Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Ty Gwyn Hall

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Ty Gwyn Hall, Abergavenny as part of its programme of assurance work. Ty Gwyn Hall is part of the Elysium Healthcare Group.

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 capture a snapshot of the standards of care within healthcare settings. This quality check focussed on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance. More information on our approach to inspections can be found here.

We spoke to the Hospital Director (Registered Manager) on 12th August 2020 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?

COVID-19 arrangements

During the quality check, we considered how the service has responded to the challenges presented by COVID-19; what changes they have made to ensure they can continue to provide a safe, effective and person centred service. We reviewed key policies, including the use of

personal protective equipment (PPE).

The following positive evidence was received:

We found the service had responded to the challenges presented by COVID-19 in a timely manner. Changes were made in the early stages of the pandemic including designated accommodation for suspect and confirmed COVID-19 cases and a temporary suspension of patients' Section 17[1] leave and visitors to the service.

We found that the service had held discussions about the implications of the pandemic with patients, families and friends, which included regular contact either in person or via email. It was positive to note that emphasis had been placed on tackling the challenges associated with COVID-19 through a collaborative approach with patients and that steps had been taken to help patients understand the changes and effects brought about by COVID-19.

We also found there to be good governance arrangements. A range of daily, weekly and monthly meetings and calls were described to us at both a group (Elysium Healthcare) and local site level, with some of these meetings set-up directly in response to COVID-19. This assured us that management had appropriate oversight of the matters affecting the service.

Other aspects of COVID-19 arrangements can be found within the sections below.

The following areas for improvement were identified:

We reviewed the COVID-19 Management Plan produced by the service and number of other documents and risk assessments. Due to the developing nature of COVID-19, we would recommend that the service takes this opportunity to review its COVID-19 Management Plan in the following ways:

- Ensure the document is reviewed and fully updated in light of the latest government and professional guidelines, including testing for both patients and staff are displaying any symptoms of COVID-19
- Ensure the document is version controlled with a table on the front the document providing a summary of any changes.

[1] 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.

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:

Changes had been made to the environment as a result of COVID-19, which included adapting a 3-bed annex into isolation accommodation for suspect and confirmed COVID-19 cases and using Pentwyn House for patients who were identified by the service as requiring to be shielded.

We were told that all patients, regardless of whether they had received a shielding letter or not, were individually assessed by the on-site clinician at the beginning of the pandemic. We were also told that a dedicated staffing team was rostered on the shielding ward to further minimise the risk of transmission.

We found entrances and exits had been repurposed to ensure an appropriate flow of patients, visitors and staff to the premises, to support personal protective equipment (PPE) and infection prevention and control (IPC) guidelines.

A Welfare Cabin had also been set-up outside the entrance to the service to provide a suitable space for staff to access and store PPE without the need to enter the inside of the hospital. Inside the service, we were informed that signage and posters had been put up to help encourage good IPC standards and social distancing around the setting. We also noted that a recent environment quality audit had been undertaken to help ensure the suitability and safety of the ward environment.

Meal times were split into two sittings to help manage social distancing, with staff and patients eating separately.

Changes were also noted regarding the reduction in the size of all meetings, encouraging staff to work from home wherever possible and the removal of unnecessary office equipment to decrease touch-points.

We found good evidence of engagement and collaboration with patients in helping them adjust to the pandemic, however, we were told that the pandemic and its associated restrictions had contributed to a deep sense of frustration for some patients. As a result, we found this had led to a spike in challenging behaviours and reported incidents on Skirrid View for the months of June and July.

The service provided evidence which demonstrated how they had managed these behaviours. This included a 24 hour on-call system for the Responsible Clinician[2] and the senior management team. We noted the policy whereby any Registered Nurse can implement 1:1 supportive observations following consultation with a clinician and that requests for additional staff can be agreed with the on-call manager.

We noted that all incidents are reported and are reviewed at a local and group (Elysium Healthcare) level. This includes review at daily clinical team briefings where incidents from the previous 24 hours are reviewed. We saw evidence that weekly senior management team (SMT) meetings and monthly Clinical Governance meeting had taken place and that incidents had been reviewed in-depth at these meetings to help identify themes and manage staffing demands.

The service explained that the number of incidents are now reducing as visiting and leave restrictions are cautiously relaxed. We saw evidence of analysis and actions taken in response to incidents. We also reviewed a recent sample of patient observation levels and found there to be a low number of 1:1 observations in line with the analysis provided by the service.

No improvements were identified.

Infection prevention and control

During the quality check, 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.

The following positive evidence was received:

We saw evidence that an infection prevention and control (IPC) audit was last undertaken in January 2020 at a group level by Elysium Healthcare. However, it is advised that a further group level audit is undertaken due to the impact of COVID-19 on IPC practices and requirements.

Despite this, we were assured that a number of additional measures had been undertaken since the start of the pandemic. This included an increase in management oversight meetings and local audits of each ward undertaken by an IPC Lead. It was pleasing to note that the service placed emphasis on spot checks by senior staff to ensure compliance with IPC standards.

The service had increased cleaning throughout the hospital and in addition had established intensive cleaning schedules for rooms involving suspect COVID-19 cases. Access to external cleaning contractors was also available if required.

[2] This is the mental health professional in charge of the care and treatment of patients that are detained under the Mental Health Act.

The service had also placed hand hygiene stations throughout the premises. It was noted that no patients had been risk assessed against having the ability to access alcohol hand gel. We were informed that availability of all types of PPE remains good and that bi-weekly stock takes are undertaken to ensure adequate provisions. The service confirmed that appropriate PPE would be used according to the infection risk (e.g. when caring for a suspect COVID-19 patient).

It was positive to note the service has worked with patients to help them understand new IPC requirements. Individual care management plans had been created along with risk assessment / COVID-19 checklists which are undertaken with each patient by an occupational therapist. These help patients to understand the importance of good hand hygiene, use of masks, and helps them to understand their personal responsibilities to each other.

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 registered manager told us that they are proud of the flexibility demonstrated by staff in responding to the challenges posed by COVID-19. The service described to us how they had undertaken forward planning exercises at the beginning of the pandemic to assess core-staffing numbers required to operate the service safely and effectively.

During the pandemic, we were told that flexibility has been increased through staff working supernumerary[3] and, on occasions, working across roles. We were also told that on-call senior management were willing and able to cover shifts when required.

We reviewed the escalation procedure and were informed that this had been supplemented by a daily report and weekly call to Elysium Healthcare in response to COVID-19, where staffing issues were reviewed.

As part of the T1 check, we also reviewed a recent sample of rotas, allocation sheets and safe

[3] Where a member of staff works in their clinical area but is in addition to the allotted staffing numbers for that shift.

staffing reports. We found that the staffing numbers were appropriate for the number of patients, and that there were adequate procedures in place to resolve any staffing issues.

During the pandemic, the service told us that they have made efforts to keep agency use to a minimum. Where we observed agency use, we were told that efforts were made to retain the same agency staff to decrease the risk of transmission and to ensure familiarity with patients and local procedures. We were also told that the service has a healthy level of bank staff and that efforts are made to limit bank staff working cross-wards.

At the time of the T1 check, there were three Registered Nurse vacancies and we were informed that the recruitment process for these posts had already begun. This will help to provide further resilience to the nurse staffing compliment going forwards.

In support of patients' rights, it was positive to see evidence that patients were engaged at an early stage of the pandemic, for example in the process of moving accommodation, and that individual views and wishes had been taken into account and implemented by the service. The registered manager told us that they placed emphasis on transparent communication with patients as an important step in supporting them to understand the service changes, their personal responsibilities and the 'new normal' outside. In support of this, we saw evidence of Community Meetings and, since the start of the pandemic, meetings with ward representatives to ensure feedback continued to be received and acted upon. The registered manager told us that they operate an open-door policy for patients and their family and friends, and we saw evidence of engagement with families.

Owing to the restrictions imposed on the service by COVID-19, a decision was made to stop visiting from family and professionals during the height of the pandemic. Section 17 and informal leave was also restricted at this time, unless deemed clinically urgent. It was positive to note that we found evidence of early and on-going engagement with patients and their family and friends to help everyone understand the need for these changes.

During this period, patients had and continue to have access to their own mobile devices and tablets. However the service also made tablets available for patients to continue to be able to contact family and friends, as well as professionals and advocacy services.

In light of this, patients were able to continue to have their care needs met, for example by having the ability to attend their Individual Care Review (ICR) meetings electronically.

It was pleasing to note that the service had set-up a tuck shop for patients and had also made fruit and toiletries available on-site in an effort to replicate what patients would ordinarily have access to when shopping in the local area.

We were told that restrictions have been cautiously adjusted by the service in line with relevant public health guidelines. The service told us that S17 leave is now supported where they can be assured that the patient is going to an appropriate household 'bubble'. In support

of this, we saw evidence that the service had implemented an updated leave risk assessment, policy and 'leave contract' for both patients and their families to adhere to before making a decision as to whether leave can be supported.

Visiting to the service had also resumed in a pre-bookable designated meeting space, subject to an appropriate risk assessment. We confirmed that all visitors were expected to wear appropriate PPE and the service confirmed that this was provided without exception.
Advocacy services[4] remained available throughout the pandemic initially via telephone calls and Skype, but an on-site drop-in clinic has now re-commenced to help ensure patients understand their rights under the Act and participate in decisions about their care and treatment.

The following areas for improvement were identified:

We found mandatory training figures to be low in some areas, notably MVA (Management of Violence and Aggression), breakaway and conflict resolution. We also noted that similarly low completion rates were identified for some of these training areas following an NHS review in September 2019.

We acknowledge that COVID-19 has resulting in the service having to pause face-to-face training during the pandemic and that the service has taken steps to instead prioritise additional IPC training.

However, due to the training having previously been identified as requiring attention, the service must ensure that these training areas are now prioritised as restrictions are eased. The service should also to explore any available alternative training methods in the interim.

What next?

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

The improvement plans should:

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

[4] An Independent Mental Health Advocate supports people to understand their rights under the Mental Health Act and participate in decisions about their care and treatment.

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: Ty Gwyn Hall

Date of activity: 12th August 2020

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 service must review its COVID-19 Management Plan in the following ways: • Ensure the document is reviewed and fully updated in light of the latest government and professional guidelines, including testing for both patients and staff who may be suspect COVID-19	s9 Independent Health Care (Wales) Regulations 2011	The Covid-19 Management plan for Ty Gwyn Hall will be reviewed and updated in line with the latest Guidance issued from Public Health Wales and Elysium Healthcare. The Management plan will be further reviewed and where necessary updated on a monthly basis or more frequently should this be required. The Management plan will be reviewed as a standing agenda item within our monthly, local Clinical Governance meeting.	Hospital Director	4th September 2020 4th September 2020 Last Tuesday of each month

	• Ensure the document is version controlled with a table on the front the document providing a summary of any changes.		The Management plan will be version controlled and a table will be included on the front of the document that will include a summary of changes when updates are made.		4th September 2020
2	The service must ensure that training areas, such as MVA, breakaway and conflict resolution, are prioritised as restrictions are eased. The service may wish to explore any available alternative arrangements in the interim.	s20 Independent Health Care (Wales) Regulations 2011	The regional TMVA lead has already scheduled training in for MVA, Breakaway and Conflict Resolution and this will gradually bring compliance in these areas up. The course has been modified in line with current Covid 19 requirements to allow for reduced class sizes and use of PPE. Compliance with TMVA, Breakaway and Conflict Resolution will be monitored at our monthly Clinical Governance meeting.	Hospital Director Hospital Director	TMVA dates: 9-11th September 2020 7 -9th October 2020 4-6th November 2020 2-4th December 2020 Last Tuesday of each month

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: Shaun Cooper – Hospital Director

Date: 27th August 2020