Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Carn y Cefn Ward, Ysbyty Aneurin Bevan Hospital, Aneurin Bevan University Health Board

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Ysbyty Aneurin Bevan Hospital, Aneurin Bevan University Health Board on 15-17 October 2024. The following hospital ward was reviewed during this inspection:

- Carn y Cefn Unit - 11 beds providing acute mental health adult inpatient services. The unit provides assessment, treatment and stabilisation of patients, from the age of 18-65 years.

Our team, for the inspection comprised of one HIW senior healthcare inspector, one HIW healthcare inspector and three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer).

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Overall, there were arrangements in place to provide patients with a positive experience during their admission on the unit. We observed positive interactions between staff and patients. All patients had personal belongings in their rooms and had access to en-suite bathrooms. Authorised leave was based on individual wishes, balanced against risks, and was generally well facilitated by unit staff. Access to mobile phones and tablets was provided.

There was a range of health promotion focused on supporting the improvement of patient wellbeing, and all patients were encouraged to make decisions for themselves, with additional support provided by unit staff when needed. Language preferences and communication needs were met, and advocacy services or involvement of relatives and carers was in line with patient wishes.

This is what we recommend the service can improve:

- The health board should explore how the garden area could be improved to add greater therapeutic value for patients.

This is what the service did well:

- Positive interactions were observed between staff and patients
- Patients had access to personal belongings, mobile phones, and informal and formal leave arrangements
- Patients were encouraged to make independent decisions relating to everyday tasks, their care and treatment, but were supported when needed.

Delivery of Safe and Effective Care

Overall summary:

The unit was well maintained, with appropriate arrangements to support staff and visitor safety. There were appropriate infection, prevention and control measures, but some small areas to strengthen were identified relating to re-usable equipment and storage. Staff were knowledgeable of safeguarding referral and incident reporting processes, which had appropriate governance review and oversight. Medicines management arrangements were generally appropriate, but some areas required strengthening, relating to storage, recording and staff knowledge.

Use of physical interventions was low on the unit, in part, due to clear evidence of preventative and therapeutic strategics to prevent the escalation of behaviours. This was supported by good levels of staff training and adherence to reporting processes.

There were good multidisciplinary team arrangements for the unit, which included co-location of teams, consistent attendance at meetings or the unit, and weekly ward rounds, with patient involvement where desired.

There was good evidence meeting the domains of the Mental Health Measure, with clear recording of patient needs, risks and corresponding care plans. This included the completion and review of risk assessments. Patients were found to be legally detained under the Mental Health Act, with access to advocacy, leave, and all other rights as prescribed by the Act.

This is what we recommend the service can improve:

- Aspects of infection, prevention and control relating to clutter and re-usable equipment and devices
- Aspects of medicines management relating to labelling, storage and disposal of medication, locking of clinical fridges, and knowledge in use of portable oxygen.

This is what the service did well:

- The unit was well maintained, with arrangements in place to keep staff and patients safe whilst on the unit
- Staff were knowledgeable of incident reporting processes, and review, oversight and feedback processes were good
- There were low levels of physical interventions in use on the unit, with appropriate training, knowledge and reporting to support this.
- Patient care and treatment planning was proportionate to their stay on the unit, with clear records, MDT and patient involvement.

Quality of Management and Leadership

Overall summary:

Governance and oversight processes appeared to work well, enabling a flow of information between the unit, senior nursing, and divisional level meetings. This was supported by local, divisional and corporate nursing audits and walkarounds on the unit.

We found evidence of good management and leadership on the ward, including experienced, knowledgeable and responsive staff. All staff on the ward appeared

to work well together throughout the inspection. It was positive to see a generally stable workforce, with a good complement of staffing and skill mix on the unit.

Overall mandatory training compliances rates were generally high among staff on the unit. We noted, however, that manual handling training required improvement. Immediate life support (ILS) training could also benefit from improved levels of trained staff. Appraisal completion rate was good, with evidence of learning and development provided in line with appraisal needs and wishes.

This is what we recommend the service can improve:

- Strengthening of numbers in immediate life support (ILS) training for nursing staff.

This is what the service did well:

- Good management and leadership, with a team that appeared to work well together
- Generally stable workforce, with a good complement of numbers and skill mix
- Overall good mandatory training compliance, with a small number of exceptions noted above.

3. What we found

Quality of Patient Experience

Patient feedback

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. Whilst only one patient questionnaire was completed, we offered to speak with all patients and spoke with several patients informally during the inspection.

Patients were generally satisfied with their experience on the unit, and positive interactions between staff, and other patients, was observed. Some feedback included more choice of snacks, and at mealtimes. This was already under review on the unit. Feedback relating to the garden has been provided below.

Person-centred

Health promotion

There was a range of health promotion focused on supporting patient wellbeing during their admission on the unit. This included therapy team led activities, such as yoga and walk and talk sessions. A new occupational therapist had recently started on the unit and was in the process of developing a new timetable, which we were told would increase the variety of activities available.

There was access to other activities on the unit, which included arts and crafts, board games, movies, and access to a pleasant outdoor space. Whilst the outdoor had walkways and seating, it has the potential to add greater therapeutic benefit for patients on the unit.

The health board should explore how the garden area could be improved to add greater therapeutic value for patients.

For patients who could access community leave, we were told that this was an important element for supporting their wellbeing and aiding a sense of calm on the unit. We found leave was regularly facilitated, with a small number of exceptions present when staffing constraints or patient presentation did not allow this.

Dignified and respectful care

We observed positive interactions between staff and patients. This included respectful conversations, unit staff respecting privacy by knocking on bedroom doors before entering and engaging in conversations with patients in rooms away from the main communal area.

All patients had personal belongings in their rooms and had access to en-suite bathrooms. Bedroom doors had observation windows with patient-controlled blinds, and doors could be locked by patients. Both could, however, be overridden by staff for safety and when completing observations.

Individualised care
Completion of everyday tasks, such as use of the laundry and kitchen, was encouraged for patients. Patients were encouraged to make decisions for themselves but were provided with additional support by unit staff when needed.

Authorised leave from the unit was based on individual wishes, balanced against risks, and was generally well facilitated by unit staff. This was reviewed in regular ward round and multidisciplinary team forums, or as required.

Patients were able to keep their own devices, such as mobile phones and tablets, on the unit. Wi-Fi was available to help patients stay in touch with friends, relatives and carers.

Patients were encouraged to bring their other devices and equipment, such as mobility aids, onto the unit at the point of admission. Some devices were accessible on the unit and assessments could be undertaken, if required.

There was information on self-help and support services available on the unit, such as advocacy and drug and alcohol services. We confirmed that one-to-one meetings between staff and patients also provided an opportunity for patients to discuss any specific needs.

Timely

Timely care
In the lead up to, and throughout the inspection, staffing numbers and skill mix were stable. We confirmed that staffing could be adjusted to meet patient needs and acuity, including increased observation levels, when necessary. We observed staff assisting patients on the unit in a timely manner throughout the course of the inspection.

The unit had a multidisciplinary team, including nursing, healthcare support, and occupational therapy staff, with in-reach from psychiatry and psychology staff,

who were co-located on the same hospital site. Weekly ward round and multidisciplinary team meetings helped to ensure timely decisions in relation to patient care and treatment.

Equitable

Communication and language
Language preferences and communication needs were recorded in care and treatment plans within patient records. Use of advocacy services was also readily accessible and used by patients on the unit.

It was positive to see a staff 'who's who?' board on display with photos. This helps patients to familiarise themselves with who is providing their care.

Interactions between staff and patients felt calm and respectful throughout the inspection.

Rights and equality
We confirmed that patient's rights in relation to the Mental Health Act were being upheld. Patients were provided with, or had the offer of, written material to explain their rights.

There was evidence of patient engagement relating to their care and treatment, including invitations to attend weekly ward rounds. Where a patient did not wish to attend, this was clearly recorded. It positive to see equally clear records regarding patient instructed advocacy or involvement of relatives, where desired.

Delivery of Safe and Effective Care

Safe

Risk management
Entrance to the unit was always secure, with restricted wider hospital access out of hours. Staff personal alarms were worn and were reported to be in good working order. Wall mounted call and emergency alarms were located around the unit, including in patient bedrooms.

The environment was generally well maintained and free of obvious estates related issues. Ligature audits were completed, which were supplemented by environmental walkaround audits. There is, however, the need to review the ligature audit to ensure:

- Date of last review is clear to establish frequency of review
- New/ residual risk score is recorded, following mitigating actions to reduce an identified risk
- Longstanding risks are regularly reviewed and acted upon according to level of risk, or marked completed, as appropriate.

The health board must review its ligature audit process and template to ensure robust management of ligature risks.

A seclusion suite was not available on the unit. There was, however, an extra care area which was not in use at the time of the inspection. The standard operational procedure for its use was in draft and would benefit from prompt ratification to ensure that the extra care area is used appropriately.

The health board should ensure that ward's draft extra care area procedure is ratified at the next available opportunity.

Infection, prevention and control and decontamination
There were appropriate arrangements in place to manage IPC effectively on the unit. All staff were aware of their responsibilities according to their roles and duties. Staff compliance with mandatory IPC training was good.

The were processes in place to ensure aspects of IPC are complied with, including cleaning schedules, environmental checks and hand hygiene audits, which were highly scored.

Patients had access to laundry facilities. All equipment was in working order, but this area was found to be quite cluttered. Staff reported that this was due to limited storage on the unit.

The health board should ensure that clutter is removed from the laundry room, and appropriate storage options explored to house equipment.

There was a range of communal equipment available, such as in communal bathrooms, and reusable devices in the clinic room. Whilst these looked visibly clean, we recommend use of systems, such as the green 'I am clean' labels, to ensure that all equipment is appropriately clean before use.

The health board should use a system, such as the green 'I am clean' labels to ensure reusable equipment and devices are easily identified as ready for use.

Safeguarding of children and adults
We found suitable processes in place to safeguard vulnerable adults. There were established processes, which staff were familiar with. This included staff knowledge and understanding of what may constitute a safeguarding concern and how to escalate concerns to ward management or the safeguarding lead nurse.

We noted that a cautious approach is taken, if there is uncertainty whether a safeguarding notification is required, the incident is flagged and reviewed by the safeguarding lead nurse.

We reviewed several incidents and found these incidents to have followed established processes at all stages of the reporting, review and follow-up stages. This included oversight through an appropriate governance structure, with identification and embedding of learning throughout the unit.

Medicines management
Arrangements for medication management were generally safe and appropriate, but some areas for improvement were found in relation to storage and disposal of medicines.

The clinic room was found to be locked at all times, and keys were kept secure. Whilst clinical fridge temperature checks were routinely checked, we observed the fridge to be unlocked when not in use.

The health board must ensure that clinical fridges are locked at all times.

We found the storage, administration and recording of controlled drugs to be well maintained. However, whilst segregated, a range of disposed of general medication was stored in an unsecured box on the floor of the clinic room.

The health board must ensure that disposed of medication is securely stored and collected for disposal in a timely manner.

Emergency equipment and drugs were found to be available, accessible and regularly checked to ensure stock remains available and in date. We found, however, that liquid drugs were not appropriately dated. We also noted that unit staff should receive refresher training on how to operate the portable oxygen cylinder safely.

The health board must ensure that all emergency drugs are dated to ensure their on-going efficacy.

The health board must ensure that all staff are appropriately trained with the procedure for operating the portable oxygen cylinder in line with Patient Safety Notice 041.

We found that patients were appropriately involved in the decisions made about their medication. This included discussion during weekly ward rounds to help patients understand about the medications prescribed, and medication leaflets would be made available if requested. The weekly ward rounds also acted as a forum to review medication to ensure their on-going clinical appropriateness.

Effective

Effective care

The system for recording incidents, including any physical interventions, was well established on the unit. Staff were aware of how to report incidents, and there was evidence to demonstrate that this was done openly and consistently. There was a clear governance structure in place for oversight of any incidents, with a feedback loop from ward management back to staff.

There was evidence of preventative and therapeutic strategies in use, to prevent the escalation of behaviours requiring the use of physical interventions, such as restraint.

Enhanced levels of observations were undertaken in compliance with health board policy. Sufficient staffing levels were observed to fulfil the necessary level of observation, and there were workforce processes in place to facilitate this, when

required. Staff knowledge and understanding of their responsibilities towards completing therapeutic observations was sound.

It was positive to see good levels of training compliance in this area, in particular completed workbooks by staff following training, to evidence their learning and understanding. Collectively, this contributed to a low use of physical interventions on the unit, reflective of the least restrictive approach working effectively to de-escalate behaviours that challenge.

We noted that the multidisciplinary team arrangements for the unit, including co-location of medical, therapy and community teams, helped to embed positive working relationships and effective liaison between teams.

Physical health assessments were undertaken at the point of admission to the unit, and we noted standardised risk assessments were used in all cases. Risk management assessments for the management of serious risks were also completed and contained a good standard of detail. There was evidence of these having been updated in line with changes in patient risk profiles.

Nutrition and hydration
We found patients had their nutritional needs assessed upon admission to the unit. This included use of All Wales clinical assessments.

In one patient record where high clinical risk was identified, we confirmed that appropriate follow up actions had been taken. This included reviews by dietetic and diabetes colleagues. In addition, weight checks were routinely recorded. It was positive to note an on-going referral to the eating disorder team was in place, as part of an individual's discharge planning arrangements.

All patients were supported to meet their individual dietary needs and preferences. Whilst some dissatisfaction was expressed by patients regarding choice and meal options, we found the meals provided were of a good standard. This included varied menus, with a range of hot meals, soups, and desserts. Healthy options were indicated on the menu to help patients make an informed choice.

Patients had access to a small kitchen to store snacks, and to make hot and cold drinks between mealtimes. There was also weekly smoothie making sessions organised by the OT to help add variety and promote healthy eating.

Patient records (Including Monitoring the Mental Health (Wales) Measure 2010: care planning and provision)

The current system for record keeping is challenging, with both electronic and paper-based records in use. This was, in part, due to limitations of the electronic system. Despite these challenges, the information contained in patient records was proportionate to the patients' length of stay on the unit, and the nature of their admission.

There was good compliance in meeting the domains of the Mental Health Measure, including clear recording of patient needs, risks and corresponding care plans, in recognised care and treatment plan templates.

There was evidence of regular patient reviews undertaken by the MDT, which included the patient, carers, relatives and advocacy, where appropriate.

Mental Health Act monitoring
We reviewed four records of patients who were detained under the Mental Health Act, and all legal documentation related to their admission was found to be compliant with the Act. There was clearly documented evidence that patient rights were being upheld in line with the Act, and patients were regularly presented with their rights and provided with written information to this effect.

Links to local advocacy services were well developed and positive working relationships had been established. We noted weekly visits to the unit by advocates who would meet in-person with patients, attend meetings, and would support patients with the preparation of any tribunal or hospital managers meetings.

Records were navigated with ease and had improved since the last inspection. We recommend however, that Section 17 leave forms are held in the readily accessible paper records on the unit. This is to ensure that Section 17 leave requirements can be accessed with ease by all staff, including those who may be new or temporarily working on the unit.

The unit was provided with sound oversight from the central Mental Health Act administration team in the health board.

Quality of Management and Leadership

Staff feedback

We invited staff to provide feedback through a survey and we received 10 responses. Staff comments were mixed, and included:

> *" Deputy ward managers are very supportive and approachable, line manager not very approachable or supportive"*

> *" The ward does not allow much progression and there does seem to be a "click" within the workplace between band 6s"*

> *"I am not employed on Carn Y Cefn ward, but I am in the CMHT next door and have a lot of dealings with the ward. Every experience I have had with the staff they have been more than helpful and are very patient focused […] In my opinion this is that most supportive, patient focused acute mental health ward within the health board"*

Leadership

Governance and leadership
Governance and oversight processes appeared to work well, enabling a flow of information between the unit, senior nursing, and divisional level meetings. Matters raised in these meetings involved patient care, workforce, quality and safety.

We found evidence of good management and leadership on the ward, including experienced, knowledgeable and responsive staff. All staff on the ward appeared to work well together throughout the inspection.

All staff who responded to the staff survey confirmed that their immediate manager can be counted on to help them with a difficult task at work. All but one agreed that they are given clear feedback and that they are asked for their opinion before decisions are made that affect their work.

In relation to senior managers, all but one staff member agreed that senior managers are visible, that communication is effective and that they are committed to patient care.

Several policies and procedures were in the process of being updated. We recommend that review and ratification of policies and procedures are prioritised, according to their level of risk. This should include prevention and management of violence and aggression (PMVA) and extra care area policies.

The health board must ensure that policies and procedures are reviewed and ratified in a timely manner. These should be prioritised according to their level of risk.

Workforce

Skilled and enabled workforce

It was positive to see a generally stable workforce, with a good complement of staff and skill mix on the unit. This is important for the patient group and nature of care provided.

All staff survey respondents felt they can meet the conflicting demands on their time at work, and that adequate supplies and equipment are available to do their job. However, a third of staff said they would welcome a greater number of staff to do their job properly.

Overall, staff mandatory training compliances rates were generally high. We noted however, that manual handling training required improvement. Staff confirmed there were imminent plans in place to resolve this, and delays had been impacted by staff absence. Staff confirmed that there are ILS trained staff on each shift, but we identified the number of trained staff could be increased. This is to ensure adequate coverage in the event of leave or unexpected absences. We, therefore, recommend that immediate life support (ILS) training numbers are strengthened among nursing staff.

The health board must ensure the numbers of ILS trained staff are strengthened to ensure appropriately trained staff are present on each shift.

Staff annual appraisal compliance to be good. There was evidence of learning and development, in line with appraisal wishes and needs. This included external training and further education opportunities.

Over two thirds of staff survey respondents said their job is not detrimental to their health, that their organisation takes positive action on health and wellbeing, and that their current working pattern allows for a good work-life balance. All were aware of occupational health support arrangements.

Culture

People engagement, feedback and learning

There were well promoted opportunities for patients, relatives and carers to provide feedback, complements and complaints. This included use of a 'You said, we did' board, posters displaying the NHS Wales Putting Things Right process, advocacy information, and information on the role of HIW. The Civica patient feedback system, an NHS Wales initiative, was in use to help support the capturing of real time feedback through QR codes and text messages to patients.

There was evidence of feedback being reviewed, responded to, and displayed on the unit. This included responding to, and oversight of, formal complaints and concerns.

Learning, improvement and research

Quality improvement activities

There was evidence of local, divisional and corporate nursing quality audits undertaken on the unit. The outcome of these audits was generally positive and fed into appropriate governance meetings for oversight. This governance structure aided the sharing and standardisation of learning across the community services division.

Regarding incidents, there was evidence of these being reported by staff in a timely manner, with appropriate review, oversight and identification of learning. There was a generally good feedback loop observed between unit management and staff.

All staff survey respondents agreed that their organisation encourages them to report errors, near misses or incidents. However, two respondents did not feel that sufficient actions are taken to ensure that they do not happen again, or that feedback about changes made is always provided. All but one respondent told us that they would, however, feel confident in raising clinical concerns.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns identified			

Appendix B - Immediate improvement plan

Service:

Date of inspection:

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate improvements identified					
2.						
3.						
4.						

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):

Appendix C - Improvement plan

Service: Carn y Cefn, Ysbyty Aneurin Bevan

Date of inspection: 15-17 October 2024

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/finding/issue		Improvement needed	Service action	Responsible officer	Timescale
1.	Patient experience	The health board should explore how the garden area could be improved to add greater therapeutic value for patients.	1) Ward Manager is in communication with the Head of Monmouthshire County Council to arrange for the concrete paving slabs to be power washed.	Ward Manager	Update to be provided by 20/12/2024
			2) New furniture for garden area to be explored. Awaiting costings for extra weighted furniture (Ryno Challenging Environments range)	Service Improvement Manager/Ward Clerk	To be costed and ordered by 20/12/2024
			3) Occupational Therapist has liaised with our Third Sector provider, Growing Space. They will meet in January to assess what is required in the garden area to create raised beds and improve the area to make it more therapeutic. This will be done in collaboration with service users and staff working on the ward.	Lead Occupational Therapist and Ward Manager in collaboration with Growing Space	Meeting to take place and specification to be agreed by 17/01/2025

Risk/finding/issue		Improvement needed	Service action	Responsible officer	Timescale
			Action numbers 1-3 will be monitored through: - • Divisional Patient Quality Safety & Learning Meeting • Patient Quality Safety Outcome Committee (PQSOC) • Patient Quality Safety Learning and Improvement Forum (PQSLI)	Executive Director of Nursing	January 2025 onwards
2.	Safe and Effective Care – Risk Management	The health board must review its ligature audit process and template.	4) All-Wales ligature group in place, in line with the National Patient Safety workstreams. This group is currently developing an All-Wales ligature risk assessment, training package and policy. The Adult Mental Health representative will feed these recommendations back to the All-Wales group on 11/12/24 and will discuss at the National Patient Safety Divisional Oversight Meeting on 11/12/2024.	Adult Mental Health Directorate Management Team	All- Wales Ligature group meeting on 11/12/2024
			5) To be discussed at the next Divisional Ligature Risk Management meeting on 10/12/2024 to agree a unified way to action these recommendations across all current Ligature Risk Assessments in the Division until the All-Wales version has been ratified.	Divisional Ligature Risk Management Meeting	To be reviewed in Divisional Ligature meeting on 10/12/2024

Risk/finding/issue		Improvement needed	Service action	Responsible officer	Timescale
			Action numbers 4-5 will be monitored through: - • Divisional Patient Quality Safety & Learning Meeting • Patient Quality Safety Outcome Committee (PQSOC) • Patient Quality Safety Learning and Improvement Forum (PQSLI)	Executive Director of Nursing	January 2025 onwards
3.	Safe and Effective Care – Risk Management	The health board should ensure that its Extra Care Area (ECA) procedure is ratified at the next available opportunity.	6) The ECA guidance has been reviewed and changed to the 'Seclusion and Segregation Policy'. This has been reviewed and ratified at the Divisional QPSE meeting.	Divisional Nurse	COMPLETE
			Action will be monitored through: - • Divisional Patient Quality Safety & Learning Meeting • Patient Quality Safety Outcome Committee (PQSOC) • Patient Quality Safety Learning and Improvement Forum (PQSLI)	Executive Director of Nursing	January 2025 onwards
4.	Safe and Effective Care – IPC	The health board should ensure that clutter is removed, and appropriate	7) Laundry Room has been decluttered, all patient belongings have been sent home with patients upon discharge and any unwanted items have been disposed of.	Ward Manager	COMPLETE

Risk/finding/issue		Improvement needed	Service action	Responsible officer	Timescale
		storage options explored.	8) Added to the ward weekly audit to ensure that all areas remain uncluttered and tidy.	Ward Manager	COMPLETE AND ONGOING
			9) The weekly audit is monitored by the Band 6 Clinical Lead Nurse.	Clinical Lead Nurse	COMPLETE AND ONGOING
			10) New boxes have been ordered and delivered to allow for more organised storage in the area.	Ward Manager	COMPLETE
			11) Additional storage/shelving has been installed in the Sluice Room and Linen Cupboard.	Ward Manager	COMPLETE
			Action numbers 7-11 will be monitored through: - • Divisional Patient Quality Safety & Learning Meeting • Patient Quality Safety Outcome Committee (PQSOC) • Patient Quality Safety Learning and Improvement Forum (PQSLI)	Executive Director of Nursing	January 2025 onwards
5	Safe and Effective Care – IPC	The health board should use a system, such as 'I am clean' labels to ensure reusable equipment and devices are easily identified.	12) 'I am Clean' Labels have been sourced and are now being used. The ward has details of the order number so that stocks can be replenished.	Ward Manager	COMPLETE
			13) Audit process in place to monitor compliance.	Ward Manager	COMPLETE AND ONGOING

Risk/finding/issue		Improvement needed	Service action	Responsible officer	Timescale
			Action numbers 12-13 will be monitored through: - • Divisional Patient Quality Safety & Learning Meeting • Patient Quality Safety Outcome Committee (PQSOC) • Patient Quality Safety Learning and Improvement Forum (PQSLI)	Executive Director of Nursing	January 2025 onwards
6	Safe and Effective Care – Medicines Management	The health board must ensure that clinical fridges are locked at all times.	14) Clinical Fridges have been added to the weekly audit to ensure that they are locked at all times.	Ward Manager	COMPLETE AND ONGOING
			15) The weekly audit is monitored by the Band 6 Clinical Lead Nurse in Charge.	Clinical Lead Nurse in Charge	COMPLETE AND ONGOING
			16) Ward induction to be updated to reflect the above.	Ward Manager	20/01/2025
			17) Clinic checks are reported through the NHS Audit, Management and Tracking (AMAT) system via the ward accreditation process and spot check audits.	Ward Manager	COMPLETE AND ONGOING

Risk/finding/issue		Improvement needed	Service action	Responsible officer	Timescale
			Action numbers 14-17 will be monitored through: - • Divisional Patient Quality Safety & Learning Meeting • Patient Quality Safety Outcome Committee (PQSOC) • Patient Quality Safety Learning and Improvement Forum (PQSLI)	Executive Director of Nursing	January 2025 onwards
7	Safe and Effective Care – Medicines Management	The health board must ensure that disposed of medication is securely stored and collected in a timely manner.	18) Surplus stock has been removed by Lead Pharmacist	Ward Manager	COMPLETE
			19) Process agreed between Ward Manager and Lead Pharmacist to dispose in a timely manner	Ward Manager	COMPLETE
			20) Medicine checks to take place weekly on the ward.	Ward Manager	COMPLETE AND ONGOING
			Action numbers 18-20 will be monitored through: - • Divisional Patient Quality Safety & Learning Meeting • Patient Quality Safety Outcome Committee (PQSOC) • Patient Quality Safety Learning and Improvement Forum (PQSLI)	Executive Director of Nursing	January 2025 onwards

Risk/finding/issue		Improvement needed	Service action	Responsible officer	Timescale
8	Safe and Effective Care – Medicines Management	The health board must ensure that all emergency drugs are dated to ensure their on-going efficacy.	21) Ward induction to be updated to reflect all emergency drugs are dated to ensure their on-going efficacy.	Ward Manager	20/01/2025
			22) This has been added to the nightly check list managed by the Nurse in Charge. This will ensure that all emergency drugs are dated on a daily basis. Nurse in Charge to ensure that any due to be out of date are disposed of and replenished in a timely manner.	Ward Manager	COMPLETE – monitoring process in place
			23) All newly qualified nursing staff have completed the Medication Management training as part of the Induction Process.	Ward Manager	COMPLETE
			Action numbers 20-23 will be monitored through: - • Divisional Patient Quality Safety & Learning Meeting • Patient Quality Safety Outcome Committee (PQSOC) • Patient Quality Safety Learning and Improvement Forum (PQSLI)	Executive Director of Nursing	January 2025 onwards
9	Safe and Effective Care	The health board must ensure that all staff are familiar in how to	24) Ward Manager to liaise with the Resus team to consider appropriate training around the use of oxygen therapy.	Ward Manager	20/12/2024

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
- Medicines Management	operate the portable oxygen cylinder	25) All staff to complete the BOC (manufacturers of oxygen cylinders) online training.	Ward Manager	31/12/2024
		Action numbers 24-25 will be monitored through: - • Divisional Patient Quality Safety & Learning Meeting • Patient Quality Safety Outcome Committee (PQSOC) • Patient Quality Safety Learning and Improvement Forum (PQSLI)	Executive Director of Nursing	January 2025 onwards
Safe and Effective care	The health board must ensure that policies and procedures are reviewed and ratified in a timely manner. These should be prioritised according to their level of risk.	26) The Divisional Nurse has introduced a Policy Group and revised tracker to ensure that polices are reviewed and ratified in a timely manner. Actions will be prioritised according to level of risk at the first meeting in December 2024.	Divisional Nurse	In progress December 2024
		Action will be monitored through: - • Divisional Patient Quality Safety & Learning Meeting • Patient Quality Safety Outcome Committee (PQSOC) • Patient Quality Safety Learning and Improvement Forum (PQSLI)	Executive Director of Nursing	January 2025 onwards

Risk/finding/issue		Improvement needed	Service action	Responsible officer	Timescale
10	Management and Leadership – Workforce	The health board must ensure the numbers of ILS trained staff are strengthened.	27) ILS training compliance is currently 50%. This is being monitored locally by the ward Manager.	Ward Manager	ONGOING
			28) 70% compliance for ILS Training to be achieved by end of January 2025.	Ward Manager	January 2025
			29) 100% compliance for ILS Training to be achieved by March 2025.	Ward Manager	March 2025
			Action numbers 27-29 will be monitored through: - • Divisional Patient Quality Safety & Learning Meeting • Patient Quality Safety Outcome Committee (PQSOC) • Patient Quality Safety Learning and Improvement Forum (PQSLI)	Executive Director of Nursing	January 2025 onwards

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): **N Gould**

Job role: **Divisional Nurse**

Date: **10 December 2024**