Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
Gellinudd Recovery Centre
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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Gellinudd Recovery Centre 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 Recovery Centre Manager and Recovery Centre Development Consultant on 11 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 reviewed documents which showed that the service had conducted the necessary risk assessments and had policies and procedures in place to ensure staff have up to date guidance regarding COVID-19 arrangements. We were told that the registered provider has employed a member of staff to coordinate its response to COVID19 based on legislation, regulations and guidelines. We were also told that legal advice is sought where necessary.

We were told that cleaning schedules within the centre had been increased. There is also an increased use of full PPE by staff which is available for staff and patients to use outside the centre. Processes are in place to ensure adequate stocks of PPE are available.
We saw evidence of infection control audits being undertaken, actions taken to address any areas of concern were also recorded.

We were told that patients and guests to the hospital are supported and encouraged to maintain social distancing within the centre. We were also told that changes had been made to both the preparation of meals and eating arrangements to support social distancing measures. Hand sanitiser and wipes are readily available throughout the centre.

Through discussion, we established that patients have been receiving regular COVID-19 updates via daily check-ins with staff, weekly meetings, and during multi-disciplinary team (MDT) meetings. Frequent communication has ensured both staff and patients have up to date advice and guidance.

We were told that the restrictions implemented have had a detrimental effect on patients and their mental health and there has been a marked increase in some patients' psychiatric symptoms. We were told the impact of the changes on patients is continually risk assessed and monitored and that efforts are made to maintain positive relationships between staff and patients.

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 the 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 the service has made changes to the environment as a result of COVID-19. These include changes to assist with social distancing measures throughout the centre. Meetings which take place within the service have been moved to the activity room to ensure that social distancing can be maintained.

We were informed that a designated isolation area has been identified for patients who are required to self-isolate. We were also told that appropriate measures are in place for any patient who falls within the shielding category.

It was explained to us that a staff room, situated outside of the main centre, provides facilities for staff to shower and change at the start and end of their shift. Laundry facilities are also available for staff to wash their uniforms instead of taking them home.

We were told patients have access to outside garden space to maintain their health and well-being and additional activities have been introduced to help keep patients occupied. It was explained to us that patients have been supported to maintain contact with families and friends through telephone calls and the use of tablets and other electronic devices.

Due to lockdown restrictions, we were told patient leave was initially restricted; however three garden areas are available within the grounds which patients could access to allow time away from the ward. As restrictions were lifted, we were told that all family visits took place within the outside garden areas and initially all leave granted was escorted in order to educate, and provide support and guidance to patients.

We were informed that, as restrictions were further eased, patients were granted unescorted leave to visit families at home, in line with the extended household guidance. We were told that the service accessed legal advice to ensure that the patient group did not experience restrictions not felt by wider society. We were told an appropriate approach had been taken to granting patient leave which was risk assessed on an individual patient basis. Where patients had not adhered to the agreed approach, we were told they had to self-isolate on their return to the service until they could be tested for COVID-19.

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 evidence of an infection control policy and other supporting policies and procedures for the prevention and control of infection which included the management of COVID-19.

We also saw evidence of regular audits being undertaken to assess and manage the risk of infection. The most recent audit was undertaken on 23 July 2020.

We were informed that on-line training relating to infection control and COVID-19 has been provided for staff.

In addition, we were told of systems and procedures in place to identify any staff or patient who may be at risk of developing, or display symptoms of COVID-19. This includes all staff and patients having daily temperature checks and staff being required to confirm and record an absence of any COVID 19 symptoms prior to starting their shift. Staff have also been educated to observe for signs and symptoms of COVID-19 in patients.

No areas for improvement were identified.

Governance

As part of this standard, HIW considered how the setting ensures that 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:

Through discussion with the manager it was established that the centre completed a recruitment drive prior to March of this year and were in a positive position in terms of staffing levels. We were told that bank staff are used when required and the service rarely needs to rely on agency staff. This was supported by a review of staff vacancies and absence data. Rotas are drafted in advance to ensure that appropriate levels of skilled staff are on duty and that staffing numbers are appropriate for patient numbers. Patient dependency levels are assessed regularly and additional staff are brought in to cover any increase in demand.

We were told that training in Strategies and Interventions in Management of Aggression (SIMA) had been suspended since lockdown in line with government guidelines due to the need for staff to interact in close proximity during the training. This is under constant review and as soon as guidelines allow, the training will be re-commence.

We were told that staff have access to support via supervision sessions and reflective group sessions that were facilitated by the service's psychotherapist. Additional support was also available, on a 1-2-1 basis both virtually and face to face, from the psychotherapist and other qualified staff. We were told that senior management have been supportive and visible

throughout the pandemic.

Through discussion we were informed that patients have continued to access wider mental health professionals including advocacy services initially through virtual meetings, however, as restrictions ease more face to face meetings are being held.

The following areas for improvement were identified:

Following a discussion with the Recovery Centre Manager and a review of data for mandatory training, we determined that compliance in some areas required improvement. This included fire training which was at 57.69% and automated external defibrillator (AED) training at 53.84%. We recommend a review of all mandatory training compliance figures and action be taken to ensure high compliance rates in all areas.

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.

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

Improvement plan

Setting: Independent Mental Health Hospital

Service: Gellinudd Recovery Centre

Date of activity: 11 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 provide HIW with details of the action it will take to ensure high compliance rates for all mandatory training for staff.	7.1 workforce	Fire training available online as interim measure until face to face can resume. HR dept has emailed links to all staff. CPR training is being sourced. RCM liaising with heartstart and other providers. Safeguarding training- dates available in Sept/ October for staff to attend.	RCM	Fire training; expected 100% compliance 2 weeks CPR: Dec 2020 (depending on COVID) Safeguarding: Nov 2020

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.

Name: J.Wheatley

Date: 07-09-2020