Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Angelton Clinic, Glanrhyd Hospital

Activity date: 3 September 2020

Publication date: 1 October 2020

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In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-80082-269-6

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Angelton Clinic, Glanrhyd Hospital as part of its programme of assurance work.

Angelton Clinic is a 42 bed unit comprising of 3 wards, which provides a service for older people with serious and enduring mental health diagnoses and dementia.

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 Service Manager and three Ward Managers on 3 September 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 were told that all patients admitted to the service undergo a period of isolation until a negative COVID-19 test result is received. The setting highlighted that timely discharge planning had enabled them to designate a dedicated ward environment for this purpose.

The setting told us that they have had no known cases of COVID-19 amongst its patients. However, we were told that a separate ward was available to isolate patients with suspected or positive COVID-19 cases, and that a dedicated ward team had been rostered to work in that area to reduce the risk of transmission.

We were told that multi-disciplinary team (MDT) meetings and ward rounds have continued. However, visiting restrictions have had an impact upon relatives and some patients. In response to this, the setting described a number of initiatives that had been implemented to support patients to stay in contact with their relatives. This included use of tablets and staff taking the time to support patients to use these. Visiting had been allowed is some circumstances, such as end of life care, with full PPE provided.

We saw evidence to confirm that COVID-19 related service updates had been communicated to patients and their relatives through letters and regular phone calls. This included engaging with families to keep them up to date on the condition of their loved ones. This was particularly important due to the deteriorating nature of the clinical conditions affecting many patients within this setting.

We were told that due to COVID-19, some patients had been reluctant to receive community nursing staff in their homes or be admitted to hospital. We were told that the service had taken appropriate steps to manage this in order to reduce the number of patients presenting upon admission with a higher level of deterioration, for example encouraging timely admission when needed.

Staff told us that full PPE was available on all wards and in sufficient quantities. We were told that staff had been face fit tested[1] and that regular training in how to don and doff PPE had been provided in order for staff to know how to safely apply, remove and dispose of PPE.

[1] Fit testing is a means of checking that a respirator face piece matches a person's facial features and seals adequately to their face.

The management spoke highly of all staff, telling us that staff had worked flexibly to ensure that the needs of patients and colleagues had been met throughout the pandemic.

We were provided with examples of initiatives that have been undertaken by staff who have been working non-clinical duties due to COVID-19. This included staff undertaking work to quality assure nursing assessment paperwork and supporting colleagues to stay up-to-date with their training.

We were told of a number of arrangements that have been put in place to support staff. This includes access to occupational health and a number of well-being sessions. We were also told that a well-being debrief session had been arranged specifically for ward management based at the Angleton Clinic to support them in their roles.

Due to the pandemic, a number of the workforce had been redeployed elsewhere within the health board. We were told that this led to unfamiliarity of agency and bank staff amongst patients causing some unsettled behaviours.

We were also told that the setting had provided some capacity as a step-down facility for patients who had been in the Princess of Wales Hospital. However, we noted that on at least one occasion the setting had received a high number of referrals in one day. This had impacted upon the completeness and timeliness of some assessments upon admission.

Despite this, the setting was able to describe the steps they had taken to appropriately manage these situations. This included block booking agency staff to ensure their familiarity with patients and ward procedures, and liaising closely with the discharge team at the Princess of Wales Hospital to ensure the appropriateness of referrals.

As a result of the steps taken by the service, these areas have not been identified as a formal area for improvement, but the health board is advised to be vigilant of these matters in its pandemic planning arrangements.

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 any pressure or tissue damage which has occurred. We also questioned the setting on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

The setting is a purpose built facility with single, en-suite bedrooms for all patients. Each

ward has access to its own garden and outdoor area. There is also access to a communal area for use by patients, visitors and professionals.

We were told that any risks to the environment are addressed immediately or escalated to senior management where necessary. We saw that there was a process in place to report risks and that an expected completion time is provided to the service management. Further details relating to this are referred to in the areas for improvement below.

The setting has a range of audits scheduled throughout the year to support patient safety, which includes audits of pressure and tissue damage. We reviewed a sample of these and found that pressure assessments had been completed daily for all patients.

We were told that falls risk assessments are completed for all patients due to the age and frailty of the patient group. We saw that ward quality audits had been undertaken to ensure that patients have been assessed for their risk of falls. We were told that this was supported by monthly patient falls meetings to review incidents and MDT to review the needs of patients considered to be at a higher risk of falls.

We reviewed one incident related to a serious fall and the service was able to fully describe what actions had been taken into response to the incident, which included environmental improvements and shared learning following the incident.

The setting placed an emphasis on their MDT approach to supporting the needs of patients. This included access to occupational therapy, which aims to provide patients with focused interventions based upon their individual needs, and other professionals, such as activity staff, dieticians, speech and language therapists and dementia care trainers. We saw evidence to reflect that this approach has enabled the service to support patients in a range of ways, such as helping patients and relatives to stay in touch, helping to facilitate safe and effective discharge, and improving meal times for patients with dementia.

The setting also described a number of other holistic activities that have supported patient well-being, particularly during the visiting restrictions imposed by COVID-19, which included gardening and a socially distanced VE Day celebration. We saw evidence of good engagement with third sector organisations in supporting these activities, of which the service were very complimentary.

For patients subject to deprivation of liberty safeguards[2] (DoLS), we were told that DoLS referrals have been undertaken in a timely manner and have remained compliant in terms of undertaking best interests assessments[3] and involving family, where applicable.

[2] The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom

[3] The purpose of a best interests assessment is to decide whether a deprivation of liberty is happening or may happen, and if it is whether this is in the best interests of the person affected.

The following areas for improvement were identified:

We saw evidence to confirm that recent ligature risk assessments had been undertaken on all wards. However, we were told that the identified remedial work is unlikely to be actioned for a significant period of time due to a backlog in the health board estates department.

Whilst the setting told us that there had not been a suicide related incident for a number of years, the health board must ensure that identified risks are remedied in a realistic timescale.

We also found that a number of environmental issues had been identified in other recent audits and had not yet been addressed. The health board must ensure that these actions are also remedied in a realistic timescale.

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 were told that up-to-date information related to infection prevention and control (IPC) is disseminated by the service manager to ward staff. We saw evidence of regular email communications from senior management and that all staff had access to the health board intranet for policies and sources of support.

We saw evidence that a number of recent IPC audits had been undertaken for all wards in the unit, and that these audits were detailed and had clear actions identified for improvement. We were told that the wards have received comprehensive support from the local IPC group who visit the wards on a frequent basis to ensure that IPC standards are being met.

We were also informed that there were no non-COVID-19 related infections within the unit. In the event of an infectious outbreak, all patients have access to single en-suite rooms to enable effective isolation.

The following areas for improvement were identified:

We reviewed two heath board wide IPC related policies[4] and found that these had last been updated in 2015 and 2017 respectively. The health board must ensure that these have been reviewed in light of the pandemic and to take account of any changes to legislation or best practice.

[4] Infectious and Communicable Diseases Procedure for Healthcare Workers; Infection Prevention and Control Strategy

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:

We were told that due to an increase in challenging behaviours, there had been occasions when there had been a significant number of 1:1 patient observations required. We found that suitable arrangements were in place to ensure that this was managed in an appropriate manner, including rostering an additional registered nurse on each shift and a daily clinical review of individual observations levels.

We reviewed a recent sample of rotas, including patient acuity and observation levels. We found that the staffing numbers were appropriate for the number of patients and that ward management were aware of the process to escalate any staffing concerns. However, we noted that there was no formal written escalation policy available for us to review. Further details relating to this are referred to in the areas for improvement below.

Recent sickness rates on the wards appeared to be stable and we were told that staff and ward management have been provided with support by occupational health where required. Similarly, we found there to be a low vacancy rate across the service.

The following areas for improvement were identified:

The health board must ensure that a formal local written escalation policy for resolving any staffing issues is produced and disseminated to all staff.

We were provided with the mandatory training statistics and found mixed levels of compliance in a number of areas, in particular low compliance for IPC. However, we acknowledge that a number of training areas had been affected by COVID-19 due to the lack of face-to-face training options.

We were also told that staff had experienced a number of on-going difficulties in accessing and navigating the electronic staff record (ESR) system in relation to training and staff appraisals.

The health board must review training compliance levels in light of the current pandemic. The health board should also explore any available alternative training methods in the interim, including provision of ESR support for ward management.

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: Glanrhyd Hospital

Service: Angelton Clinic

Date of activity: 3 September 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	We saw evidence to confirm that recent ligature risk assessments had been undertaken on all wards. However, we were told that the identified remedial work is unlikely to be actioned for a significant period of time due to a backlog in the health board estates department. Whilst the setting told us that there had not been a suicide	2.1	Angelton Clinic together with Ward 14 and PICU on the Princess of Wales Hospital Site will undergo ligature upgrade works over the next 6 months. All three wards in Angleton support patients with functional and organic illnesses. The evidence is clear that patients with an	Director of Operations, Bridgend ILG	Completion 01/05/2021

	related incident for a number of years, the health board must ensure that identified risks are remedied in a realistic timescale.		organic illness and cognitive impairment have a very low risk of suicide, but they do have significant dementia-friendly environmental needs. This is a balance that we strive to maintain and keep under review. The usual proportion of patients with a functional illness being admitted is less than 10%. All patients have a comprehensive risk assessment that includes risk of self-harm and suicide, any patient identified as being at risk of self-harm or suicide will be nursed on enhanced observations and have access to therapy staff to help mitigate this risk. Work to upgrade the older adult admissions wards in Angelton Clinic has been prioritised. Following anti-ligature risk assessments one designated male and female bedroom on Ward 2 will be		

			upgraded to reduce ligature risk. Any patient presenting with self-harming risk will be transferred into these rooms. In addition, the Mental Health Lead Nurse for Bridgend ILG has been working to ensure that patient safety risks for the older adult population are mitigated through relational, adequate staffing levels and psychological intervention. The Health Board Mental Health policies in relation to Patient Observation and Risk Management are in the process of being updated, and protocols for ligature risk management are also included in the Health Board plan. All the current outstanding issues are recorded through the Estates Planet system. These include: Roof improvements, replacement door handles, replacement	Nurse Director, Bridgend ILG Health Board Mental Health Head of Nursing Head of Estates,	Completion local Older Adult Mental Health Protocol 30/09/2020 Completion of all Health Board Mental Health policies 01/12/2020 Completion 01/04/2021
	We also found that a number of environmental issues had been identified in other recent audits and had not yet been addressed. The health board must ensure that these actions are also remedied in a realistic timescale.				

			flooring and fire door to Ward 1 Kitchen.	Bridgend ILG	
2	We reviewed two heath board wide IPC related policies[5] and found that these had last been updated in 2015 and 2017 respectively. The health board must ensure that these have been reviewed in light of the pandemic and to take account of any changes to legislation or best practice.	3.1	The Health Board is currently reviewing and updating its IPC strategy. The new IPC strategy will be presented to the next IPC committee meeting in October 2020 for approval, then for sign off. This will be in place across the Health Board by 01/12/2020	Senior Nurse for IPC	Completion 01/12/2020
3	The health board must ensure that a formal local written escalation policy for resolving any staffing issues is produced and disseminated to all staff.	7.1	The Bridgend Mental health Clinical Service Group will produce an escalation policy for resolving any staffing issues and sent to the ILG Director of Nursing for approval The Bridgend Mental Health Clinical Service Group will ensure the policy is shared	Bridgend Mental Health Clinical Service Group Head of Nursing and Service Manager Bridgend Mental Health Clinical Service	Completion 30/09/2020 Completion 31/10/2020

[5] Infectious and Communicable Diseases Procedure for Healthcare Workers; Infection Prevention and Control Strategy

			across the two Mental Health Clinical Service groups in the other localities to ensure shared learning and consistency across Mental Health Services CTM UHB wide	Group Head of Nursing	
4	The health board must review training compliance levels in light of the current pandemic. The health board should also explore any available alternative training methods in the interim, including provision of ESR support for ward management.	7.1	The Health Board recognises that the overall performance in regard to staff completing their mandatory training across many services and at all levels of the organisation has been impacted upon by the COVID pandemic. The position of each clinical and administrative area is now well understood across the health board and through both the new Integrated Locality Group (ILG) operating model and within corporate departments, targeted actions plans to improve such are being re-established. These plans are being monitored through the ILG performance review mechanisms and are being supported by the Workforce &	ILG lead Corporate team managers Director of Workforce & Organisational Development and Director of Operations	Action plans by 31/10/2020 with 80% compliance achieved by 31/03/2021

			Organisational Department Business Partners. All ILGs and Corporate Departments will be targeted with remedial action plans being set by 31/10/2020 with a trajectory of improvement to the 80% levels by 31/03/2021. These will be monitored by the Director of Workforce & Organisational Development and Director of Operations with bi monthly reports through to the Management Board. The Health Board is also exploring alternative means of providing fire training to staff (at least in the short-term while social distancing measures remain in place), and reducing the requirement for face-to-face training, while considering relevant statutory requirement. With regard to Face to Face Infection, Prevention & Control training, we currently run the following courses: Level 1 (all staff) E learning		

			Level 2 (patient facing staff) E Learning Level 3 (clinical managers) Face to Face, which did stop due to Covid19 pandemic however, this face to face training recommenced September 2020. Donning and doffing face to face (supplemented by on line resources) is provided for all staff who are required to wear PPE across the health board.		

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: Ana Llewellyn, Nurse Director – Bridgend ILG

Date: 04 December 2020

(Revised v2 Improvement Plan)