and control.

No information was displayed specifically for patients on COVID-19 or infection prevention and control measures. However, staff confirmed that patients were provided with an easy read booklet and the information it contained was reinforced by staff verbally. Staff also described that patients are encouraged and supervised to wash their hands regularly as part of the infection prevention and control arrangements.

The environment allowed for patients to have their own bedroom, bathroom, lounge and dining space to help reduce the spread of COVID-19.

Nutrition and hydration

Staff described that patients had a choice of food and drink and confirmed that patients' specific dietary requirements were accommodated. At the time of our inspection we were told that one patient required a modified diet and saw that this was provided. Staff were available to offer support to patients to eat their meals according to their assessed needs.

Due to the arrangements in place to reduce the spread of COVID-19, patients had to eat their meals in their designated areas, away from other patients. One

of these areas had a coffee table, rather than a suitable dining table and the other had an outside picnic bench due to the previous table being broken by the patient. We were told that this was the only option available. Arrangements should be made to provide tables that are more suited to being used as dining tables.

Improvement needed

The health board is required to provide HIW with details of the action taken to provide suitable dining furniture for patients to use while accommodated at the unit.

Medicines management

A current written medicines policy was available. This set out the arrangements to promote the safe handling of medicines used at the learning disability service.

We saw that medicines were stored securely and in accordance with the manufacturers' instructions with appropriate records maintained.

We inspected a sample of three patients' medication administration records and found these had been completed fully. However, two of the records did not have details of whether the patients had any known allergies. In accordance with the policy, where there are no known allergies, this should be recorded in the allergy box on the chart.

We inspected the emergency kit and could not find evidence of recent checks being made of the emergency drugs and equipment. We were informed that there was a possibility that checklists used to record checks of the drugs and equipment may have been filed. However, these were not provided when requested on the day of the inspection. Therefore, it was not possible to establish when the emergency drugs or equipment were last checked and whether the emergency kit was complete and safe to use in the event of a patient emergency. This presents a potential risk to patient safety should the required emergency items not be available or safe to use.

Our concerns regarding this matter were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

Improvement needed

The health board is required to provide HIW with details of the action taken to promote adherence to the medication policy in relation to staff recording the allergy status of patients.

Safeguarding children and adults at risk

Senior staff confirmed that a written policy and procedures were in place for responding to safeguarding concerns. Senior staff also described suitable arrangements for reporting and referring safeguarding concerns.

Information provided by senior staff confirmed that all staff working at the learning disability service were up to date with safeguarding training.

Effective care

Safe and clinically effective care

We considered the arrangements in place to meet patients' needs in respect of their behaviour that may challenge.

We reviewed the care records for the two patients being accommodated at the unit at the time of our inspection. Both patients had written Positive Behaviour Support Plans, which set out proactive and reactive strategies that could be used by staff to manage the patients' behaviour. Staff described that a reactive strategy used for one patient was for staff to withdraw and lock the door to bathroom, while continuously observing the patient. While the plan was very detailed, it did not make reference to locking the bathroom door or where staff should record their observations.

The unit manager confirmed that staff would complete a behavioural management tool to help identify and understand reasons for behaviour that may challenge. The unit manager also confirmed advice was available from health board's Specialist Behaviour Team in this regard.

Incidents of behaviours that may challenge and the use of restrictive practice were recorded and reported by staff via the health board's DATIX incident reporting system.

We were provided with summary of incidents reported over the previous three months. We identified that staff used the least restrictive de-escalation methods with physical intervention only used where absolutely necessary. However, the

data indicated that there had been an increase in the use of seclusion during February and March and this did not appear to have triggered a specific review as described by the arrangements for monitoring and overseeing incidents of restrictive practice.

Written policies were in place for the use of restrictive practice. However, the policy Management and Aggression was dated for review in August 2017.

Improvement needed

- The health board is required to provide HIW with details of the action taken to ensure patients' Positive Behaviour Support Plans fully reflect the actions to be taken by staff and where to record observations.
- The health board is required to provide HIW with details of the action taken to ensure reviews of the use of seclusion are completed in accordance with the arrangements for monitoring and overseeing incidents of restrictive practice.
- The health board is required to provide HIW with details of the action taken to review the policy Management and Aggression.

Record keeping

We found that care records relating to patient care were being maintained and being stored appropriately.

The records demonstrated involvement by the multi-disciplinary team and how decisions relating to patient care had been made. However, we did identify some gaps within the admission and initial risk assessment documentation, where required information had not been recorded.

Improvement needed

The health board is required to provide HIW with details of the action taken to promote the full completion of admission and initial risk assessment documentation.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

A management structure was in place and clear processes for reporting and accountability were described and demonstrated.

We identified that the health board needs to take more proactive action in addressing estates related issues.

Our observations indicated that staffing numbers and skill mix were appropriate to meet the assessed needs of the patients. However, comments made by staff confirmed this was not always the case. We have asked the health board to take action to address the comments received by staff during our inspection.

We identified good compliance with the health board's mandatory training programme and all staff at the unit had received an appraisal of their work within the last year.

Governance, leadership and accountability

Senior staff described the management structure and the arrangements for monitoring the quality, safety and performance of the learning disability unit and the service as a whole. Clear processes for reporting and accountability were described and demonstrated.

Senior staff provided details of the governance structure for the health board's Learning Disability Delivery Unit. This clearly demonstrated the various committees, sub committees and groups making up the governance structure.

We were provided with an example of a recent Performance Dashboard presented to the health board as part of the quality and safety and performance monitoring arrangements. This included a range of pertinent data as to the operation of the health board's learning disability service. While arrangements

were described, our findings in respect of the environmental issues identified suggests that more proactive action could be taken by the health board in addressing estates related issues.

Senior staff described that in response to COVID-19, changes had been made to promote patients' safety and wellbeing when needing to access the health board's learning disability services. We were told the health board was considering plans for the modernisation of the learning disability services as a whole. At the time of our inspection, the future purpose of the learning disability unit was undecided. Until this is decided, this is likely to cause challenges to the health board with regards to future planning for staffing and creating an environment that is suitable for the intended patient group.

At the time of our inspection, an experienced unit manager, who is a registered nurse, was in charge of the unit. The manager demonstrated a clear understanding of the needs of the patients accommodated at the unit.

Improvement needed

The health board is required to provide HIW with details of the action taken to ensure where estates related issues are identified, timely remedial action is taken as necessary.

Staff and resources

Workforce

At the time of our inspection we were told that the staffing numbers and skill mix were appropriate to meet the assessed needs of the patients accommodated at the unit. Our observations also confirmed this.

However, we were also told that there have been times when the staffing numbers have been below that required to allow staff to effectively support and observe patients. Discussions with staff indicated that they felt overworked and demoralised.

Senior staff confirmed there were vacancies at the unit and recruitment was ongoing. Information provided to us showed these were equivalent to 4.22 full time staff to include both registered nurses and healthcare assistants.

Information provided to us showed that the unit's average compliance with the health board's mandatory training was 94 percent. This exceeded the health

board’s target of 90 percent with all staff having completed training in the majority of topics set.

We also found that all staff at the unit had a personal development appraisal review (PADR) within the last year.

Improvement needed

The health board is required to provide HIW with details of the action taken to address the comments received by staff during our inspection.

4. What next?

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 when and how the findings identified will be addressed, including timescales
- 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.

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.

5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our 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
Our immediate concerns were dealt with via HIW's immediate assurance process.	-	-	-

Appendix B – Immediate improvement plan

Hospital: Learning Disability Service (Ref 21160)

Date of inspection: 15 March 2022

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.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
HIW requires details of the action taken by the health board to make safe the garden and patio areas.	Standard 2.1	The majority of the fencing has now been put back up, but this does need to be replaced. In the interim, service users are supervised at all times when accessing the garden to ensure their safety. There is ongoing communication with estates about the timescale for the replacement of the remaining fence. The issues identified by HIW for action will not be added retrospectively to the walk-through document, but the completion of action to address them will be monitored via this action plan.	Ward Manager / HB Estates Dept.	Part complete: to be completed by 30th April 2022

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
	Standard 2.4	Patients have not accessed the outdoor area without staff support to ensure the items / broken fence were not a risk to their safety. The broken furniture / clinical waste bin and other items have now been removed.	Ward Manager / HB Estates Dept.	Complete
HIW requires details of the action taken by the health board to make safe the bathroom located in the annex.	Standard 2.1	Drain has now been replaced.	Ward Manager / HB Estates Dept.	Complete
HIW requires details of the action taken by the health board to review the general risk assessment for the unit.	Standard 2.1	Environment assessment and anti-ligature assessment repeated on 21.3.2022. The general Health and Safety Walk-through Inspection Findings to be repeated by the Directorate Manager; action plan to be reviewed.	Directorate Manager, Learning Disabilities	30th April 2022
HIW requires details of the action taken by the	Standard	Weekly checks are undertaken by	Ward Manager	Completed 22.3.22

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
health board to show that the emergency equipment and drugs are subject to regular checks to confirm that these are available and safe to use.	2.1	ward staff. Previous sheet had been filed on 8.3.22. Shared with HIW following visit. The disposable gloves are kept at the PPE stations and the unit has a significant stock of every size, therefore no further stock needed at this time. Replacements for the eye pads have been ordered as the date had expired on the previous items. The AED (for which a check is not marked on the example checklist embedded) has since been checked. It will be ensured that AED checks are recorded on future weekly check documents.		14.04.22 AED check complete

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): Stephen Jones

Job role: Nurse Director, Mental Health & Learning Disabilities Service Group

Date: 22.3.2022 / 14.04.2022

Appendix C – Improvement plan

Hospital: Learning Disability Service (Ref 21160)

Date of inspection: 15 March 2022

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	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board is required to provide HIW with details of the action taken to ensure the unit environment is maintained to a satisfactory standard.	4.1 Dignified Care	Unit environment is the responsibility of Unit manager and is under constant review. Process in place for all maintenance requests to be reported to estates and follow up for outstanding work to the estates manager. Record of requests now kept on the unit and follow up request and emails sent to ensure timely follow up. Escalation of work not completed in a timely fashion is escalated by ward manager and directorate manager. This	Unit manager, Directorate Manager & Estates department	In place

Improvement needed	Standard	Service action	Responsible officer	Timescale
		is reviewed monthly. The Service Group Quality Assurance Framework includes unannounced quality checks that includes environmental issues. A formal Environmental Audit takes place annually with Health and Safety which is reported to Directorate General Manager. Immediate assurances were provided in respect of the bathroom, broken items and fence Identified by review team and this work has been completed. Of the 5 bedrooms on the unit, there are 2 bedrooms that are currently decommissioned [TEXT REDACTED FOR THE PURPOSE OF PRIVACY]. One of these decommissioned bedrooms is being used for storage and the curtains for the room are currently not in place due to COVID. The three bedrooms being used for patient's bedrooms have shutters,		

Improvement needed	Standard	Service action	Responsible officer	Timescale
		curtains currently not being used due to COVID IPC management One bedroom window has been locked due to patient's regular pattern of behaviour putting faeces through the window into a shared patient area. We are exploring alternative clinical options to provide more scope for providing increased ventilation and choice. In the meantime opportunities are taken daily for improving airflow when not using the room. The other bedroom window that could not be opened has been reported to estates and work is being followed up in accordance with process outlined above. There is no confirmed date for replacement as of yet but this is for follow up in the next monthly estate meeting in June.		July 2022 June 2022
The health board is required to provide HIW with	4.2 Patient Information	Information is provided to individuals on admission, this includes COVID	Unit Manager	17th June

Improvement needed	Standard	Service action	Responsible officer	Timescale
details of the action taken to display relevant information within the unit that patients may find helpful e.g. health promotion material, about advocacy available, COVID-19 information and how to provide feedback or complain.		information. The unit will provide accessible Information in the foyer identifying how to provide feedback or make a complaint and general health promotion information for patients and visitors. Information on the IMHA service is available for patients and is provided on an individual basis, however they will have already received this information if they have an advocate already allocated.		
The health board is required to provide HIW with details of the action taken to promote the timely assessments of patients in accordance with the Deprivation of Liberty Safeguards (DoLS).	6.2 Peoples rights	A record of DoLS status and date of authorisation is maintained in the patient's record. A renewal form is sent 6 weeks before the end date, and a reminder is sent to the DoLS team at 3 weeks to avoid any authorisations lapsing. If it transpires that the DoLS authorisation gets to the stage that it does lapse this is recorded as a Datix incident and We have ensured that this	Divisional Manager Unit Manager	Completed Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		is then reviewed and escalated. This was appropriately escalated to the DoLS Lead. The Health Board is aware of a backlog of DoLS applications. This is a National Issue and Welsh Government have provided funding for Health Boards to address this. SBUHB has employed agency Best Interest Assessors and the outstanding assessments at [TEXT REDACTED FOR THE PURPOSE OF PRIVACY] have now been processed and DoLS are in place.	Corporate Head of Nursing LPS	Completed
Delivery of safe and effective care				
The health board is required to provide HIW with details of the action taken to provide suitable dining furniture for patients to use while accommodated at the unit.	2.5 Nutrition and Hydration	The temporary dining table has been removed and table and chairs now provided.	Unit Manager	Completed
The health board is required to provide HIW with details of the action taken to promote adherence to the medication policy in relation to staff recording the allergy status of patients.	2.6 Medicines Management	Allergy status on the medication chart has been completed for all inpatients Medication audits will capture this	Unit Manager	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		information going forward.		
The health board is required to provide HIW with details if the action taken to ensure patients' Positive Behaviour Support Plans fully reflect the actions to be taken by staff and where to record observations.	3.1 Safe and Clinically Effective care	New observation policy has now been implemented, observation care plans are in place and the observation policy sets out the elements of recording patients observations. PBS management strategies are included in the PBS plans.	Unit Manager	Completed
The health board is required to provide HIW with details of the action taken to ensure reviews of the use of seclusion are completed in accordance with the arrangements for monitoring and overseeing incidents of restrictive practice.	3.1 Safe and Clinically Effective care	Datix incidents are completed for all use of seclusion, the seclusion paperwork is attached to Datix. All incidents of seclusion are reviewed in weekly ward rounds and if required any new management strategies are included in an updated PBS plan. Within the MH and LD Service Group Health and Safety group Datix information is provided on a bi monthly basis. On a monthly basis the LD performance scorecard collates and reviews incidents reported on Datix	Unit Manager, Lead Nurse and Directorate Manager	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken to review the policy Management and Aggression.	3.1 Safe and Clinically Effective care	The unit environment has been cleansed of all hard copy policies with staff reminded to access operational policies from the intranet where all most up to date policies are held. Unit staff have also been asked to ensure that they are aware of the current policy content to avoid any confusion with the erroneous copy provided to HIW. The extant Management of Violence and Aggression Policy is attached below. It is due for review in October of this year.	Head of Health & Safety	Completed
The health board is required to provide HIW with details of the action taken to promote the full completion of admission and initial risk assessment documentation.	3.5 Record keeping	All admission and initial risk assessment documentation is completed, and we incorporate the patient's individualised care plans, e.g. PBS plans as part of this initial assessment All staff have been reminded of ensuring they incorporate and refer to the patient's PBS and care plans in their	Unit Manager	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		initial risk assessment. Regular audits of record keeping are being undertaken as part of the Service Group's implementation of the Quality Assurance Framework. These bi-monthly audits are reviewed within the Directorate and reported through Divisional Governance structure to provide assurance of meeting standards.	Lead Nurse	Bi-monthly audits are in place.
Quality of management and leadership				
The health board is required to provide HIW with details of the action taken to ensure where estates related issues are identified, timely remedial action is taken as necessary.	Governance, Leadership and Accountability	We continue to liaise with estates and Senior Managers for escalation and completion of estates issues. Record of requests kept on the unit and follow up request and emails sent to ensure timely follow up. Escalation of work not completed in a timely fashion is escalated by ward manager and directorate manager Monthly meetings with estates now	Unit Manager & Estates	22nd June

Improvement needed	Standard	Service action	Responsible officer	Timescale
		being established to review works required		
The health board is required to provide HIW with details of the action taken to address the comments received by staff during our inspection.	7.1 Workforce	There is a schedule in place for monthly team meeting with ward manager and staff team, regular supervision with individual staff. This provides a forum for the discussion and sharing of issues facing the unit and Division and developing solutions. Senior nurse lead and Directorate manager liaise regularly with the unit and staff team, and meet with individual staff members as and when requested. Staff wellbeing and experience is reported within the Divisions governance structure so management are aware of and can act on developing issues. The Divisional Management team hold regular Q&A sessions for all staff across the Division to help listen to staff. There are national challenges in the training and recruitment of Registered	Unit Manager, Lead Nurse and Directorate Manager	Process in place & Newly qualified staff recruited via streamlining Sept 2022.

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Learning Disability Nurses. The Service group has Monthly Nurse Workforce meetings where issues of recruitment, retention use of flexible workforce and the patient experience are covered. The Learning Disabilities Division has a workforce plan that addresses current workforce pressures using resources across the three Health Board areas to deliver safe care. The recruitment process for newly qualified nursing staff is via the streamlining process, September 2022 is the expected start dates for staff via the streamlining process.		

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): Stephen Jones

Job role: Service Group Nurse Director

Date: 01.06.22

Mental Health & Learning Disabilities Service Group

Quality & Safety Committee Exception/Update Report

Title of Report: Service user/Carer Feedback and Involvement Team Update

Date of report: 25th April 2022 **Reporting Period:** Annual Report 2021-2022

Report prepared by: Service User/Carer Feedback and Involvement Team

Report approved and presented by: Marie Williams, Head of Nursing Quality Governance and Improvement

TOP 3 Priorities/Risks & Actions/Mitigation (from the report below)			
Key Area to note		**Brief Description**	**Action/Mitigation**
1.	**Numbers of referrals**	During the reporting period we have had a steady influx of referrals. Busiest month November 2021 (67) Quietest months May 2021 and September 2021 both with 13	The team will continue to make further engagement with the identified low flyers and help support them in collecting feedback for their areas/service.
2.	**Areas of learning and improvement**	During this period the team received no ratings of 'Poor' or 'Never'.	This is potentially due to the current way in which service users are chosen to participate in the feedback. A new pilot is underway to capture feedback following assessments with the CRHTT.
3.	**Engagements with the team**	There are a few areas of the service group that are yet to engage. Highest areas of engagement are regarding Admission/discharge from inpatient setting (60) Lowest areas are Outpatients clinic (1) Areas of non- engagement CRHTT and Forensic	The team are continuing to adapt/utilise their bespoke, semi structured interview to enable more teams/areas to engage fully. We have adapted to using Teams/ Face-time as well as telephone conversations and developing bespoke paper templates for areas where communication with telephones is difficult or prohibited

Overview of 2021-2022	**Narrative of findings**	**Survey Analysis**
	From April 1st 2021 to March 31st 2022 the team received 200 referrals that resulted in completed telephone interviews. Of these 200 referrals, 69 were family members, 24 were carers and 107 were service users.	PDF Service Wide report.pdf

	60 were relating to admission/discharge from inpatient setting. The ages ranged from 16-75+ <u>Summary Per Question:</u> 93% Found the area helpful, 96% Found everyone friendly and caring, 95% Found staff always listened, 92% Said that they always had choices. <u>Over All experience:</u> Of the 200 completed interviews 93% said that their overall experience was 'Very Good', 3.5% said that their overall experience was 'Helped with some things', 1.5% said that their overall experience was 'Not much help, 2% said that their overall experience 'Did not help'.	
Overview of Mental Health Division report	**Narrative Of Findings**	**Survey Analysis**
	During the reporting period there were 159 completed interviews relating to the mental health division. Of these 159 completed interviews, 147 said their overall experience was 'Very Good' or 'Good'.	Mental Health .pdf
Overview of Learning Disabilities Division Report	**Narrative Of Findings**	**Survey Analysis**
	During the reporting period there were 42 completed interviews relating to the learning disabilities division. Of these 42 completed interviews, 41 said their overall experience was 'Very Good' or 'Good'.	Learning Disabilities.pdf
Overview of Forensic Division Report	**Narrative Of Findings**	**Survey Analysis**
	During this reporting period we received 0 referrals from the Forensics division.	Forensics.pdf
Overview of Friends and Family	**Narrative of Findings**	**Survey Analysis**
	During this reporting period there was 60 completed surveys online. Of these, 48 said that their overall experience was 'Very Good' or 'Good'.	Friends and Family Test.pdf

Learning Opportunities and Points To Note	The Challenges of engaging with some services have been difficult but we have endeavoured to continually adapt our approach and to develop new innovative ways of moving forward. Whilst some areas have been a little reticent in engaging we have started to arrange meetings with Team Managers via Microsoft Teams followed up by Face-to-Face meetings with their teams over a hand over period so we can meet both shifts and explain our Feedback Service and clarify our aims.

Next Steps	We are exploring a new reporting structure from next month onwards. The aim is to produce reports that form the style of an info graph so will be more visual, with the addition of the usual style that includes the narrative We continue to engage with ward managers and teams and have started going back to the first areas of engagement. We pick up on Staff Changes and movement and re-introduce ourselves at any opportunity. We will be looking into developing lunch and learn sessions to advertise our team in an effort to learn from any negativity and put things right hopeful that with direction Service wide Improvements and the avoidance of Complaints

Tier 1 Target Health Care Associate Infection Reduction Improvement Plan, 2022/23

Service Group: Mental Health & Learning disabilities

Date: 24.04.2022

Outcome Objective

Welsh Government Targets - To reduce Health Care Associate Infections by 10-15%

Green	On target for completion by deadline date or completed.
Amber	Delay or risk of delay but some progress is being made. Escalation may be required to Directorate/Locality, Site and/or Executive Lead.
Red	Progress not being made, or very significant delay in progress. Escalation to Executive Lead required.

	OBJECTIVE	ACTION	BY WHOM	Q1	Q2	Q3	Q4	PROGRESS; ASSOCIATED RISKS	STATUS (RAG)
1									
	1 A Delivery Group IP&C structure and management system for Infection reductions will be in place	The service group will identify a clinical lead for IPC and HCAI across sites to align with expectations from corporate structures.	MH/LD Unit Nurse Director	IPC and HCAI Lead will be identified. MHLD SG to review interface between IPC and physical health group to inform reporting assurance pathways.	Ongoing monthly monitoring through Divisional performance scorecards, HCMS, DATIX, Quality assurance reporting structures			MHLD SG have confirmed new governance (March 2022) IPC Lead identified – Paula Hopes HoN. HCAI Lead – Clare Taylor, Head of Nursing for Forensic Services. Both IPC & HCAI leads for MH/LD are linked	

								into HB corporate structures MHLD SG monthly IPC meetings scheduled for 2022. To clarify if IPC and HCAI's will be managed in the same Service Group meetings due to volume of crossover.	
		The Service Group will identify, assess and manage risks in relation to HCAIs, antimicrobial stewardship, decontamination and immunisation through the governance structure.	Unit Nurse Director	Establish a multi professional IPC group as part of MHLD SG Governance structure. This will be led by identified IPC Lead Nurse. Communicate expectations to all clinical staff in their role in the Tier 1 HACI through sharing of action plan.	Ongoing monthly monitoring through Divisional performance scorecards, HCMS, DATIX, Quality assurance reporting structures.			Achieving via IPC lead and service group IPC approach.	
		Scope All Wales IPC tier 1 policies to inform localised Service Group IPC policies where this is appropriate.	Quality Governance HoN, MHLD SG Policy Group, MHLD SG IPC Group,	Undertake scoping of All Wales IPC Policies to inform localised need.	Identify leads for localised policy developmen t taking a multi	Communicat e and disseminate policies across the MHLD SG promoting	Through quality assurance framework and MHLD SG Governance	Scoping has commenced through IPC Governance group	

			Heads of Departments		professional approach	IPC as everyone's business.	structures, Monitor application of IPC policies for assurance purposes		
2	**Objective**	**ACTION**	**BY WHOM**	**Q1**	**Q2**	**Q3**	**Q4**	**PROGRESS; ASSOCIATED RISKS**	**STATUS (RAG)**
	2 Health Care staff will receive regular training in practical infection prevention and control techniques, including staff actions to prevent and manage patients with HCAI	To maintain a minimum 90% compliance with mandatory training.	Heads of Department		Ongoing monthly monitoring through Divisional performance scorecards, HCMS, DATIX, Quality assurance processes			Service Group have achieved over 90% each month from April 2021-March 2022. Monthly Lead Nurse Quality Assurance audits in place. Areas of concern or hotspot areas will undergo specific focus in collaboration with IPC Colleagues.	
		85% Aseptic Non Touch Technique (ANTT) compliance for clinical staff. All trained clinical staff will be assessed as competent in ANNT.	H0Ns, Learning and Development Ward/Team Manager	Confirm current compliance for baseline to inform roll out of training programme Identify staff to attend training the trainer programme	Train the trainers will complete ANNT training programme Develop and begin roll out of ANNT training programme	Ongoing monthly monitoring through Divisional performance scorecards, Divisional Quality assurance processes Quality Governance Structures		Staff names from MH & LD provided to Joanne Walters IPC in April 2022 to organised ANTT train the trainer sessions. ANNT train the trainer nominations ANTT train the Trainer LD April 202	

		85% compliance for all clinical staff in Level 2 IPC training.	Heads of Department	Disseminate How To Guide from IPC to correct access of IPC on ESR. Establish an accurate baseline for MHLD SG compliance with L2 IPC training on ESR. Include L2 IPC training on divisional scorecards	Ongoing monthly monitoring through Divisional performance scorecards, Divisional Quality assurance processes Quality Governance Structures		Divisional performance scorecard currently reports on Level 1 IPC training not L2 Access to IPC L2 training via link: https://sbushare.cymru.nhs.uk/sites/InfPrevCont/SiteAssets/SitePages/Training%20and%20E-learning/How%20to%20access%20IPC%20Level%202%20training%20via%20ESR.pdf	
		Scope a collaboration with IPC for training in the prevention and management of UTIs specific to the patient population of MHLD SG.	Designated IPC HON lead and IPC Service Group Leads.	Establish the specific clinical needs of patients in MHLD SG to inform skills requirements its clinical (multi professional) workforce	In collaboration with IPC and clinical colleagues, develop a multi-professional bespoke training programme based on the clinical needs analysis under taken in Q1.	Ongoing monthly monitoring through Divisional performance scorecards, Divisional Quality assurance processes Quality Governance Structures	IPC in collaboration with SG leads has commencing scoping to inform bespoke training.	

		Each ward area will have access to local hand hygiene trainers to achieve and sustain 100% hand hygiene training within a rolling training programme. March 2022 Hand Hygiene 92.1%	Lead Nurses/Heads of Nursing	Scope availability of hand hygiene trainers across MHLD SG to identify areas for focus of trainers. Source availability of HB hand hygiene training to meet MHLD SG need	Ongoing monthly monitoring through Divisional performance scorecards, HCMS, Divisional Quality assurance processes Quality Governance Structures			Scoping has commenced through Service Group IPC Governance group	
3	**OObjective**	**ACTION**	**BY WHOM**	**Q1**	**Q2**	**Q3**	**Q4**	**PROGRESS; ASSOCIATED RISKS**	**STATUS (RAG)**
	3 Prompt detection of Tier 1 HCAI cases, appropriate sampling, prompt isolation, diagnosis and treatment of positive cases.	Each case of a Tier 1 HCAI will receive a rapid multi-disciplinary review to inform learning opportunities and inform the ongoing management and prevention of HCAI Medical and Service Group directors to undertake scrutiny of the	Lead Nurses/HoN/ Medical and Nurse Director	To communicate to clinical areas expectations of the rapid MDT review process for all Tier 1 HCAI. Ongoing monitoring through Divisional performance scorecards, HCMS, Divisional Quality assurance processes	Ongoing monthly monitoring through Divisional performance scorecards, HCMS, Divisional Quality assurance processes Quality Governance Structures			Service Group IPC governance group are exploring systems for rapid MDT reviews and reporting of learning through governance structures	

		rapid MDT review for assurance.		Quality Governance Structures			
		Unexplained diarrhoea poster and SIGHT mneumonic poster will displayed in every clinical area.	HONs	Relevant posters to be disseminated a displayed. Review compliance through Quality assurance and quality governance processes for assurance.	Ongoing monthly monitoring through Divisional performance scorecards, HCMS, Divisional Quality assurance processes Quality Governance Structures	Requires baseline audit of compliance across all clinical areas.	
		To collaborate with the IPC team to increase awareness of timely and good quality samples and how to obtain those.	HON's/ IPC MHLD SG Link	To undertake a baseline needs analysis to inform training programme.	In collaboration with IPC to develop a training package based in work in Q1 and plan roll out of same. / Ongoing monthly monitoring through Divisional performance scorecards, HCMS, Divisional Quality assurance processes Quality Governance Structures Ongoing monthly monitoring through	Baseline training need analysis being taken forward through IPC governance group	

Objective	ACTION	BY WHOM	Q1	Q2	Q3	Q4	PROGRESS; ASSOCIATED RISKS	STATUS (RAG)
Environmental cleanliness and mitigation of risk to others	Hand hygiene compliance and adhering to the rules on 'bare below the elbow' audited monthly.	Ward Managers/Lead Nurses.	Ongoing monthly monitoring through Quality assurance processes, senior nurse leadership walkabouts, MHLD SG Quality Governance Structures				Monitored in monthly HCM's reporting. March 2022 Hand Hygiene Audits achieved over 90% in inpatient services.	
	Cleanliness & maintenance of the ward environment and equipment to be monitored by domestic supervisors and ward manager.	Hotel Services and Ward Managers	Establish with Hotel Services a Standardised approach implementing and auditing to be considered in Service Group IPC meeting.	Ongoing monthly monitoring through Quality assurance processes, hotel services cleanliness audit structures, senior nurse leadership and IPC walkabouts, MHLD SG Quality Governance Structures			Action in Q1 commenced through service group IPC governance group	
	To review the use of washing machines in clinical areas that support patient rehabilitation and implement appropriate actions to prevent risk of cross contamination.	IPC and Service Group IPC Leads.	Collate a baseline of clinical areas where patient washing machines are in use and current practice measured against IPC Standards	MHLD SG and IPC to review baseline data collated in Q1 to inform a collaborative risk management plan for clinical areas to prevent risk of decontamination.	Ongoing monthly monitoring through Quality assurance processes senior nurse leadership and IPC walkabouts, MHLD SG Quality Governance Structures		Q1 Baseline information being collated through service group IPC governce group	

5	Objective	ACTION	BY WHOM	Q1	Q2	Q3	Q4	PROGRESS; ASSOCIATED RISKS	STATUS (RAG)
	Preventing Infections	Identify infection indications across the MHLD SG. Improve compliance with 'Start Smart Then Focus' (SSTF) antimicrobial stewardship programme, with timely feedback of results to Service Groups	Pharmacy and Medical staffing	Gather data from antimicrobial audits to identify and better understand the indications of infections within MHLD SG. Continue quarterly audits by Pharmacy, with feedback to Service Group Quality Governce Structures.	Utilise data gathered in Q1 to inform workforce training requirements in relation to Tier 1 HCAI. Work with pharmacy and IPC colleagues to develop training programme as indicated specific to the MHLD SG indication data	Ongoing monthly monitoring through Divisional performance scorecards, HCMS, Divisional Quality assurance processes Quality Governance Structures		Q1 work commenced with pharmacy through Service Group IPC governance group	
		With low numbers of Tier 1 HCAI MHLD SG will explore with IPC how to present data in terms of numbers of days free from infection. All wards will display *days free*	Service Group IPC Leads/MHLD SG IPC Link	Work with IPC link nurse and agree time parameters for a baseline measurement for clinical areas to display *days free* data.	Develop ongoing systems for measurement of compliance of displaying data on days free	Ongoing monthly monitoring through Divisional performance scorecards, HCMS, Divisional Quality assurance processes Quality Governance Structures		To be reported in next IPC HB Quality Priority Meetings	

		performance against HCAI		Engage with clinical staff for them to have ownership of reporting data at ward level	from infection.			
		Promote handwashing before meals and after toilet use for our patients and service users.	IPC and Service Group IPC Leads.	Baseline observations on handwashing to be conducted. Assess environments and consider equipment/resource needs.	Develop health promotion activities on hand washing and supporting materials	Ongoing monthly monitoring through Quality assurance processes senior nurse leadership and IPC walkabouts, MHLD SG Quality Governance Structures	Q1 work being collated through service group IPC governance group	

Mental Health & Learning Disabilities Service Group

Clinical Audit Newsletter – Spring 2022

Welcome to the fifth Mental Health and Learning Disabilities Service Group Clinical Audit Newsletter. As the Clinical Audit Subgroup, we would like to share with you the role and function of the group, its membership and key documents and processes to support you with Clinical Audit.

Clinical Audit Subgroup Overview

Presentation on current set up with the Clinical Audit Sub group and the Clinical Audit activity

Please click on the icon to see the presentation

Microsoft PowerPoint Presentat

Next Clinical Audit event –
11/7/22 at 1.15-17.00 and if you could put in that box.
Any enquiries/to request a link contact-
marie.williams6@wales.nhs.uk
Programme of events to be confirmed

Clinical Audit Proposals and Outcomes

A proposal is required to register your audit. This is submitted on the HB SharePoint site. Once submitted it will be forwarded for approval by the Mental Health and Learning Disabilities Service Group Clinical Audit Subgroup. We meet on a bi-monthly basis. Outcomes are also required to be submitted to the SharePoint site. If you have any queries please email Marie.williams6@wales.nhs.uk and/or Shelley.Horwood@wales.nhs.uk

Please click on the links to access the Share Point site

Registration

Outcomes

Clinical Audit Event – 21st March 2022

The Mental Health and Learning Disabilities Service Group Clinical Audit Subgroup hosted the 9th Clinical Audit event. At the event, recent clinical audit activity findings were presented and discussion around the outcomes, learning and improvements identified to inform the outcomes document.

Prescribing for substance misuse: alcohol detoxification in adult mental health inpatient services

Sue Jones presented POMH-UK Quality Improvement audit.

AWMSG information:

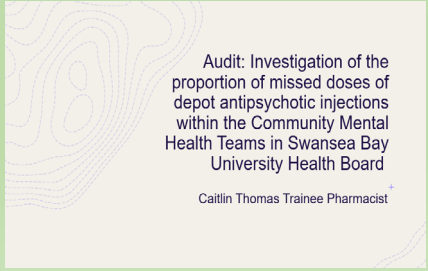
https://awmsg.nhs.wales/files/guidelines-and-pils/educational-pack-material-to-support-appropriate-prescribing-of-hypnotics-and-anxiolytics-across-wales-pdf/

Please click on the icon to see the presentation

Microsoft PowerPoint Presentation

Audit: Investigation of the proportion of missed doses of depot antipsychotic injections within the Community Mental Health Teams in Swansea Bay University Health Board

Presented by Caitlin Thomas.



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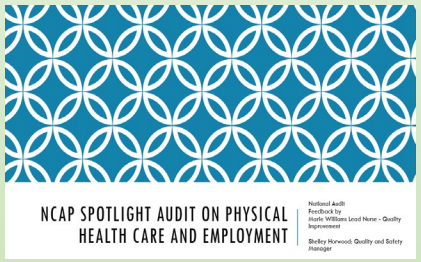
Microsoft PowerPoint Presentation

NCAP Spotlight Audit on Physical Health Care and Employment

Presented by Shelley Horwood



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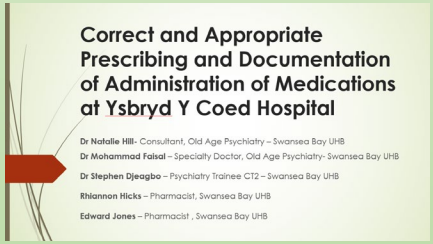
Microsoft PowerPoint Presentat

Correct and Appropriate Prescribing and Documentation of Administration of Medications at Ysbryd Y Coed Hospital.

Presented by Stephen Djeagbo



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Microsoft PowerPoint Presentat

Audit: Assessment of Mobility for Prevention of Falls in Elderly Patients Prescribed Antipsychotics

Presented Rhiannon Lewis.

Please click on the icon to see the presentation

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