Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

St Teilo House
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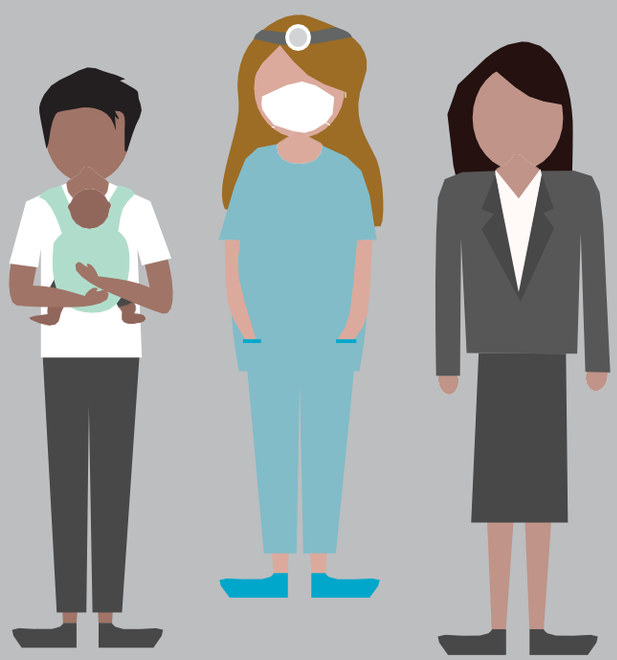

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of St Teilo House as part of its programme of assurance work.

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 Care Standards Act 2000, Independent Health Care (Wales) Regulations 2011 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 Registered Manager on 13 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:

Evidence supplied showed that procedures had been implemented in order to maintain a safe environment throughout the pandemic.

COVID-19 specific risk assessments had been implemented for individual patients. Patients being transferred in and out of the hospital were tested for COVID-19 and no transfers went ahead without a negative result obtained beforehand.

Increased hand hygiene provisions were implemented including training and guidance for the patients, as well as increased training for staff members.

We were told that no confirmed cases of COVID-19 had been reported within the staff or patient group.

The evidence supplied showed increased cleaning schedules had been implemented along with the use of personal protective equipment (PPE). Provisions had been made to maintain adequate stock levels of PPE with regular stock checks taking place.

Updates on COVID-19 were given at the daily meetings. Patients and staff were encouraged to seek support when needed. Patients and staff watched the daily government updates together to look for any changes to be made as a result of COVID 19 and regular communication had been encouraged with staff.

No areas for improvement were identified.

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:

We were told that due to the layout of the ward area, no physical changes to the environment were needed as social distancing could be achieved. Meal times were staggered to maintain social distancing and staff would eat in the board room when the communal area was full.

We were told that cleaning schedules had been amended to enable more frequent cleaning of all patient and staff areas. All rooms on the ward were single rooms with en-suite facilities therefore suitable to provide isolation if the patients test positive for COVID-19.

Patients being transferred in or out of the hospital were not moved until a negative COVID-19 test was obtained.

The registered manager told us patients had been able to access both of the hospitals external garden areas to maintain health and wellbeing. Tablet devices had also been purchased to enable patients to maintain contact with family and friends. Some patients had access to their own mobile phones and this enabled them to maintain contact with family and friends.

We were told that ward rounds and multi-disciplinary meetings involving external professionals had continued. Where face to face meetings had not been possible, telephone and video calls had been used to ensure patients continue to have access to external professional services, including advocacy.

During the initial stages of lockdown, patients' leave was restricted in line with the Government guidelines. As restrictions were reduced, patients leave status had been reviewed and amended to reflect current guidelines. Staff continue to support patients to safely access the community, in line with individual risk assessments and care plans.

We were reassured from the documents submitted, and from discussions with the hospital manager, that any patient or staff diagnosed with an infectious disease would be managed appropriately.

The registered manager informed us that a tuck shop had been set up for patients to order snack foods, toiletries and other supplies. These were put on a weekly groceries order that is delivered to the hospital.

No areas for improvement 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 there were policies and procedures in place for the prevention and control of infection. These had been amended to reflect the management of COVID-19. The policies and procedures were reviewed and updated regularly. Patients and staff were informed of any updates via an online daily communications update and regular meetings.

We were told that stock levels of personal protective equipment was monitored regularly and were maintained to ensure at least 14 days' supply of PPE was available. The registered

manager told us that regular audits were undertaken to assess and manage the risk of infection.

The registered manager told us that training in relation to infection prevention and control and COVID-19 had been provided to staff via an online programme with a completion rate of 81.5%.

There were systems and procedures in place to identify any staff or patient who may be at risk of developing, or display symptoms of COVID-19. Each patient had an individual COVID-19 care plan and risk assessment, in line with government guidelines. Regular health checks were performed on all patients, which includes taking temperature and monitoring of any COVID-19 related symptoms.

We were told that the daily 10 o'clock meetings had gone ahead. During these meetings information and updates were given to the patients in a group environment. A weekly meeting was also held every Friday and People's Council meetings were held every four weeks. This ensured patients were having access to support and the Registered Manager stated that patients were also made aware that they could access support from the staff, whenever necessary.

No areas for improvement 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 informed us they had been in post since 2016 and had a good understanding of their responsibilities including the hospital's escalation and reporting processes. The Registered Manager was supported by the Operations Director and Regional Nurse Director. There is a daily phone call with the Operations Director and Regional Nurse Director. The Registered Manager also had direct access to the Operations Director and Regional Nurse Director, when further support was required.

We were told that during the initial stages of lockdown and throughout the pandemic, only one staff member had to shield due to COVID-19 and there had been no sickness due to COVID-19.

Patient dependency levels were assessed regularly and additional staff brought in to cover increase in demand. The Registered Manager has the autonomy to increase staff numbers when needed, without authority from senior management.

Staff training was ongoing and mostly delivered online. Compliance could therefore be monitored by the Registered Manager. Face to face training had been undertaken where social distancing rules could be adhered to.

The Registered Manager told us that staff support had taken place during the daily meetings and through access to external professionals such as a Mental Health first aider and drop in sessions with the psychology department.

Mental Health Act reviews, and other contact with external professionals, to include advocacy, has continued through phone calls and teleconferencing. Since the lifting of restrictions put in place due to COVID-19, the service was allowing more on site visits to take place, which were conducted outside at present. Similarly, some patients had been able to access the community and visit family members, in line with current guidelines.

We saw evidence that staff appraisals were taking place with a compliance of 60.9%. We have seen that a further 12% were assigned to be completed.

The Registered Manager confirmed that they had not seen a rise in challenging behaviour or restraint. We saw evidence of an up to date restraint policy.

No areas for improvement were identified.

What next?

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

Improvement plan

Setting: St Teilo Hospital

Ward/Department/Service (delete as appropriate): St Teilo Hospital

Date of activity: 13 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	No improvements identified.				

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:

Date: