Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Setting Name: Ty Llidiard

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Ty Llidiard, Child and Adolescent Mental Health Inpatient Unit, Princess of Wales Hospital, Bridgend, within Cwm Taf Morgannwg University Health Board, 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 ward manager on 09 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 saw evidence to show that the service has conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands stemming from the COVID-19 pandemic.

We were told that training specific to COVID-19 had been delivered to all staff by the health board.

We were told that no confirmed cases of COVID 19, or any other infectious diseases, have been reported within the patient group.

We were told that cleaning schedules have been increased and the use of personal protective equipment (PPE) has been optimised with adequate stocks sourced at the outset.

We saw evidence to show that infection control audits have been completed on a regular basis and any areas of concern highlighted have been addressed.

We were told that patients and staff have been receiving regular COVID-19 updates during daily meetings. Regular communication has ensured everyone has up to date advice and guidance on COVID-19.

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 care and treatment according to their needs.

The following positive evidence was received:

We were told that changes have been made to the environment as a result of COVID-19. These include the setting aside the extra care ward where patients could be isolated should they test positive for COVID-19. Cleaning schedules have been amended to enable more frequent cleaning of all patient and staff areas.

We were told that additional activities have been provided to keep patients occupied. Tablet devices have also been purchased to enable patients to maintain contact with family and friends. Some patients have access to their own mobile phones and this has enabled

them to have contact with family and friends.

We were told that multi-disciplinary team meetings involving external professionals have continued and that all reviews scheduled under the Mental Health Act 1983, have been undertaken within prescribed time frames. Face to face meetings have not been possible therefore telephone and video calls have been used to ensure patients continue to have access to external professional services, including advocacy.

We were told that patients' leave had been restricted initially. However, as restrictions reduced, all patients' leave status was reviewed and amended to reflect the changes in government guidelines. Staff have continued to support all patients to safely access the community throughout the period, in line with individual risk assessments and care and treatment plans.

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

We saw records of incident reviews and use of restraint for the months of June, July and August 2020. Records reflect the nature of the incidents and actions taken. We were told by the ward manager that the number of incidents and the use of restraint had reduced slightly during the pandemic, and that this was mainly due to a more static patient group who were less exposed to influences outside of Ty Llidiard, as a consequence of a reduction in home leave.

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 to show that there are policies and procedures in place for the prevention and control of infection. These have been amended to reflect the management of COVID-19. The policies and procedures are reviewed and updated regularly. We were told that patients and staff are informed of any updates.

Regular audits are undertaken to assess and manage the risk of infection. We were told that the most recent infection control audit was undertaken on 02 September 2020, and that the report was not yet available.

We were told that training relating to infection control and COVID-19 has been provided to staff by the health board.

We were told that there are systems and procedures in place to identify any staff or patient who may be at risk of developing, or display symptoms of COVID-19. We were told that risk assessments have been completed for all staff and, depending on the risk level, the organisation will determine whether or not the staff member needs to isolate.

No areas for improvement were identified.

N.B Since we undertook our quality check, we were informed by the health board of a serious incident that occurred within the unit, two days following our remote quality check. We were informed that a young patient had absconded from the unit. We sought assurance from the health board that any immediate risks to patient safety relating to door security had been addressed. This assurance was received. A Child Practice Review is to independently investigate this incident, we await the outcome of the review and will continue to monitor the service.

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 ward manager told us that they are well supported by their line manager.

We were told that the emphasis had been on supporting patients in the community where possible in order to reduce admissions. Patients were supported on a remote basis by staff based at Ty Llidiard, before being transferred into the care of the community Child and Adolescent Mental Health Service (CAMHS) team.

We were told by the ward manager that staff sickness levels had been comparatively low over the past three months. This was reflected in the supporting documentation provided. We were also told that all current staff vacancies had been filled and the ward manager was awaiting confirmation of start dates for the new staff. Most of the nursing posts had been filled through promotion of existing staff. This ensures familiarity with the service and

continuity of care. Use of agency staff has been minimal, with ward staff working overtime to cover any shortfall. The ward manager assured us that arrangements were in place to monitor and support staff in order to ensure that they do not become tired and over worked.

We were told that patient dependency levels is assessed regularly and additional staff brought in to cover any increase in demand. Although the service can accommodate up to 15 patients, current occupancy levels were said to be limited to nine. This is mainly due to the dependency needs of the patients currently accommodated and the additional pressures on staff in continuing to support up to five patients on home leave.

We were told that staff training is on-going with use of in-house facilities and e-learning. We were told that staff support and supervision takes place both informally, on a day to day basis, and more formally through the annual appraisal process. Staff support includes case supervision where staff are able to discuss matters relating to the individual patients that they support.

We were told that Mental Health Act reviews, and other contact with external professionals, to include advocacy, has continued through phone calls and video conferencing. The service has been responsive to the lifting of restrictions put in place due to COVID-19 through reviewing risk assessments, and allowing more on site visits to take place, making use of the family flat, which undergoes a deep clean after each visit. Similarly, some patients have been supported at home and consequently have been able to access the community and visit family members, in line with current guidelines. We were told that additional safeguards have been set in place to monitor who the patients come into contact with in order to support the government's track and trace process.

The following areas for improvement were identified:

We were told that there were some issues with availability of the community based CAMHS due, in the main, to staff re-deployment and changes to working practices which prevented patients from moving on. We were told that this was not confined to Cwm Taf Morgannwg University Health Board alone, and that other health boards who place young people at Ty Llidiard were experiencing similar problems. The health board must ensure the availability of adequate community based Child and Adolescence Mental Health Services in order to facilitate timely discharge from inpatient services and to ensure that patients' changing care and support needs are appropriately met.

We were also told that there was an increase in admissions of patients with learning disabilities due to closure of specialist services such as schools. These admissions are not reflective of the Ty Llidiard service specifications and have caused additional issues in respect of some patients, particularly in relation to behavioural management. The health board must ensure that admissions into Ty Llidiard are reflective of the unit's service specifications.

We were told that some elements of mandatory training had lapsed during the pandemic due to the unavailability of suitable training sessions. This was reflected in the training matrix provided. The health board must ensure that all staff have completed training in all mandatory subjects.

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:

Ty Llidiard, Child and Adolescence Mental Health Inpatient Unit

Date of activity: 09 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	The health board must ensure the availability of adequate community based Child and Adolescence Mental Health Services in order to facilitate timely discharge from inpatient services and to ensure that patients' changing care and support needs are appropriately met.	5.1 Timely Access	Within CTM staff have been redeployed to the Community Intensive Treatment Team (CiTT) to ensure that any vacancies / sickness are covered and to maintain capacity. The position will be continually monitored to ensure that the team is functioning to avoid inpatient admission and support discharge. This will form part of the agenda for discussion at the weekly CAMHS COVID meeting	Deputy Head of Nursing	Complete

			so that any concerns regarding capacity can be escalated and acted on. Note: This improvement is relevant to Health Boards across South Wales and so to ensure that this is also acted on across South Wales, this has been discussed to commissioners for escalation to Health Boards	Director of Nursing Bridgend ILG	Complete
2	The health board must ensure that admissions into Ty Llidiard are reflective of the unit's service specifications.	5.1 Timely Access	Admissions are accepted following tier 4 assessment e.g. a review by nursing and medic staff from Ty Llidiard. A message will be sent to the Medical and Nursing Leads on the unit advising that the admission criteria within the commissioner Service Policy must be adhered to or, if an admission is felt to be necessary outside this, escalated to the Senior Management Team for approval.	Clinical Service Group Manager	24.09.2020
3	The health board must ensure that all staff have completed training in all mandatory subjects.	7.1 Workforce	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	ILG Lead Corporate Team Manager Director of Workforce &	Action plans by 31 October 2020 with 80% compliance

			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 action 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 and Organisational Department Business Partners. All ILG and Corporate Departments will be targeted with remedial action plans being set by 31 October 2020. With a trajectory of improvement to the 80% levels by 31 March 2021. These will be monitored by the Director of Workforce and 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	Organisational Development and Director of Operations	achieved by 31 March 2021

			place and reducing the requirement for face to face training while considering relevant statutory requirement. With regard to face to face infection, prevention and control training we currently run the following courses Level 1 – (all staff) ELearning Level 2 – (patient facing staff) E learning Level 3 – (clinical managers) Face to Face, which did stop due to Covid 19 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: Chris Coslett

Date: 24.09.2020