Action PLAN: Quality Assurance Improvement Service review

Service: Caswell Assurance Review

Date of inspection: May 2019

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	Service action	Responsible officer	Timescale	Update
Care and Treatment Planning:-				
• Care plans are sometimes generic in nature and not always person centred. Some of the care plans were very similar for different patients on the same ward	Task & Finish group set up to review care plans. Meetings have commenced in Nov 2019.	Dr Alyson Witts	Feedback August 2020	The care plan task and finish group have completed their review and are presenting their recommendations to the HOD meeting. An implementation plan will then be developed.

Improvement needed	Service action	Responsible officer	Timescale	Update
• It was not always evidenced that needs identified within the patients CTP documents were always addressed via the care plans developed within Caswell Clinic.	Task & Finish group set up to review care plans. Meetings have commenced in Nov 2019.	Dr Alyson Witts	Feedback August 2020	The care plan task and finish group have completed their review and are presenting their recommendations to the HOD meeting. An implementation plan will then be developed.
• There does not appear to be a process in place for developing care plans from an MDT perspective.	Task & Finish group set up to review care plans. Meetings have commenced in Nov 2019.	Dr Alyson Witts	Feedback August 2020	The care plan task and finish group have completed their review and are presenting their recommendations to the HOD meeting. An implementation plan will then be developed.
• Care plans are mainly developed by nursing staff on the wards. There is little or no reference to how other professions	Task & Finish group set up to review care plans. Meetings commenced in Nov 2019.	Dr Alyson Witts	Feedback August 2020	The care plan task and finish group have completed

Improvement needed	Service action	Responsible officer	Timescale	Update
within the clinic plan to support the patient through their admission. Other members of the MDT sometimes complete support plans which are kept separately from plans on the wards.				their review and are presenting their recommendations to the HOD meeting. An implementation plan will then be developed.
• QAIS auditors identified that one newly admitted patient only had an enhanced Care Programme Approach (CPA) plan which was relevant to his previous community placement. There was no evidence of a relevant care plan to meet his needs whilst an inpatient. The use of enhanced CPA is no longer considered best practice for Welsh patients.	New admission standard is two weeks to devise care and Treatment plans. The standards has been reiterated to clinical teams. Monthly audits are completed.	Service Manager	January 2020	Completed
Meaningful and Culturally Appropriate Activities:-				
• Some of the patients expressed concern about the level of activity on the ward. This was reinforced when actual individual activity planners were viewed by the QAIS	Group timetable is reviewed every two months with patients in the groups review meeting.	Jan Day	January 2020	Completed

Improvement needed	Service action	Responsible officer	Timescale	Update
auditors , some planners did not evidence planned activity each day with evidence that up to 4½ days of the 7 day week being unpopulated in some case.	Individual activity planners are used to identify the activities patients have individually chosen to engage in. There is a comprehensive timetable of activities available 7 days of the week, most activities included on the timetable take place in the activity rooms off the clinic, which is called “the street”. There are on ward based activities set for some ward e.g. Penarth and Newton. The one to one psychological therapy sessions are not included on planners. The issue of having a set number of days was discussed with QAIS team to clarify the value of a populated planner if patients do not wish to engage. As a service we review the hours of activities each patient has engage in on our weekly activity sheets.			

Improvement needed	Service action	Responsible officer	Timescale	Update
	Example: 25 leave audit 16.06.19 - 22.06.19.x			
• The female patients expressed concern to QAIS auditors that most of the activities were more geared to the male patients.	This has been recognised and plans are in place to address identified issues. A questionnaire is to be distributed on the women's ward asking for preferred activities and suggestions for future groups. A number of women only activities have already been added to the weekly planner including: Evening exercise classes Yoga and relaxation sessions On ward baking evenings Women only gym sessions	Jan Day	February 2020	The occupational Therapist for the women's service attends the ward community meeting, activities are reviewed and planned. There are a number of women only groups e.g. ward based activity group, Gardening sessions, art, craft and pottery groups. Specific times to use the gym, during the day and the evening. Guitar

Improvement needed	Service action	Responsible officer	Timescale	Update
	Further discussions regarding preferred activities will be invited during the weekly community meeting on Newton ward.			tuition and drumming sessions Open relaxation yoga sessions The Skills for Living Group resources have been adapted for a female only group
Nutrition:-				
• Whilst QAIS auditors evidenced nutritional assessments being undertaken, no clear action plans, to meet the needs of the patients, were developed following these assessments.	Any nutritional risk assessment that highlights weight loss or gains, individual plans are completed as and when required for patients. However for the majority of patients the issues of weight gain are discussed on an individual basis	Sharon Rees/Simon Rogers	January 2020	Completed

Improvement needed	Service action	Responsible officer	Timescale	Update
	by the clinical team members and G.P. if required. Operation Energise has commence in January 2020 to promote health and wellbeing issues.			
• Where nutritional needs were identified, there was no clear evidence of referrals being made to other disciplines e.g. Dietetics, Speech and Language Therapy (Salt), dentistry etc.	Input to the service from other areas is limited to a referral basis. Referrals are made as and when required. Reiterate to staff to save a copy of referrals to the patients' health record  Clinical Team Referral to Dietician	Sharon Rees/Simon Rogers	January 2020	Completed
• The development of nutritionally balanced menus was unclear as the QAIS auditors were informed that the menus were developed by housekeeping, admin and dietetics	Each time a new menu is commenced the dietician is involved and tasting sessions arranged for patients and staff to try the new items. Example of taster session:	Jax Segust	January 2020	Completed

Improvement needed	Service action	Responsible officer	Timescale	Update
	 24.04.19 Portion sizes and taster sess  24.04.19 Portion sizes and taster sess Liaising with dietitian allocated to Caswell to formulate traffic light system for the menu.			
Multi-disciplinary team meeting:-				
• The document entitled 'Mental Health Action Plan' in patient notes stated that the document should be reviewed weekly by the Clinical Team Meeting. There was not always evidence of this review being undertaken.	MDT reports are completed on a weekly basis for the clinical team meetings that includes information on the patients presentation as a whole which includes a number of areas e.g. mental health, risks, activities undertaken, engagement, family/carer issues, clinical dynamics, physical health.	None	none	Completed
• Care plans were not always discussed in Clinical Team Meetings attended by QAIS auditors. Discussion was generally about activities undertaken, incidents that have occurred and general physical/mental	MDT reports are completed on a weekly basis for the clinical team meetings that includes information on the patients presentation as a whole which included is e.g. mental health, risks, activities undertaken, engagement, family/carer	None	None	Completed

Improvement needed	Service action	Responsible officer	Timescale	Update
health state. 4 Multi-disciplinary team meeting	issues, clinical dynamics and physical health.			
• There was no clear evidence that the patients care and treatment plans effectiveness and outcomes from care and treatment interventions, risk assessments management plans and discharge plan were reviewed in the Clinical Team Meeting.	Information is feedback at weekly clinical team meetings. If there are actions required these are set as actions and carried each week until completed. The 6 monthly care and treatment plan review meeting take on overview of the patients care and set new care and treatment plans.	None	None	Completed
• It was unclear how outcomes from the Clinical Team Meeting were delivered to the wider nursing group and reflected in the care planning process.	Following clinical team meetings, outcome and actions are documented in each patient's health records and cascaded in the handovers. Patients are given individual feedback if they decline to attend clinical team meetings.	none	None	completed
• It was clear that some care plans had not been reviewed for a significant period of time for example on one ward, QAIS auditors identified a patient going through	The service standards are care plans are reviewed 3 monthly and patients views are incorporated with this and reviewed. If patients refused to sign this is to be document on the care plan. There are	Ward managers	January	completed

Improvement needed	Service action	Responsible officer	Timescale	Update
the discharge process but with care plans dated 2016.	monthly audits completed and actions identified.			
• Evidence didn't reflect that all patients had been involved in the review of their care plan.	The service standards are care plans are reviewed 3 monthly and patients views are incorporated with this and reviewed. If patients refused to sign this is to be document on the care plan. There are monthly audits completed and actions identified.	Ward managers	January 2020	Completed
• The clinical records did not evidence a robust review process. The QAIS auditors found that often the review paperwork contained only a date, brief comment (e.g. care plan remains relevant), signature. There was not always evidence to suggest that the interventions had been successful for the individual or alternative option considered to promote engagement etc.	Weekly Clinical Team Meeting reports are provided to the clinical team reviews (ward rounds), these provide a review of the action plans. Care and Treatment Plan (CTPS) reviews are held 6-12 monthly and at these meeting CTP reports are completed which provide a review of the interventions and update of the care and treatment plans.	Audit group	March 2020	Completed
Pharmacological Interventions and Medicines Management:-				
• Completed LUNSER's [Liverpool University Neuroleptic Side Effect Rating	LUNSER's provide a useful review of side-effect profiles. Generally, however,	Dr Mark Janas/ Dr	January 2020	Completed

Improvement needed	Service action	Responsible officer	Timescale	Update
Scale – rating scale for measuring the side-effect of antipsychotic medication] were not always discussed at the Clinical Team Meeting.	the Clinical Team are already aware of a patient's side-effects as nursing staff usually bring any concerns and changes directly to the attention of the medics, outside of Clinical Team Meetings. If there is anything to note, this is fed back during the medical feedback at Clinical Team Meetings and minutes accordingly. The usefulness of LUNSER's, however, is in its ability to detect trends in terms of changing side-effects. The LUNSAR's provide a rating scale for quantifying these changes in side-effects profiles. As such, LUNSAR scores tend to be reviewed on a monthly basis. Recent discussions with regards to improving nursing feedback proformas for Clinical Team Meetings, have indicated that plotting graphs of LUNSAR scores would be a useful addition in helping the Clinical Team measure trends in side-effect profiles.	Rebecca Lendon		

Improvement needed	Service action	Responsible officer	Timescale	Update
• The log to record the completion of the LUNSER was not always completed	Weekly audits take place of each patients physical health monitoring. Ward Managers and individual Primary nurses are sent copies of the audits to ensure recording is evidenced and not missed. Evidence: Physical Health Pack audit question Physical Health Audit 08.01.2020.do	W/Ms	January 2020	Completed
• A patient, admitted in February, was due to receive depot medication on the 3rd of the May but did not receive this until the 7th of May. There was no reason documented to explain why the medication was delayed.	Medication error policy is adhered to, if a medication error occurs the staff nurse or doctor completed a DATIX incident form and a reflection form.	Health Board	January 2020	Completed
• Self-medication spot checks were not always completed as required. E.G. the patient spot check should have been	All Qualified nurses have been reminded of the 48 hr patient spot check standard	W/M	January 2020	Completed

Improvement needed	Service action	Responsible officer	Timescale	Update
completed every 48hrs but this was recorded as only occurring once or twice weekly.	and the importance of recoding it has been completed.			
• The storage arrangements for patients on self-medication were not secure. For example one patient had an unsecured medication box in his room and the key was left on the box, a bottle of Lactulose was left on the window in the patient's bedroom and the patient's bedroom was unlocked.	All Qualified nurses have been reminded to discuss with their patients on self-medication the exceptions of the self-medication policy.	Kelly O'Sullivan /Julie Ingram	January 2020	Completed
• It was not clearly evidenced that the effectiveness and side effects of medication was always reviewed via the Clinical Team Meeting.	Reviewing service standards to consider the feedback received. Pharmacological Interventions and Medicines Management:- LUNSER's provide a useful review of side-effect profiles. Generally, however, the Clinical Team are already aware of a patient's side-effects as nursing staff usually bring any concerns and changes directly to the attention of the medics, outside of Clinical Team Meetings. If	Dr Mark Janas/ Dr Rebecca Lendon	January 2020	Due to be updated

Improvement needed	Service action	Responsible officer	Timescale	Update
	there is anything to note, this is fed back during the medical feedback at Clinical Team Meetings and minutes accordingly. The usefulness of LUNSER's, however, is in its ability to detect trends in terms of changing side-effects. The LUNSAR's provide a rating scale for quantifying these changes in side-effects profiles. As such, LUNSAR scores tend to be reviewed on a monthly basis. Recent discussions with regards to improving nursing feedback proformas for Clinical Team Meetings, have indicated that plotting graphs of LUNSAR scores would be a useful addition in helping the Clinical Team measure trends in side-effect profiles.			
Physical Health and Health and Well Being Promotion:-				
• The health action plans appeared generic and not person centred. Where specific health needs were identified there were no specific action plans to meet those needs.	Task & Finish group set up to review care plans. Meetings commenced in Nov 2019.	Dr Allyson Witts	August 2020	The care plan task and finish group have completed their review and are presenting their

Improvement needed	Service action	Responsible officer	Timescale	Update
				recommendations to the HOD meeting. An implementation plan will then be developed.
• Physical health interventions were not fully reviewed in the Clinical Team Meeting.	We recognise the importance of the Clinical Team being aware of changes in both the patient's mental and physical health. There do exist occasions where some clinical changes are not communicated fully in the Clinical Team Meetings. This is because the physical health may have been reviewed by a GP, a junior doctor not attached to the team or by medics in another hospital. Relevant details of these reviews are usually communicated to the Clinical Team via the junior doctor attending Clinical Team Meetings, however, when there is no junior doctor present/available, we recognise that elements are not always communicated.	Dr Mark Janas/ Dr Rebecca Lendon		

Improvement needed	Service action	Responsible officer	Timescale	Update
	In recognition of this, a review of the Clinical Team Meeting proformas will focus on recording relevant physical health measures, preferably in chart form so that any changes in trend can be monitored.			
• For those individuals who have been admitted for over a year there was not always evidence of repeated physical examination.	Medical reviews are completed and reported at CTP reviews by the medical reports.	None	N/A	No Changes required
• Whilst the NEWS score was undertaken there was no evidence that actions required for specific scores were undertaken. For example one of the patients had an increased score up to 3, there was no evidence that four hourly observations were undertaken in line with NEWS standards. There was no	Staff review the news scores in line with a patient known history and therefore may not increase the patient's observation as per NEWS standards. This is particularly recognised for patients that are prescribed Clozaril.	None	N/A	No Changes required

Improvement needed	Service action	Responsible officer	Timescale	Update
documented rationale for the four hourly observations not being undertaken.				
• The care plan for monitoring of those on anti-psychotic treatment was a standard/generic care plan. For example there was no evidence of bowel monitoring for those patients prescribed Clozapine. The QAIS auditors were made aware that a patient had recently been admitted to secondary care for faecal toxicity. In addition the QAIS auditors did not see evidence of physical health monitoring for all of those patients on regular high dose analgesics	Task & Finish group set up to review care plans. Meetings commenced in Nov 2019.	Dr Allyson Witts	Feedback August 2020	The care plan task and finish group have completed their review and are presenting their recommendations to the HOD meeting. An implementation plan will then be developed.
Physical Interventions and/ or Seclusion/Time Out /Intensive Support:-				
• The QAIS auditors were informed that staff were taught prone restraint techniques.	Caswell clinic continue to teach prone restraint techniques, which are only used as a last resort, when it is proportionate to the risks posed for the minimum time possible, This is in line with current NICE (2015) guidelines. Caswell clinic is	Dan Wilcox	N/A	No changes required

Improvement needed	Service action	Responsible officer	Timescale	Update
	working to align the RPI training package with the new Restraint Reduction Network (Wales) standards. The use of restraint positions is kept under review in RPI steering group meetings.			
• The QAIS auditors were informed that there only one seclusion facility in the hospital. This was located on Penarth ward which is a male ward. Patients requiring seclusion therefore had to be escorted through communal corridors/main thoroughfare. The QAIS auditors were not assured of how dignity and privacy were maintained and protected.	The Service procedure for the safe and dignified transfer of both male and female patients in an emergency situation requiring transfer into seclusion from their ward to the seclusion room is to shut the street to reduce the movement by staff and patients. All patients on wards are asked to vacate clinical areas and court yards whist transfer occurs. This will be set out into a procedure for the service.	Sharon Rees	February 2020	Completed - Procedure developed
Psychological / therapeutic interventions:-				
• There were no psychological interventions or validated outcome measures documented in the patients files. It was	Review need / develop psychology care plans detailing nature of psychological work, duration, assessments measures /	Dr Kim Liddiard	August 2020	Reviewing the use of separate psychology care plans as part of

Improvement needed	Service action	Responsible officer	Timescale	Update
therefore unclear what the patients were working towards in terms of their psychology pathway.	outcomes and who is working with the individual.			Care plan task and finish group.
• One patient interviewed by the QAIS auditors stated that once specific therapies are identified, there was frustration at the waiting time for the programme to commence, therefore impacting on their ability to progress with their pathway.	• Group referrals are centrally co-ordinated and managed / overseen by the PCG. • Individuals referrals to specialist therapies (i.e. CAT / FT) is held by the relevant individuals and discussed / coordinated via the PCG • The service is now keeping waiting times data. All waiting times below standard of 26 weeks	Dr Kim Liddiard	March 2020	Completed
Supportive and Therapeutic Patient Observations:-				
• Care plans relating to observations were found to be generic and not personalised to the patient's needs.	Task & Finish group set up to review care plans. Meetings commenced in Nov 2019.	Dr Allyson Witts	Feedback August 2020	The care plan task and finish group have completed their review and are

Improvement needed	Service action	Responsible officer	Timescale	Update
				presenting their recommendations to the HOD meeting. An implementation plan will then be developed.
• The rationale for undertaking enhanced observation was not clearly recorded in the clinical records.	Increase of observations is usually discussed with the patient and their presentation is documented in the health records. The observations are recorded in the health records with by the staff member who has undertaken the observations. Patient who require have a flexible observation plan.	Ward Managers	January 2020	Completed
• There was no clear evidence to confirm that observation levels were reviewed regularly or via the Clinical Team Meeting.	Information on the patient's presentation is provided, patients have flexible observation plans that are increased and decreased outside of the clinical team meetings.	None	January 2020	Completed

Improvement needed	Service action	Responsible officer	Timescale	Update
• QAIS auditors were informed that for interment (five minute/fifteen minute) observations there is no observation monitoring record for each distinct period of observation identifying the start time, finishing time date and signature of the person undertaking the observations.	All observations are recorded in the patients' health records on the continuation sheets. The service is currently reviewing guidelines and use of the value of 5mins observational checks. Service is reviewing guidance and procedures to reflect all wales observation policy and to be in line with NICE guidance	Lucy Lewis / Jo Sullivan	Dec 2020	
• Observation records were not always recorded at the end of each period of observation.	Entries are made at the end of each shift regards observations being maintained as prescribed by the clinical team Weekly audits are also complete of clinical entries which also include if Observations have been recorded.  Audit of Patients Observation and Lea	Ward Managers	Monthly	Audit reviews completed.

Patient Visitors

13. Name of Visitor Has been recorded
14. Relationship of Visitor to patient has been recorded
15. Observation levels required for visit has been documented
16. Specific grade and gender required for visit has been documented
17. Contact number for visitor has been recorded.

Improvement needed	Service Action	Responsible officer	Timescale	Update
• On examination of the observation policy, the QAIS auditors identified that there was no clear guidance relating to observation monitoring recording, for example what, where and how to evaluate the observations.	Patient observations are written in each patient's health records for each shift. The patients on high observation levels is records on the 24hr report. Incorporate this information into the observation policy. 24hr report template: 24 hour report template.doc An observation checklist has been completed.	Ward Managers	July 2020	Complete
Safety and Welfare of Patients:-				
• There was no staff call system on all of the units for patients to summon assistance from staff.	There is an assistance alarm in every room on each of the wards. The assistance alarm is for both patients and staff to summon for assistance if required for support for physical difficulties or indeed to manage any escalating risks.	Service Manager	N/A	No changes required

Improvement needed	Service action	Responsible officer	Timescale	Update
	Patients have one in their bedrooms. Community meetings to reiterate on a regular basis that staff can be summoned for urgent assistance in this way.			
• Staff on some wards informed the QAIS auditors that there were insufficient personal alarms.	All wards have wall alarms that can be accessed by staff and patients. Quotes obtained for staff to have alarms on their person. Costs submitted to Health Board.	Service Manager	funding requested	ongoing
• QAIS auditors identified that on wards where personal alarms were available, these were not always used by staff. Therefore it was unclear if routine safety and maintenance checks were carried out on these alarms.	Newton ward and Penarth ward have screech alarms the use of these is to be reviewed	Thomas Wilcox /Nerys Guild	Sept 2020	ongoing
Risk Assessment and Risk Management:-				

Improvement needed	Service action	Responsible officer	Timescale	Update
• It was unclear the nature of the short term risk assessment tool used on some wards.	DASA is currently being used on Penarth ward and Newton HDU. Initial evaluation revealed administration problems which undermined its efficacy and so training has been developed and rolled out and a follow up evaluation will be completed to see if it is viable to extend its use in the service (i.e. to Tenby ward).	Dr Kim Liddiard	Sept 2020	Training completed and 2nd evaluation due to commence
• The Risk Management Action Plans did not appear to be reviewed or updated.	HCR20's are audited on a monthly basis Task & Finish group set up to review care plans. Meetings commenced in Nov 2019.	Dr Allyson Witts	Feedback August 2020	The care plan task and finish group have completed their review and are presenting their recommendations to the HOD meeting. An implementation plan will then be developed.
• There were some generic risk management plans in place that were completed for all patients even if risks did	Following the PK inquiry set risk management plans were identified, which include,	None	N/A	No Changes required.

Improvement needed	Service action	Responsible officer	Timescale	Update
not exist. Staff at the clinic state that these are completed for all patients following a directive from Welsh Government following the Kahn enquiry in 2003.	• Assessment of Mental Health • Physical Health Monitoring • Medication • Substance Misuse • Potential Risk to Others			
• The ligature risk assessments were not comprehensive, for example they did not identify specific rooms in some areas. The QAIS auditors observed that on the assessment document, bedrooms were identified as a group but some beds were anti-ligature where others were not.	Ligature risk assessments are updated to the Cwm Taf format to enable the anti-ligature works to be reviewed.	Service Manager	November 2019	Completed
• On Cardigan Ward the QAIS auditors requested to view the ligature risk assessment but this was not available to view.	Ligature risk assessments are updated to the Cwm Taf format to enable the anti-ligature works to be reviewed.  ligature risk assessment Cardiga	Service manager	November 2019	Completed
Complaints:-				

Improvement needed	Service action	Responsible officer	Timescale	Update
• One patient stated that when complaints had been made, via the advocate, that they did not always have feedback or see changes	The service adheres to the putting things right NHS Wales process. All complaints are recorded on the DATIX system and feedback is provided within 30 days.	Service manager	none	No Changes required.
Discharge Planning :-				
• QAIS auditors could not identify references to a robust discharge process in all patient records.	CTP review are held, care coordinators are invited, patients are invited and asked who they would like to attend. Service has an embedded step down and discharge guide already followed by clinical teams.  Patient Step Down Checklist (2).docm	Amanda Watkins / Julie Davies	None	No Changes required.
• QAIS auditors were informed during feedback that there were discharge plans in place but that these were held with the community teams and that, because if this, ward staff were sometimes unaware of discharge plans.	Discharge plans are discussed in the CTP review meetings, where the primary nurse, MDT, the patients care coordinators and the patients' health board CHC team are invited. The care and treatment plans are updated if required. When specific leave plans are	Amanda Watkins / Julie Davies	None	No Changes required.

Improvement needed	Service action	Responsible officer	Timescale	Update
	made these are made and reviewed in clinical team meetings and information cascaded to all.			
• QAIS auditors identified that there were issues with internal transfer of patients from one ward to another. For example one patient was due to transfer to Ogmore but there had been difficultly with staffing levels to facilitate visits which created increased anxiety for the individual. There was no evidence that the primary nurse allocated on the admitting ward is participating in the Clinical Team Meeting prior to the patients move to provide continuity of care.	Patients are assessed outside of the clinical team meetings and information is feedback to the clinical team meetings. The primary nurse is named prior to transfer when possible, and liaises with the patient outside of the clinical team meetings. Some patients choose to move only when the bed is available as to avoid upheaval of going back and forth. The wards complete an inter ward transfer document to review readiness for transfer and patients opinion is included.	None	None	No Changes required
Information and Communication:-				
• QAIS auditors could not identify in all areas that the patient had relevant consent documentation.	All consent to treatment e.g. C02 and Co3 is audited weekly basis, with a monthly audit reports being completed.	W/M	None	No Changes required.

Improvement needed	Service action	Responsible officer	Timescale	Update
	Consent to share confidential information is gained via the CTP review and is minuted on the CTP minutes. Patients are sent individual letters requesting information on who they would like invited to their CTP reviews.	Clinical Teams		
• The telephone was located in the communal area and this did not offer privacy to the patient.	All patients can ask to make private phone calls. Signs are placed above communal phones informing patients of this. Individual use of personal mobiles is being risk assessed and due to be piloted across all 5 wards.	Kelly O'Sullivan	March 2020	Completed
• QAIS auditors were not assured how access to the phone was risk managed for example that phone was not cordless and the cord could potentially be used as a weapon or ligature.	The phones are kept in communal areas to manage these risks and when required patients can use the phone in the interview/side rooms to make private phone calls.	W/M	None	No Changes required

Improvement needed	Service action	Responsible officer	Timescale	Update
• The ward guide was not readily available on all wards.	Ward booklets to be updated.	Ward Managers / Judith Stolzenburg	Feb 2020	All ward booklets are on the wards
Leave:-				
• QAIS auditors identified inconsistences between patients care plans for leave and MHA Section 17 leave documentation. One care plan stated that the patient could have 30 minute section 17 leave but the leave form stated 15 minutes.	The section 17 leave forms are part of the audits and any issues identified are raised with the RC.	None	None	No Changes required
• Some patient's fed back that on occasion their leave would be affected staff availability.	Every effort is always made to prioritise leaves being completed as planned. However if there are acuity issues attempts are made to gain support from other clinical team members to support the leave or the leave is rearranged at the earliest convenience.	None	None	No Changes required

Improvement needed	Service action	Responsible officer	Timescale	Update
Respecting Privacy, Dignity, Equality, Diversity and Human Rights:-				
• QAIS auditors identified that some bedroom areas were viewable from the outside recreational areas.	The service is being reviewed for Anti-ligature works, as part of this we have requested the windows be replaced with privacy film. As an interim measure patients are asked if they want the temporary window film in their rooms	Service Manager	Unknown	No update for anti-ligature works Patients asked if they want window film in their rooms.
• Some of the rooms used for patient's storage was not adequate or organised in an appropriate manner. For example, on Newton Wards the storage room has no shelving and patient's property was stored on the floor in black bags.	The ward manager is reviewing the room as it is a bedroom that has been converted and considering options to improve the storage.	Ward manager	April 2020	Storage has been reviewed and improved.
• QAIS auditors identified that patient rights were not read regularly in accordance with	The rights are usually read on admission and then on a yearly basis. The Mental	Ward Managers/	July 2020	Complete

Improvement needed	Service action	Responsible officer	Timescale	Update
the Mental Health Act 1983 (2007). For example one patient had been admitted to Penarth Ward in January 2018 had their rights read in February 2018 they have since transferred to Tenby Ward and there was no evidence of their rights being read since.	Health Act Team contact each ward to inform them that individual rights are due and if they haven't received individual patient's copies. Monthly audit to commence by ward clerks July 2020	Ward clerks		
Clinical Records:-				
• The organisation of clinical records was found to be confusing with both a shared computer drive and paper records available, each patient had a current clinical file and archive files.	The main patients health records are the files kept in the ward clerk's office. The current and relevant patient information e.g. care plans continuous sheets are kept in the nursing offices and transferred to the main patient health records one out of date or no longer required. Information is saved to a patient drive to save electronic documents and to enable information sharing.	None	none	No Changes required
• Mental health act documents were not kept in the current clinical files including detention papers, section 132 rights and consent to share information. There were	The main patients health records are the files kept in the ward clerk's office. The current and relevant patient information e.g. care plans continuous sheets are	None	None	No Changes required

Improvement needed	Service action	Responsible officer	Timescale	Update
several different formats for some documents for example the physical health record.	kept in the nursing offices and transferred to the main patient health records one out of date or no longer required.			
• The recording of attendance/non-attendance at activities, psychology etc. was not evident.	All patient contact is recorded in the patient's continuation sheets, which includes non-attendance.	None	None	No Changes required
• The Paper records are only completed by nursing staff the wider MDT keep their own clinical records	All patient contact is recorded in the patient's continuation sheets, which includes non-attendance. If other disciplines complete specific elements e.g. psychology assessments a report is completed and this is then put in the patients' health records.	None	none	No Changes required
• The QAIS auditors were informed that clinical records were regularly audited however this audit was not produced during the review.	The audits are held on a drive and reviewed monthly.	None	None	No Changes required
• Documentation within the clinical records was not contemporaneous for example in some files the recovery star had been completed on admission however no	Primary nurses' complete monthly reviews.	Ward Managers	Completed	Complete

Improvement needed	Service action	Responsible officer	Timescale	Update
plans had been formulated from this and the recovery star had not been completed again to show progress and changing needs.	Information from the recovery star is provided at clinical team meetings and in CTP reviews. Each ward completes an audit of patients' recovery star progress on a monthly basis.			
• Daily notes entries are brief and do not always consider the patients mental state and any changes to this.	The staff record the patient's presentation at the end of each shift, in this the staff document on the patient's presentation, their engagement in activities their engagement with others which all contributes to their mental state.	None	none	Complete
• Some entries for patients are stored on a shared electronic hard drive with the rest in paper files.	The main patients' health records are the files kept in the ward clerk's office. The current and relevant patient information e.g. care plans continuous sheets are kept in the nursing offices and transferred to the main patient health records one out of date or no longer required.	None	None	Complete
Emergency Planning and Response :-				

Improvement needed	Service action	Responsible officer	Timescale	Update
• It was not clear to the QAIS auditors that fire evacuation procedures are rehearsed on all units.	Table top exercises are being planned with the Cwm Taf fire officer	Kirstie Bissmire	April 2020	Due to COVID this has been delayed
Environment:-				
• The unit is not entirely anti- ligature specification. Work is in progress for this to be achieved however only so much money per year is awarded to the hospital to carry this out. Therefore there are some bedrooms that are full anti- ligature specification and others with none. Some of the bathroom areas are also not anti-ligature specification.	Cwm Taf is reviewing the anti-ligature requirements.	Dermot Nolan	Unknown	ongoing
• Outside areas of the hospital have not been maintained, gardens and courtyards were overgrown and unkempt.	Requisitions are placed with the estates department.	Estates Locality Manager		Ongoing liaison with Cwm Taf estates departments
• Due to the state of the gardens it was unclear how the security of the hospital was maintained.	Requisitions are placed with the estates department.	Estates Locality Manager		Ongoing liaison with Cwm Taf estates departments

Improvement needed	Service action	Responsible officer	Timescale	Update
• Maintenance did not appear to be undertaken in a timely manner. For example one patient had reported raised flooring in their bathroom no work was carried out until an incident occurred in which the patient fell and injured themselves then the work was completed that day, however the same problem had been reported on the flooring in the next room and this had still not been fixed at the time of the QAIS auditors review	Requisitions are placed with the estates department.	Estates Locality Manager		Ongoing liaison with Cwm Taf estates departments
• It was not clear that any checking of the environment was undertaken as standard practice in order to keep on top of maintenance issues.	Daily security checks are completed in line with the RCPsych standards. Any works required requisitions are placed with the estates department.	Estates Locality Manager	N/A	Completed on a daily basis.
• There are numerous blind spots within the wards, there are no safety mirrors etc. fitted to mitigate any risks from these.	Update the previous review completed re parabolic mirrors	Kirstie Bissmire	Sept 2020	ongoing

Improvement needed	Service action	Responsible officer	Timescale	Update
• One of the Male wards overlook the female ward and there is no privacy screening on the windows. The QAIS auditors were informed that patients had been asked and had chosen not to have this as they could use curtains for privacy. However the QAIS auditors were concerned how the privacy of patients without capacity or who may be experiencing disinhibition was maintained. Bedrooms on Penarth also did not have privacy glass and windows can be seen from main hospital corridor.	The service is being reviewed for Anti-ligature works, as part of this we have requested the windows be replaced with privacy film. As an interim measure patients are asked if they want the temporary window film in their rooms	Thomas Wilcox W/M	Ongoing	No update as yet on the anti-ligature works Patients are asked if they want window film in their rooms.
• Around the unit in both communal shared areas and individual wards there was noted to be cleaning products considered Control of Substances Hazardous to Health (COSHH) items left out.	Wards individually risk assess during each shift the access to certain substances e.g. washing up liquid to enable patients to engage in activities on the wards.	Ward Managers	None	No Changes required
• Some small side rooms appear to have no purpose and have random items left in them, patients spoken to during the review	Change of rooms such as side rooms are discussed in community meetings.	Ward Managers	Ongoing	Ward mangers are documenting discussion in the

Improvement needed	Service action	Responsible officer	Timescale	Update
had ideas of how these rooms could be used to improve patient experience.	When funds become available or raised for the specific purpose of changing the rooms the wards do change them.			ward meeting minutes.
• Rooms used for the storage of patient items were in poor order and had no shelving fitted meaning patients property was kept in bin bags on the floor. This was particularly evident in the High Dependency Unit area of Newton ward.	The ward manager is reviewing the room as it is a bedroom that has been converted and considering options to improve the storage.	Ward Manager	April 2020	Storage has been reviewed and improved.
• Outside courtyard area of Penarth unit was overgrown and had broken/rotten wooden fencing (which could be used as a weapon). Staff advised that area is accessed by patients with staff.	This area is risk assessed. Requests have been submitted for estates to review.	Estates Locality manager	Unknown	Ongoing liaison with estates.
Medical Devices and Resuscitation Equipment :-				
• There were no robust arrangements for the routine servicing and calibration of all medical equipment	This is completed by EBME in the health board which has a record of all the equipment that they oversee. This servicing is automatically completed on a yearly basis.	EBME	None	No Changes required

Improvement needed	Service action	Responsible officer	Timescale	Update
• There were no robust audit arrangements for the routine inspection of medical equipment. Where issues identified, there was no documentation to what actions were implemented to resolve the issues. In addition, it was unclear if corrective action was taken in a timely manner.	QAIS reviewer informed that EBME have a list of the equipment within the service and yearly arrangements in place to complete yearly audits. If any requirements are needed within the year equipment is sent to EBME for repair.	EBME	None	No Changes required
• The area use for the storage of resuscitation equipment was not clearly identified.	The resuscitation equipment is kept in all the treatment rooms and this is part of the staff induction to the wards. The equipment is audited.	Ward managers	None	completed
• There was no evidence to confirm that clinic room temperatures were routinely checked with appropriate action being implemented when required	When there are issues regarding the temperatures being above 25 degrees for an extended period of time air Con units are used in these rooms to reduce the temperatures.	Ward Managers	Completed	Completed
Robust Governance and Accountability :-				
• There is evidence that some clinical practice within Caswell Clinic is not concurrent with good/best practice. For example, the QAIS auditors were informed	Following the PK inquiry set risk management plans were identified, which include,	Dr Allyson Witts	Feedback August 2020	The care plan task and finish group have completed their review and are

Improvement needed	Service action	Responsible officer	Timescale	Update
that following a significant event in 2003 that Caswell Clinic were directed by Welsh Government to use a specific format for action plans for risk, mental health and other areas. There was no evidence to confirm that this practice has been reviewed since this time. For example Person Centred Planning, the Mental Health Measures Act 2010 and Positive Behavioural Support have all come into practice since this time but do not appear to be considered.	• Assessment of Mental Health • Physical Health Monitoring • Medication • Substance Misuse • Potential Risk to Others As part of the task and finish group this may be reviewed.			presenting their recommendations to the HOD meeting. An implementation plan will then be developed.
• Due to the issues identified during the review the QAIS auditors were not assured about the robustness and efficacy of the current audit systems and processes in place. For example 'Newton Ward-Ligature Risk Assessment' only address communal areas of the ward it does not identify the individual bedrooms that are not yet equipped with anti-ligature fittings. The clinic room/medical equipment audits were not found to be adequate. For example room	See previous actions and a monthly audit report has been developed.	W/M	Feb 2020	Completed

Improvement needed	Service action	Responsible officer	Timescale	Update
temperatures were not recorded, there were no arrangements for the servicing of equipment and there was equipment (e.g. the ECG and nebuliser) that had not been serviced and was still in use. At times there was no evidence that corrective actions were taken where issues were identified.				
Staff:-				
• QAIS auditors were concerned that the staffing may be reduced due to the restrictions on smoking areas. For example patients having to be accompanied off the site on multiple occasions throughout the day may compromise staffing levels on the wards.	The service does not support leave specifically for smoking purposes.	Service Manager	None	No Changes required

Service representative

Name (print):

Job role:

Date: