Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Seren Ward, Royal Glamorgan Hospital

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Seren Ward, Royal Glamorgan Hospital as part of its programme of assurance work. At the start of the pandemic, the ward was operating as a single 19 bedded dementia unit. The unit is now operating as an 11 bed and 8 bed unit, with fully independent facilities; ensuring there is no flow between the separate units.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality Checks are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the ward manager on 20 April 2021 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How are you ensuring that the environment is safe and suitable for the needs of patients at this time? What changes, if any, have been made to the physical environment, ward routines and patients' access to leave as a result of COVID-19?
- How is the risk of infection assessed and managed to keep patients, visitors and staff safe?
- Considering the impact of COVID-19, how are you discharging your duty of care against the Mental Health Act and how are patients' rights being safeguarded?
- How are you ensuring that there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed?

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and use of restraint and seclusion. We also questioned the setting on the changes they have made to make sure patients continue to receive the care and treatment according to their needs.

The following positive evidence was received:

The changes that had been made to the environment as a result of COVID-19 were described. These included closing the doors between the two parts of the unit, making it two separate units. This enabled the patients to be cohorted as required into patients with COVID-19 (red) and non COVID-19 (amber)[1] areas, with the patient groups nursed separately. The bed capacity was then flexed as required in response to clinical requirements. The extra surge capacity by converting non-clinical space into a seven bed unit (ward 23), was also described, to provide further flexibility. The ward attempted to limit the numbers of hospital staff on the ward, this included catering staff. Food was delivered to the outside of the ward then given to patients on trays by staff, who also made hot drinks for patients on the ward. The medical cover for patients was normally managed by four consultants, one for each of the mental health regions covered by the hospital. During the pandemic the consultant cover was carried out by one consultant on the ward, again to limit numbers. Staff on the ward were required to wear appropriate personal protective equipment (PPE) as appropriate. This included masks, visors, aprons and gloves, as necessary.

The wider leadership team initiated a daily “bronze” meeting, during which there was the opportunity for the senior nurse and the ward managers to share COVID-19 information and discuss approaches to management as they arose. The standing agenda items included PPE supplies, staffing, absence due to COVID-19 and the management of the staffing shortfall across the ward and the mental health unit as a whole. There was also an opportunity to problem solve issues of patient flow, with consideration of surge capacity and at times, the daily changing patient numbers. On a patient level, infection, and latterly vaccination, rates were monitored, and changes to processes and guidelines were shared and circulated with staff. The ward championed the early implementation of the inpatient vaccination, in line with the measures implemented within care homes, as there were commonalities with the patient groups. On the ward, the twice-daily safety briefing was the mechanism for local communication of guidance, safety alerts and learning.

Whilst, we were told that patients were verbally informed of the changes on an ongoing bases, their acuity made it difficult to maintain information and re-assurance was regularly given to the patients. The ward manager stated that they wrote letters to families at the

[1] Those patients who are not displaying symptoms of Covid-19 and are not likely to be potentially infectious (not previously Covid-19 positive, not living/ in close contact with someone isolating or Covid-19 positive).

start of the pandemic to describe the arrangements of care for patients and also called them when visiting would re-start. The guidance given to families, included information on COVID-19 and PPE measures.

The ward manager stated that there had not been a significant increase in challenging behaviour during the pandemic. When this had occurred, the level of harm caused was low due to staff interventions. There had not been recent instances of restraint, although safe hold techniques were used on patients, where required. The ward manager stated that there was a need for the safe hold, particularly when prevention and management of violence and aggression (PMVA)[2] had to be used by intra-muscular[3] methods.

We were told that there were daily ligature point checks and a weekly walk round of the ward along with a ligature point environmental audit being updated every six months. We saw evidence of this audit dated February 2021 together with the further control measures that were put in place.

Whilst, in line with national guidance, we were told that there was no routine visiting onto, nor leave arrangements from the ward, this was not a blanket approach. There had been occasions where the multi-disciplinary team (MDT) had agreed to a managed visiting process by approved family members. This was in order to facilitate palliative visits, or supporting persons with restricting dietary behaviours who would benefit from the support from those they were familiar with. In this case, families were advised on the use of, and supplied with, PPE and the visit was individually risk managed. When possible these supportive visits took place outdoors in the ward garden. Where section 17[4] leave had continued, this required the family isolating before the visit and the patient was swabbed for the presence of COVID-19 both before and after the visit.

We were told that the nursing staff facilitated online contact between family and patients online. A small number of tablets were purchased, as well as cordless phones that had allowed a more flexible approach to communication. Instead of face to face contact between staff and families, the named nurses (both registered nurses and healthcare support workers (HCSW)) had planned weekly contact with families. This enabled the opportunity to share information and address any outstanding queries and concerns. In addition, the ward manager had continued the pre-COVID-19 arrangement of having protected time during the week when they were available for contact by family members.

The ward manager also described changes that had been made on one side of the ward to improve the environment for patients. A small room had been changed into a patients dining

[2] PMVA is a method of conflict management to 'breakaway' from patients and/or to execute physical restraint.
[3] Intramuscular injection, often abbreviated IM, is the injection of a substance into a muscle. In medicine, it is one of several methods for parenteral administration of medications.
[4] Section 17 of the Mental Health Act allows detained patients to be granted leave of absence from the hospital in which they are detained. Leave is an agreed absence for a defined purpose and duration and is accepted as an important part of a patient's treatment plan.

area and a larger area had been converted into a lounge. There was a proposal for this room to be further improved for patients, by using technology to reduce agitation. This would include a sensory area, with an interactive board and RITA[5] system. Additionally, the ward manager spoke of the proposal to appoint a band four HCSW to an activity coordinator role. The function of this would be to support meaningful activity on the ward in line with behavioural care plans developed by the team. It was anticipated (based on evidence from wider learning) that the impact would be fewer incidents including falls, and a reduction in difficult behaviours and subsequent use of "as required" medication to manage.

The following areas for improvement were identified:

We were provided with a copy of the health board policy for the Recognition, Prevention and Therapeutic Management of Violence and Challenging Behaviour. This was requested to support the methods we were told were used on the ward to care for patients that had the potential to become violent and display challenging behaviour. Whilst the methods that were described were in accordance with the policy, the policy was overdue for review (15 February 2020).

The health board must ensure that the document is reviewed and updated as necessary. The health board must further ensure that a process is put in place to ensure all documents are reviewed in a timely manner, before they become overdue for review.

Infection prevention and control (IPC)

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. We considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments. We reviewed key systems including the use of PPE.

The following positive evidence was received:

We were told that enhanced cleaning methods had been implemented in light of COVID-19 to ensure IPC standards were maintained. This included using sterilising fluids and also hydrogen peroxide vapour (HPV)[6] in addition to disinfectant wipes. The HPV was used when patients were moved, at the same time the privacy curtains would be changed. The methods of disseminating COVID-19 guidance and changes were described, including using handover of shifts, to pass on information. We were told that there was also a COVID-19 learning board in the staff office.

[5] RITA, which stands for Reminiscence Interactive Therapy Activities, is an innovative, evidence-based, state-of-the-art digital therapy system which allows patients to use apps, games and other leisure activities as part of their hospital recovery.

[6] https://www.cleanroomtechnology.com/technical/article_page/Total_elimination_of_pathogens_using_HPV/58232

The ward manager stated that patients would be initially isolated into non ambulatory or compliant patients, in single rooms with staff using barrier nursing[7]. This provision was in line with health board IPC guidelines. To aid this cohorting, nursing staff had been working in specific areas where possible, with minimal footfall from other disciplines. This included the psychology and occupational therapy staff changing their work patterns in order to work exclusively on the ward. MDT meetings and professionals' meetings initially took place virtually, either through video calls or teleconferencing.

We were told that staff had received training on the use of oral nasal disposable mask respiratory protection (FFP3)[8], although they had not had cause to use them. Posters were displayed on the use of PPE. Initially staff were trained by the IPC nurses on the donning and doffing of PPE. There were disposal bins for used PPE and trolleys with fresh PPE, outside the doors to the ward and the various parts of the unit. Patients were also encouraged and were taken, where necessary, to the handwashing facilities, to further prevent any transmission of infections.

The method to review patients on admission by a doctor, for the risk of contracting COVID-19 was described. We were told that patient records were reviewed on admission to check whether they had been vaccinated against COVID-19. Patients were also swabbed every five days to ensure they had not contracted COVID-19.

We were told that staff were encouraged to use lateral flow tests and they had all been vaccinated. Furthermore, staff were attempting to place patients, who were able to be discharged, back to the community.

The routine IPC audits that were carried out by the IPC team were described. The ward manager was also responsible for the weekly environmental and hand hygiene audits. We were provided with evidence of this and the ward manager stated that they had action plans in place to address any issues identified. We also saw evidence of the annual IPC audit from February 2021 and the action plan from the ward to rectify the issues raised.

The ward manager stated that there had been a significant impact on the behaviour of the patient group when access to and from the ward for patients and visitors was stopped. However, there had been some benefits, the reduced patient movement had given the nursing team occasion to make a ward a calmer place for the patients. There had been a refocus on psychological therapies and an increased opportunity for creativity of intervention on the ward, for example the bonfire night celebrations.

[7] The aim of barrier nursing is to protect medical staff against infection by patients and also protect patients with highly infectious diseases from spreading their pathogens to other non-infected people.

[8] The need for FFP3 Mask (oral nasal disposable mask respiratory protection) to be worn is identified through clinical risk assessment. The mask is used to protect against respiratory borne pathogens. To use these masks, relevant staff must be 'face fit tested' to ensure that they can achieve a suitable face fit of the mask and that it operates at the required efficiency.

We were told that there had been instances of healthcare acquired (nosocomial) infections during the pandemic. The ward manager described the actions taken to reduce any further cross infections, such as the use of ward 23 as described above. The investigation into these outbreaks was described, including a timeline of the positive results to identify any triggers, such as patients not being tested before admission, from the community. The actions taken included increased swabbing of patients, isolating patients where possible and additional governance on the handover of patients. Lessons learned were disseminated to staff through the handover briefings, monthly team meetings and regular supervision and discussions with staff.

No improvements were identified.

Governance

As part of this standard, HIW considered how the setting ensures there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed. We also questioned the setting about how, in light of the impact of COVID-19, they are continuing to discharge their duty of care against the Mental Health Act and safeguarding patients' rights.

The following positive evidence was received:

The governance in place to oversee the implementation of changes to patient care during this time and the safeguarding of patients' rights was described. Access to the Mental Health Review Tribunal[9] continued by conference call, although we were told that only one had been carried out, in the last year.

We were told that care treatment plans were completed on admission and updated as required. These were checked by the ward manager twice a month. We saw evidence of this check and of the action taken against any notes made.

The method that the ward used to ensure current staffing levels met patients' needs and acuity was discussed. We were told they were agreed in advance and refined as necessary before the day of the shift to ensure there was safe staffing of the ward. The ward saw an increase in staffing during the pandemic to take account of the number of enhanced observations on the ward, which required additional staff. Additionally, we saw evidence on the use of bank staff and staff overtime to ensure that the ward was staffed appropriately. We were told that there was a nurse staffing programme with Health Education and Improvement Wales (HEIW) that was looking at the need and acuity in the ward and pressures

[9] A mental health tribunal is a specialist tribunal empowered by law to adjudicate disputes about mental health treatment, primarily by conducting independent reviews of patients diagnosed with mental disorders who are detained in psychiatric hospitals, or under outpatient commitment, and who may be subject to involuntary treatment.

in the wards[10].

We were told that new starters, regardless of grades were provided with supervision from the next grade up. The ward manager described how the ward tried to arrange the work of teams and of the patients, in "bubbles", working as a group to provide patient centred care.

Well-being initiatives were described, which included the hospital psychologist providing one to one and group drop in sessions for staff. Additionally, there was a telephone provision for night staff to discuss any concerns. We were told that the hospital also engaged with a company that provided employee benefits including physical, financial, mental health and well-being for staff. This provision was in addition to the occupational health service.

The ward manager described the patient access to wider mental health professionals such as advocacy, social workers and community psychiatric nurses as well as the consultants who worked on the ward. Initially, staff encouraged patients to do this online, but this was now done through face to face meetings.

We were told that staff had access to mandatory training, as well as access to computers, to undertake this training on the ward. There was also protected time for staff to undertake this training. Where staff had an interest in attending or undertaking training outside the mandatory training, such as wound care, they would be booked on these courses. However, we noted some poor compliance in some areas of training, more detail is described in the areas for improvement below.

The ward manager was very positive in describing the support provided by senior management. Senior staff were also seen on the ward regularly and we were told that the senior nurse worked closely with staff on the ward. We were told that there was a rights based approach across the service. Nursing staff also worked towards a code of conduct and duty of care, such as the Nursing and Midwifery Code (NMC)[11] standards and the health board values and standards.

The following areas for improvement were identified:

We were provided with evidence that showed that compliance with mandatory training was low. This was mainly in the face to face training modules. The percentage (%) compliance included; PMVA, the three modules at 10%, 23% and 45% respectively; fire training 10%; basic life support (BLS) 0%; intermediate life support (ILS) eight percent; and COVID risk assessments at 46%. There was evidence of some online training such as dementia awareness and equality at between 80% and 90%. The reasons given were COVID-19 and the inability to have face to face training. The ward manager also stated that a number of staff had issues with using the technology due to limitations in their knowledge and lack of confidence in using computers. The ward manager further said that patient care was the ward focus and training compliance

[10] https://heiw.nhs.wales/programmes/all-wales-nurse-staffing-programme/
[11] https://www.nmc.org.uk/standards/code/

had slipped. We were told that face to face training had now re-started and all staff were booked on PMVA courses with an aim for all staff to have completed this training by October 2021. All relevant staff were also booked on ILS courses and staff would be booked on the BLS course once dates of the training were received.

The health board must ensure that compliance with mandatory training is completed and kept up to date. Additionally, a process needs to be put in place to ensure future compliance with mandatory training.

We were told all incidents were investigated and the results were recorded on Datix, the system used to record incidents. We also saw evidence of the numbers and actions for these incidents. Whilst the ward manager provided a review of the three months incidents for this quality check, there had not been a regular monthly review.

The health board is to ensure that monthly reviews of incidents are carried out on the ward and that these are reported to management for action, where necessary.

The evidence provided, showed that four patients were overdue a Deprivation of Liberty Safeguards (DoLS)[12] review. We were told that DoLS applications within the health board routinely last for 6 months. A renewal has to be completed at least 28 days before it was due to expire. The ward manager stated that this oversight was noted when the information was requested from the health board mental health act team for this quality check. We were told that the necessary applications have since been completed and were now in place. Further, the ward will be provided with a monthly update of the applications that were due to expire in the next month. The ward manager also stated that these dates were diarised and included on the patient status at a glance board[13].

The health board is to provide assurance that regular, timely reviews are carried out of DoLS authorisation and that these authorisations are maintained up to date, in the future. The health board should also consider that there is a process in place to ensure compliance with DoLS authorisations across the health board.

We saw evidence of the weekly section 58[14] audit that was carried out on the ward. However, we were not provided with evidence of any regular audits of the detention paperwork for patients subject to the Mental Health Act, along with an action plan of how any areas identified would be addressed. These audits should be completed by the mental health act administrator who check that all the detention documents are correct and that all patients are legally detained. We were told that there had not been any requirement to carry out this

[12] DoLS are a set of checks that are designed to ensure that a person who is deprived of their liberty is protected, and that this course of action is both appropriate and in the person's best interests.
[13] The Patient Status At A Glance board is a clear and consistent way of displaying patient and staff information within hospital wards.
[14] Section 58 of the mental health act is largely concerned with consent to treatment by patients detained under the act.

action on the ward and that the mental health office kept a database and sent regular updates of when dates were due to expire.

The health board is required to ensure that the relevant area in the health board carry out regular audits of the paperwork relating to the mental health act. The results must then be provide to the ward for them to carry out any actions.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it 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 Quality Check.

As a result of the findings from this quality check, 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.

Improvement plan

Setting: Royal Glamorgan Hospital

Ward: Seren Ward

Date of activity: 20 April 2021

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The health board must ensure that the Recognition, Prevention and Therapeutic Management of Violence and Challenging Behaviour policy document is reviewed and updated as necessary. The health board must further ensure that a process is put in place to ensure all documents are reviewed in a timely manner, before they become overdue for review.	Standard 2.1 Managing Risk and Promoting Health and Safety	• Policy MH031 Therapeutic Management of Violence and Challenging Behaviour will be reviewed, updated where necessary, circulated for consultation and submitted for approval at the next Health Board Clinical Policy Group. • The Health Board is reviewing their processes for management of both Clinical and Non-Clinical Policies. The Clinical Policy Group (CPG), that	Lead Nurse for Mental Health, RTE ILG CTMUHB Clinical Policy Group Chair	30 June 2021 30 June 2021

			oversees the adoption and management of clinical policies, is in the process of being redesigned. This redesign will consider the approach to central control, storage and archive of policies within the Health Board including how it can improve how it proactively identifies and notifies policy authors as and when policies are coming up to their review point.		
2	The health board must ensure that compliance with mandatory training is completed and kept up to date. Additionally, a process needs to be put in place to ensure future compliance with mandatory training.	Standard 7.1 Workforce	• 85% of applicable staff groups will be fully compliant with mandatory training in PMVA, ILS/BLS and Fire training. Progress towards this target and future training compliance rates will be managed using ESR and monitored through line management arrangements. Deviation from the proposed improvement trajectory and failure to maintain the target levels of compliance will be escalated at Clinical Service Group Performance Review meetings. • Mandatory training compliance to be included as a standing agenda item during line management sessions. • Compliance to be reported on and monitored in the Clinical Service	Senior Nurse, Older Persons' Mental Health RTE ILG	10 July 2021

			Group (CSG) Workforce and Organisational Development meeting and ILG Performance Review meeting		
3	The health board is to ensure that monthly reviews of incidents are carried out on the ward and that these are reported to management for action, where necessary.	Standard 3.1 Safe and Clinically Effective Care	• All incidents are subject to daily review by the Ward Manager/Deputy Ward Manager. • A report of incidents, by ward and by type, will be submitted to the Clinical Service group (CSG) Quality Safety, Risk and Experience (QSRE) meeting for scrutiny and assurance. This takes place at a monthly frequency. • The monthly CSG QSRE assurance report will include incidents that have been escalated for action where needed. • Incident trends, themes and exceptions are reported on a quarterly cycle to enable a longitudinal perspective. This will also be to the Clinical Service group (CSG) Quality Safety, Risk and Experience (QSRE) group. (next quarterly report June 2021)	Lead Nurse for Mental Health, RTE ILG	Complete 31 May 2021 31 May 2021 30 June 2021
4	The health board is to provide assurance that regular, timely reviews are carried out of DoLS	Mental Capacity Act 2005 Schedule	• Monthly reports will be sent from the DoLS Team to the ward manager on Seren listing all patients subject to	CTMUHB Head of Safeguarding	31 May 2021

	authorisation and that these authorisations are maintained up to date, in the future. The health board should also consider that there is a process in place to ensure compliance with DoLS authorisations across the health board.	A1 Standard 3.5 Record Keeping	DoLS. • Deputy ward manager (DoLS Champion) will review the expiry dates of DoLS. authorisations on a monthly basis and proactively ensure that authorisations do not lapse. • Patient Safety at a Glance (PSAG) boards/diary will now include DoLS status. • DoLS compliance rates will be included in the monthly CSG QPSE reports.	 Senior Nurse, Older Persons' Mental Health, RTE ILG Senior Nurse, Older Persons' Mental Health, RTE ILG Lead Nurse for Mental Health, RTE ILG	 31 May 2021 31 May 2021 Complete
5	The health board is required to ensure that the relevant area in the health board carry out regular audits of the paperwork relating to the mental health act. The results must then be provided to the ward for them to carry out any actions.	Mental Health Act 1983 Standard 3.5 Record Keeping	• An audit of the statutory documentation for all patients currently detained under the MHA 1983 will be undertaken. The results will be shared with the ward and an action plan developed to address identified areas for improvement. Results will be shared with the ward team. A workstream to develop a rolling programme of MHA audit will be taken forward but completion dates fall over a longer timespan than that of the Quality Check action plan. This will include:	CTMUHB Mental Health Act (MHA) Senior Team	30 June 2021

			➢ spot check audits to ensure continued assurance		30 September 2021
			➢ A dataset of all audit results to enable, ward level audit feedback and performance and quality reporting information for evidence driven improvement interventions		30 September 2021
			➢ Review of current training access and materials		30 September 2021
			➢ Reinstatement of MHA overview training utilizing digital platform MS Teams		30 September 2021
			➢ Redevelopment of MHA SharePoint intranet site to become a hub of all information, training materials and external sign posting.		30 December 2021

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.

Name: Carole Tookey, Rhondda & Taf Ely Integrated Locality Group Nurse Director

Date: 11.05.2021